Preventing Youth Suicide through Gatekeeper Training

A Resource Book for Gatekeepers

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1998
7th edition 2004

Introduction to This Gatekeeper Resource Book

The purpose of this book is two-fold. First and foremost, it is to be used as an integral part of an interactive youth suicide prevention gatekeeper training. Second, since it contains more information than can possibly be covered in a one-day training, it is designed to serve as a resource book for trained gatekeepers. This is neither a comprehensive book on suicide nor a treatment manual. It is not intended to be a stand-alone suicide prevention effort. It provides basic information about suicide prevention, offers guidelines for crisis intervention, builds support for survivors of suicide, and provides valuable resource information. The Maine Youth Suicide Prevention Program is a program of the Maine Children's Cabinet.

The development and production of this resource book is supported by Grant #1 MCH-234003-01 from the Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, and the Maine Department of Human Services, Bureau of Health with funds from Appropriation Account #015-10A-2106-012.

To learn more about Maine's Youth Suicide Prevention Program, call:

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Credit and citation information may be found in the appendices. We recommend this material, as well as those resources noted in the appendices be consulted for further information.

For materials and resources on youth suicide prevention, call the Office of Substance Abuse Information and Resource Center -- 1-800-499-0027.

Maine's Statewide Crisis Hotline: 1-888-568-1112

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APPENDICES

AGENDA – Full Day

Maine Youth Suicide Prevention Gatekeeper Training

(Times Frames & Content may vary depending on needs of participants)

Check-in

Pre-Test

- **Welcome & Introductions & Expectations**
- **The Nature of the Problem of Suicide-What the Statistics Tell Us**
- **Myths & Facts / Beliefs & Attitudes**

Break

- **Risk & Protective Factors, Warning Signs & Clues**
- **Responding to Suicidal Behavior**
- **How to Estimate the Risk of Suicide**

Lunch Break

- **Practice Suicide Intervention Skills**
- **Working w/ Parents& Guardians Through a Child's Suicidal Crisis**

Break

- **Managing the Aftermath**
  The Aftermath of Suicidal Behavior & Suicide in Schools
  Suicide "Survivors" and Suicide Bereavement
- **The Importance of Self-Care**
- **Closing Activities**
  Questions and Answers
  Post Test & Process Evaluation
  Credits*, Certificates, Adjournment

* Contact Hours are available from the University of Southern Maine, the American Nurses Association of Maine, and Maine Emergency Medical Services.

Maine Youth Suicide Prevention

Education, Resources and Support–It's Up to All of Us.

Fact Sheet on Youth Suicide in Maine

Youth Suicide:

- Suicide is the 2nd leading cause of death in Maine for youth aged 15 – 24.
- The suicide rate among Maine youth age 10 to 24 was higher than national youth suicide rates for 7 out of 10 years from 1991 - 2000.
- There is an average of 24 suicides annually among 15 – 24 year olds, and 1 to 4 suicides each year among youth under age 15.
- From 1991 to 2000, five Maine males completed suicide for every one Maine female for ages 10 to 24.
- The rate of firearm suicides is a significant factor in Maine's elevated youth suicide rate. Fifty percent, or 5 of 10, youth suicides are committed with a firearm. The rate of suicide by firearm among Maine youth is slightly higher than the national average.
- Males are more likely to use a firearm than females in Maine. During the same ten years, 62% of males, age 10 to 24, used a firearm, whereas 50% of females used a firearm.

Attempts:

- During the four years from 1998 to 2001, 1,068 youth between 10 to 24 years old were admitted to a hospital for self-inflicted injuries for a rate of 83.75 per 100,000. This is an average of 267 hospitalizations a year. Of these hospitalizations, the majority were as a result of intentional poisonings (an average of 214 cases per year, rate 67.2 per 100,000).
- During two years from 1999 to 2000, there were 1,245 EMS ambulance visits involving suicidal youth, or about 623 runs per year. Thirty percent of all EMS responses for concern of suicide were for this age group, which makes up only 22% of the population.
- In the 2001 Youth Risk Behavior Survey, 19% of Maine high school students reported seriously considering suicide while 9% reported having made at least one attempt in the last 12 months. Five percent reported that they sustained an injury, poison or overdose that required medical treatment by a doctor or nurse.

Data from the Maine Office of Data, Research, and Vital Statistics, Maine Hospital Discharge Database, Emergency Medical Services records, and Maine YRBS. Updated 7-03

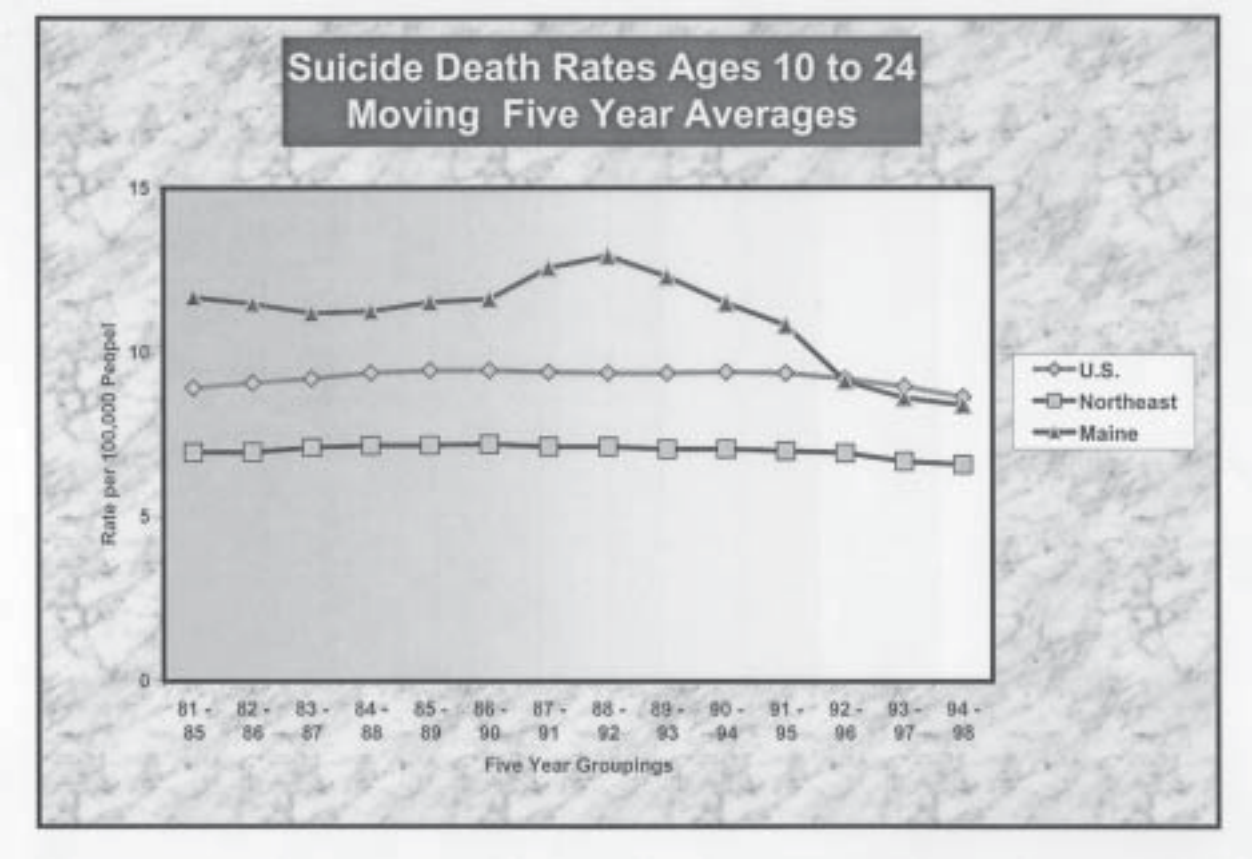
Distributed by the Maine Youth Suicide Prevention Program, 287-8900, or 1-800-499-0027

Understanding the Use of Data When Small Numbers are Involved

It is necessary to be very cautious in referring to and using annual mortality (death) rates when the numbers are small. The National Center for Health Statistics qualifies their reports by noting that rates based on fewer than 20 deaths are not considered reliable.

Rates based on small numbers are subject to chance variations. That is, large swings in rates can occur with a difference of one or two deaths.

Due to the small number of Maine youth suicide deaths each year, rates are calculated in five year groupings to give a more accurate picture of trends. Expanding the period of time studied makes the data more reliable.



State of Maine's Youth Suicide Prevention Efforts

The Maine Children's Cabinet has made youth suicide prevention a priority and is committed to addressing the serious, multi-dimensional issue of youth suicide. Several strategies have been integrated into the comprehensive Maine Youth Suicide Prevention Program (MYSPP). The goal of these combined strategies is to reduce the number of attempted and completed youth suicides and to address some of the situations which lead young people to suicide. Statewide efforts are designed to:

- Increase public awareness about how to help prevent youth suicide
- Reach groups of youth known to be generally at high risk with prevention education and intervention information
- Support youths known to be at high risk for self-destructive behaviors with skill building and supportive services to improve individual and/or family functioning
- Encourage and support existing prevention efforts which promote positive youth development
- Develop and/or continue evaluation and surveillance strategies on all program efforts

Statewide activities include:

- Statewide Crisis Hotline (1-888-568-1112)
- Statewide Information and Resource Center (1-800-499-0027)
- Dissemination of print materials and public service announcements
- Youth Suicide Prevention Gatekeeper Training (full-day)
- Suicide Prevention Awareness Sessions (1-2 hour workshops, seminars, conference presentations)
- "Training of Trainers" to present Suicide Prevention Awareness Sessions
- Training for Health Teachers on how to provide School-based Suicide Awareness Education for youth
- Training facilitators to provide skill building groups for youth
- Education on the importance of restricting lethal means to vulnerable youth
- Technical assistance to develop local youth suicide prevention activities
- Data collection, analysis, and dissemination

Rationale for Gatekeeper Training

Unless involved in the mental health field, few people have in-depth knowledge about suicide. Nevertheless, suicide touches most people's lives. It is an emotionally charged topic with a long history clouded by myths and misconceptions. The misinformation perpetuates the personal and social elements related to suicide including denial, shame, stigma, fear, and guilt. Recent years have brought a marked increase in research, knowledge, clinical services, and public awareness about the topic of suicide. Gatekeeper training is designed to provide participants with:

- Increased general knowledge about the nature of suicidal behavior
- Personal confidence and specific skills to recognize, respond appropriately, and refer a suicidal person for help
- Knowledge about how to interact with and assist family and friends in the aftermath of a suicidal event

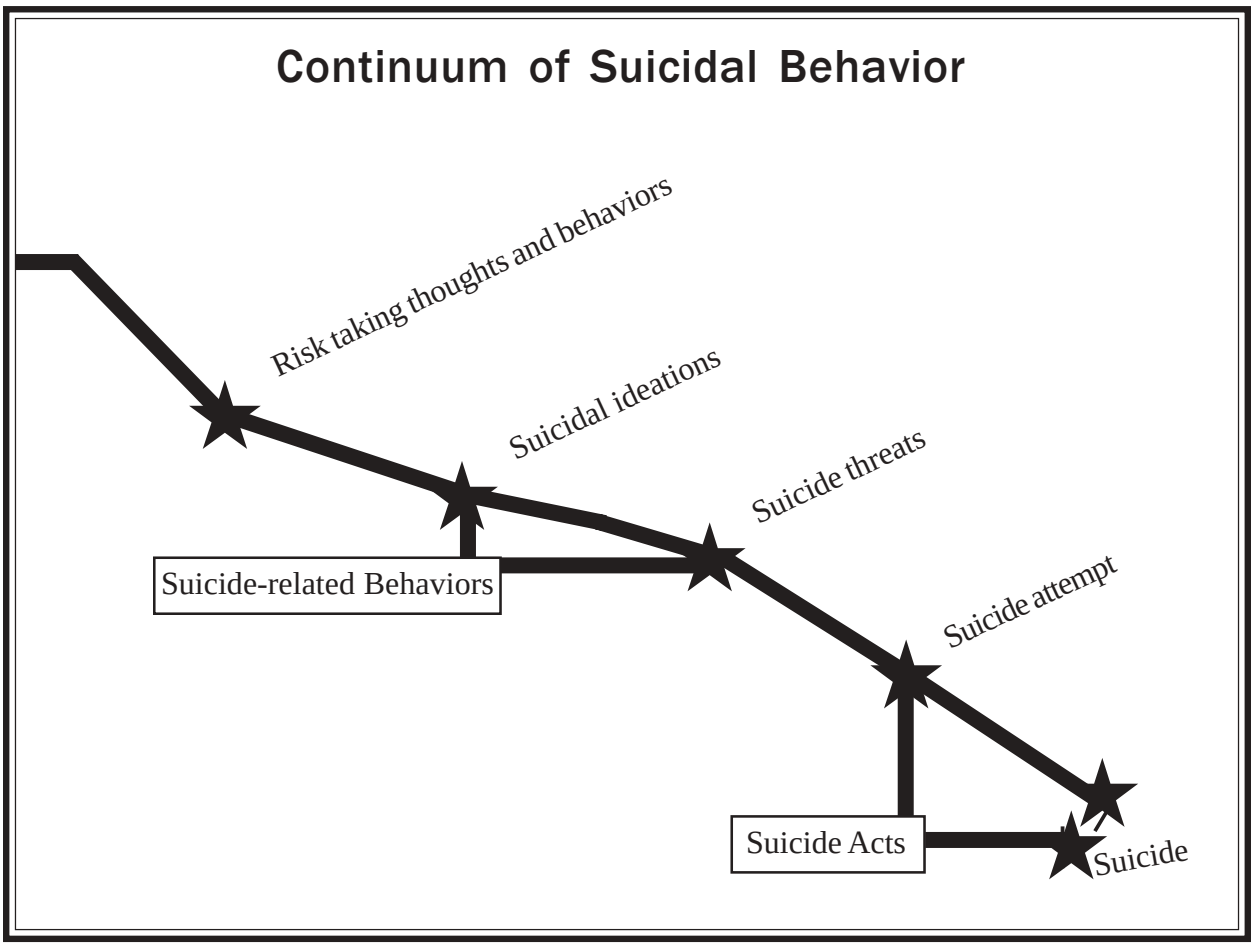
Gatekeeper is a term used to define the role of people who know basic suicide prevention and intervention steps. Gatekeepers are individuals who by the nature of their job, their special interest in people, or in their personal relationships and friendships are in a position to observe high-risk behaviors and take action when necessary. The term "gatekeeping" describes the protective functions the gatekeeper uses in the process of using his or her critical skills in recognizing, responding to, and helping suicidal persons get the help they need.

Gatekeeper Training is the process by which individuals acquire basic suicide prevention and intervention skills. This training focuses on the prevention of youth suicide, but most of the information transfers to suicidal people of any age. The skills and concepts taught in this workshop are easy to learn. While this particular program has been developed for adults, it incorporates some teaching methods appropriate to use with youth by an individual experienced in facilitating youth groups.

Participants are not expected to be an "expert" at the conclusion of the program, nor will they be expected to present themselves as one. The information is not intended in any way to train gatekeepers to replace counseling or mental health services. It is intended to offer hope through positive action in the event of a suicidal crisis.

Language Describing Suicidal Behaviors

The language of suicide is expressed differently by various generations, genders, and ethnicities. In this manual, suicide-related behaviors include any potentially self-injurious behavior for which there is evidence the person intended at some level to kill him- or herself or wished to convey the appearance of intending suicide for some other reason, such as punishing others or receiving attention. It is important to understand that the behaviors appear on a continuum. The behaviors are listed below to reflect increased intensity of suicidal behavior as it moves from risky behavior to a suicide death.



Risk-taking Thoughts and Behaviors
While not necessarily suicide-related, these are ideas and actions for which there is a high likelihood of injury or death, such as engaging in reckless sports, undertaking dangerous activities, consuming large amounts of alcohol, drinking and driving, autoeroticism.

Suicidal Ideation
Any self-reported thoughts or fantasies about engaging in suicide-related behavior. Example: A young person's English class journal entry describes intense feelings of sadness and thoughts of suicide, death, or "ending it all."

Suicidal Threat
Any interpersonal action, verbal or non-verbal, indicating a self-destructive desire, but stopping short of a directly self-harmful act, that a reasonable person would interpret as a suicide-related communication or behavior. Example: A young man threatens to kill himself if his girlfriend breaks up with him.

Suicidal Act or Suicidal Gesture
A potentially self-injurious behavior or act symbolic of suicide, but not a serious threat to life. The act may accidentally result in death, injuries, or no injuries. The individual may report wanting "to see what would happen."

Suicide Attempt
A non-fatal outcome for which there is evidence (either explicit or implicit) that the person believed at some level that the act would cause death. A suicide attempt may or may not cause injuries. Attempted suicides include acts by persons whose determination to die is thwarted because they are discovered and resuscitated effectively, or the chosen method was not lethal. The individual, frequently, reports that the intention was to die. DO NOT refer to a non-fatal suicide attempt as a "failed attempt."

Suicide or "died by suicide" or "died of suicide"
Someone takes his or her own life with conscious intent by lethal means from, for example, use of firearms, injury, poisoning or suffocation. "Committed suicide" implies some level of criminality and "completed suicide" implies earlier attempts when there may have been none. Both terms (committed and completed) perpetuate the stigma associated with suicide. The use of the word "successful" to describe suicide is discouraged, instead say "died by suicide" or "died of suicide." Sensitive use of suicide related language is appreciated.

Sub-intentional Death
Covert or subconscious act of placing self in very vulnerable position, such as victim precipitated homicide, wandering out into oncoming traffic, or jumping out of a moving vehicle.

Suicide Pact
Joint suicides of two or more individuals (close friends, lovers, etc.) which are the result of an agreed upon plan to complete a self-destructive act together, or separately but closely timed. Suicide pacts are a very real part of suicidology and historically have been represented in fiction as well as fact.

Contagion or "Copy-Cat" Suicide
A process by which exposure to suicide or suicidal behavior of one or more persons influences others to attempt or commit suicide. Non-fictional media coverage of suicide has been associated with a statistically significant excess of suicide, which appears to be strongest among adolescents. Several well-publicized "suicide clusters" have occurred. Citizen/community education is vitally important to reduce this risk.

Murder-Suicide
Not to be confused with a suicide pact, this is an event in which one individual murders one or more people and then takes their own life by suicide. The murder victims may be family members, friends, acquaintances, or strangers.

Suicide by Cop
Also referred to as "police assisted suicide" or "victim precipitated homicide," this is another phrase that can mean very different things, depending on how it is used. Sometimes desperate people put themselves in very dangerous positions. Their intent is to die, but rather than kill themselves, they display threatening behaviors to which a policeman will respond and likely kill them. Another scenario, fortunately quite rare, is when a policeman who wants to end his/her life decides to set up colleagues on the job to "take them out." More frequently cops who commit suicide do so in ways to spare their colleagues, and do so with a degree of dignity. All of these behaviors are very difficult for police professionals.

Suicide Survivor(s)
This term is used in two ways. One way is to describe someone who actually attempts and then survives a suicide attempt. The second use describes family members and close friends of a person who has actually died by suicide. If confused, be sure to clarify the use of the term.

Self-Harm
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 cuts across the boundaries of race, gender, education, sexual preference, and socioeconomic bracket. While difficult to distinguish from a suicide attempt, it is important to understand that the person who engages in this behavior does not intend to die as a result of their actions. They use this behavior to get relief from intense emotions, to calm and soothe themselves. 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.

Twilight Language

"Twilight language" concerns, from psychology, the hidden significance of dates and other signs, from religious studies, the hidden symbolism that lies in stories and texts, and from criminology, the profiling insights that have revealed the ritualistic nature of certain crimes and violent incidents.

Other

Facts You Need to Know About Suicide

Misinformation about suicide stands in the way of providing assistance to those in danger. To be an effective gatekeeper, it is important to dispel the "myths" of suicide with some basic facts about suicide and suicidal people. Knowledge about suicide gives us the confidence to recognize suicidal behavior and intervene in constructive, responsible ways.

The facts listed below are not prioritized in any way. They are all important. The numbers are only for ease in reference.

Fact #1

Talking about suicide or asking someone if they feel suicidal will not put the idea in their head or cause a person to kill themselves.

Most people thinking about suicide want very much to talk about how they are feeling and are relieved when someone else recognizes their pain. To avoid the subject of suicide can be deadly. Once you ask someone about suicide and they respond "yes," you must be prepared to stay calm, take the time to listen, persuade them to get help, and help them identify resources.

Fact #2

Few attempted or completed suicides happen without some warning.

The survivors of a suicide often say that the intention was hidden from them. It is more likely that the intention was not recognized. Research has demonstrated that in over 80% of completed suicides, a warning sign or signs were given.

Fact #3

There are no special/certain types of people who commit suicide.

Suicidal behavior cuts across all socioeconomic boundaries. People of all ages, races, faiths, and cultures die by suicide, as do individuals from all walks of life, all income levels. Popular, well-connected people who seem to have everything going for them as well as those who are "down and out" die by suicide. Suicidal youth come from all kinds of families--rich and poor, happy and sad, two-parent and single-parent. Most who die suffer from serious mental illness;

many of whom have not been diagnosed; some have no diagnosable mental illness. We have to pay serious attention to all suicidal talk and behavior.

Fact #4 Suicidal young people can help themselves.

When contemplating suicide, young people develop a distorted perception of their actual life situation and what solutions are appropriate for them to take. However, with support and constructive assistance from caring and informed people around them, young people can gain the life skills necessary to manage their lives. They do not want to die, they want their pain to go away.

Fact #5 Suicide "secrets" and/or "notes" must be shared.

Where the potential for harm, or actual harm, is disclosed then confidentiality cannot be maintained. A sealed note with the request for the note not to be opened is a very strong indicator that something is seriously amiss. A sealed note can be a late sign in the progression towards suicide. Never promise to keep a friend's suicidal thoughts a secret.

Fact #6 Depression, anxiety, mood disorders, substance abuse, and conduct disorders are the most common factors found in suicidal youth. Some, however, have no diagnosable underlying illness.

While mood disorders, conduct disorders, and substance abuse are the most common co-morbid factors, they may or may not be present when a person attempts or dies by suicide. Suicide comes from having more pain than is manageable. In fact, some people who are suicidal appear to be happier than they have been in a long time because they believe they have found a "solution" to all of their problems. Also, extremely depressed people often do not have the energy to kill themselves. Suicidal behavior is very complicated and to a large degree remains a mystery.

Alcohol/drugs and suicide often go hand in hand. Alcohol and other forms of substance abuse cloud judgment and even people who don't normally drink will often do so shortly before killing themselves. Alcohol is a factor in at least a fourth of youth suicides.

Fact #7 Suicide is preventable.

It is simply not true that "once suicidal, always suicidal." Young people can gain the life skills, wisdom, and maturity necessary to manage their lives. Most people who are considering suicide will be suicidal for a relatively short period of time. Most young people are suicidal only once in their lives. Given proper assistance and support, there is a strong possibility that there will not be another suicidal crisis. The more effort that is made to help an adolescent identify stressors and develop problem-solving skills during the post-suicidal crisis period, and the more time that passes, the better the prognosis.

Fact #8 Youth most commonly share their thoughts, problems, and feelings with other youth.

Evidence shows that suicidal youth are far more likely to confide their suicidal thoughts and plans with peers rather than adults. Some adolescents 'ask' for help through non-verbal gestures rather than express their situation verbally to others.

While it is common for young people to be defensive and resist help at first, these behaviors are often barriers imposed to test how much people care and are prepared to help. For most adolescents considering suicide, it is a relief to have someone genuinely care about them and to be able to share the emotional burden of their plight with another person. When questioned some time later, the vast majority express gratitude for the intervention.

Fact #9 Suicide is not painless ... not an "easy way out."

Many suicide methods are very painful. Fictional portrayals of suicide do not usually include the reality of the pain. The pain to the suicide victim, of course, extends to the survivors of the victim, too.

Fact #10 Most suicidal youth are not mentally ill.

Although suicidal adolescents are likely to be extremely unhappy and may be classified as having a mood disorder, such as depression, most do not have a diagnosed mental illness. However, there are small numbers of individuals whose mental state meets psychiatric criteria for mental illness and who need psychiatric help.

Fact #11 People who show marked and sudden improvement after a suicide attempt or depressive period may be in great danger.

The three months following a suicide attempt are critical, especially if the person shows sudden improvement. The apparent lifting of the problems could mean the person has made a firm decision to kill himself and feels better because of this. The initial support and attention may be waning, and life is returning to "normal." The person may be facing the same problems and may have the energy to plan the next attempt. It is a very dangerous time.

Fact # 12 People who talk about suicide may very well attempt or complete suicide.

Talking about suicide makes people uncomfortable. Talking about suicide can be a plea for help and it can be a late sign in the progression towards a suicide attempt. Seven of every ten suicide attempts or completions are preceeded by talk of suicide. All talk of suicide must be taken seriously. Those who are most at risk may also show other signs apart from talking about suicide. It is crucial to remove lethal means from the environment of someone who is talking about suicide.

Fact #13 Suicide is not inherited.

Although suicide can be over-represented in families, there is no "suicide" gene. Members of families share the same emotional environment and the completed suicide of one family member may well raise the awareness of suicide as an option for other family members. Suicide is seen as one model for "coping" in some families and, therefore, its continued expression in certain families should be taken very seriously as a "risk factor."

Fact #14 Suicidal behavior is not just a way to get attention.

All suicide threats and attempts must be treated as though the person has the intent to die. Do not dismiss a suicide threat or attempt as simply being an attention-gaining device. It is likely that the young person has tried to gain attention and, therefore, this attention is needed. The attention that they get may well save their lives.

Fact #15

There is strong evidence that sexual minority youths are more likely than their peers to think about and attempt suicide.

Risk due to discrimination, victimization, or identity confusion because of sexual orientation, as with race and ethnicity, are important factors to consider in youth suicide prevention. Research studies vary greatly in their estimates of gay, lesbian, bi-sexual, transgender, and questioning (GLBTQ) youths who die by suicide. Recent analyses of research indicate that even though adolescents who report same-sex romantic attractions or relationships are at more than two times the risk for suicide attempts, the overwhelming majority report no suicidality at all. Further research needs to be done on the risk factors as well as the unique strengths that characterize the lives of sexual minority adolescents.

Fact #16

Any concerned, caring friend can be a "gatekeeper" and may very well make the difference between life and death.

All people who interact with suicidal adolescents can help them by way of providing emotional support, encouragement, information, and resources. Psychotherapeutic interventions also rely heavily on family and friends providing a network of support.

Fact #17

Not every death is preventable.

No matter how well intentioned, alert, and diligent people's efforts may be, it is impossible to prevent all suicides. Human nature is difficult to predict. It is important to realize that we will not be able to save everyone. It is important to understand that the only person responsible for the suicide is the person who decides to kill himself or herself. It is equally important to be sensitive to the fact that some people make very impulsive decisions, leaving no time for intervention.

Youth Suicidal Thoughts and Feelings: Understanding Risk & Protective Factors Recognizing Warning Signs and Clues

What We Know

- There is no typical suicide victim.
- There are no absolute reasons for suicide.
- There are no all-inclusive predictive lists of warning signs.
- Suicide is always multi-dimensional.
- Preventing suicide must involve many approaches.
- Most people do not want to die.
- Ambivalence exists until the moment of death.

And

- If you reduce the risk factors, you reduce the risk of suicide.
- If you enhance the protective factors, you reduce the risk of suicide.

From a Suicidal Person's Point of View:

- **A suicidal person's life is in crisis.** A crisis is *any* situation that calls for a response that is difficult to figure out. Crises are *normal* and they may cause anxiety which produces extreme thinking, "either/or" thinking, tunnel thinking, hopeless-helpless feelings. We all need *experience* in handling crises.
- **A suicidal person sees suicide as the solution to his/her problems,** one way to escape from painful and overwhelming circumstances. Understanding this perspective helps Gatekeepers to support the individual in efforts to define the problem/issues and other alternative solutions.
- **Suicidal thinking is irrational.** Suicidal people do not have to be insane or crazy, but their thinking may very well be irrational. They are not thinking about the consequences of their actions. They aren't focused on the impact their actions may have on themselves or their families. Their thinking becomes very narrow as they think about their pain and problems with tunnel vision, and while their decision to end their life makes rational sense to them, it makes no sense to their loved ones.

- **Almost all suicidal people are ambivalent.** They wish to live AND they wish to die. We MUST support the side that wants to live but we must NOT discount the side that wants to die. Letting them talk openly about both wishes lowers the anxiety. Listening and caring save lives.
- **Suicide is an act of communication.** Normal communication has broken down and this person is sending a desperate message in reaction to overwhelming circumstances of one kind or another. Gatekeepers may be able to help open up and/or clarify communication between the person and others.

A Word About Very Young Children

Suicide is a rare event in children under ten years old, but they are fully capable of understanding the concept and completing the act. Suicides occurring among very young children are often masked as "accidents," such as the child riding a tricycle or bicycle out in traffic or accidentally "hanging." Generally speaking, when a very young child exhibits suicidal behavior, it is related to external stressors, such as rejection, loss, family deterioration, neglect, and abuse. As the child ages, there is a switch to more internally related stressors such as guilt, aggression, low self-esteem, sense of failure, rage, or hopelessness. See "Additional Materials" section for more on young children.

Signs of Suicide Come in Several Forms

To recognize a suicide crisis you must have knowledge of the potential risk factors, the warning signs, and other clues. Suicide literature provides several different lists of warning signs and clues, risk and protective factors. The average gatekeeper cannot be expected to memorize these lists. However, it is important to be able to recognize the signs of a potential suicidal crisis and understand how quickly a young person can develop suicidal thoughts and feelings.

Given that adolescence is a time of great change and mood swings, viewing a young person who may be at risk for suicide from many perspectives is important. Avoid giving any one sign too much significance. Look for the number of signs, the pattern (several related signs), the duration (two weeks or more of a given pattern), and the intensity of a particular crisis event. Pay special attention to any signal that suggests despair, isolation, depression, distress, and hopelessness. Take the perspective of the person who may be suicidal, and pay attention to your "gut" feelings. It is the combination of feelings and events that may be lethal.

If the thought that someone might be suicidal has crossed your mind, chances are high that it has already crossed their mind.

Risk Factors and Warning Signs

Risk factors are stressful events, situations, and/or conditions that may increase one's likelihood of attempting or dying by suicide. A risk factor is a characteristic that presents itself in statistically significant numbers in a large sample of individuals who have died by suicide. Risk factors do not predict imminent danger of suicide for a particular person. They serve as an indication that an individual *may be* at higher risk. Knowledge of risk factors may suggest a line of questioning and remind us to routinely consider the risk of suicide in our work with individuals. Not all risk factors carry equal weight. Some are more critical than others. For example, multiple previous attempts raise the risk more than a single previous attempt. Other critical factors include having a detailed suicide plan. That is to say, the more resolved and less fearful of suicide a person is, the greater the risk.

Risk Predictors are characteristics of a specific individual that indicate the likelihood of imminent suicide for that person. There is no research to date that shows that a particular set of risk factors can accurately predict the likelihood of imminent danger of suicide for a specific individual. The nature of suicide includes situational, psychological, and biological factors. There is no "typical" suicidal person because each one has varying degrees of external stressors, internal conflict, and neurobiological dysfunction contributing to their suicidal ideation. Suicidal behavior is the most complicated of human behaviors.

Warning signs are changes in a person's behaviors, feelings, and beliefs about oneself for a period of two weeks or longer which are considered to be maladaptive or out-of-character for the individual. Remember to notice or try to discover the pattern, the duration, the intensity, the possible presence of a crisis event, and how the behavior compares to what would be considered normal for this individual. Please note that the warning signs for suicide are very similar to the signs of depression.

It may be helpful to think of the path to attempted or completed suicide as a journey. It is a journey that begins with an idea and ends with an act. Anyone thinking about suicide has to come up with a plan of how, when, and where they will end their life. Young people sometimes behave impulsively and act in just a matter of hours. Some youth suicides follow a conflict or fight, while others follow days, weeks, or months of thinking about self-destruction. The two-week time frame mentioned above represents an average crisis period. It is important to consider the personality of the individual involved and pay attention immediately if you think the situation warrants it.

Other kinds of warning signs and clues: To further complicate the picture, it is important to understand that it is possible for an adolescent to become suicidal without exhibiting any behavior that we ordinarily think of as "depressed" or "suicidal." Some are very clever at "masking" depression by disguising it with impulsive, reckless, and aggressive behavior. They produce a certain excitement by living on the edge. This serves to hide their pain from the world. Parents may react to this kind of behavior with anger and frustration and often find themselves unwilling or unable to help.

Remember, many of us truly believe that people who talk about suicide don't actually do it. The fact is, most people do verbally communicate their intent during the few days prior to their attempt. Perhaps they are checking to see if anybody out there is listening! Sometimes the verbal clues are very direct and sometimes they are coded clues. Examples of what might be said are included in a list on page 26.

When multiple factors overlap in such a way that the pain becomes overwhelming, the idea of suicide as a solution to human suffering may be considered. Youth suicide attempt data collected in Oregon from 1990 to 1993 listed the most commonly reported reasons for the attempt as family discord (59.4%), argument with boyfriend or girlfriend (32.6%), and school related problems (23%.) Other reasons included sexual abuse, physical abuse, or substance abuse.

When family and friends try to understand why a young person attempted or completed suicide, it is common to find that different people held different pieces of the puzzle. It is likely that no one person had enough knowledge about the number of risk factors, was aware of enough warning signs, or had recognized enough clues or observed enough behaviors to be absolutely sure that suicide was a real possibility for a particular individual. That is why we all need to be educated and be willing to talk more openly when something "in our gut" raises a red flag or when we recognize the clues. We need to know what to do, what to say, and how to access, obtain, or arrange for appropriate professional help.

In Summary

It is the combination of risk factors, warning signs, and other kinds of clues that may be lethal. A young person in crisis is unlikely to self-refer to a mental health professional or even pick up a telephone and call a crisis hotline. Intervention is unlikely unless someone recognizes the crisis, responds appropriately, persuades the individual to get help, and helps with the referral process. Preventing suicide is everyone's business.

Protective Factors

Protective Factors are the positive conditions, personal and social resources that promote resiliency and reduce the potential for youth suicide as well as other related high-risk behaviors. Just as suicide risks rise from an interaction between familial, genetic, and environmental factors, so do protective factors. They help keep risk factors from becoming overwhelming.

Internal/Personal Protective Factors

- Dominant attitudes, values, and norms prohibiting suicide, including strong beliefs about the meaning and value of life
- Life skills (i.e., decision-making, problem-solving, anger management, conflict management, and social skills)
- Good health, access to health care
- Best friends, supportive significant others
- Religious/spiritual beliefs
- A healthy fear of risky behavior, pain
- Hope for the future
- Sobriety
- Medical compliance
- Good impulse control
- Strong sense of self-worth
- A sense of personal control

External/Environmental Protective Factors

- Strong interpersonal bonds, particularly with family members and other caring adults
- Opportunities to participate in and contribute to school and/or community projects/activities
- A reasonably safe, stable environment
- Difficult access to lethal means
- Responsibilities/duties to others
- Pets

The Profile of a High Risk Youth

Risk factors *most strongly* associated with suicidal behavior:

- One or more prior suicide attempt(s) (the strongest predictor of suicide)
- Depression lasting longer than two weeks; anxiety
- Suicidal ideation and threats of suicide; homicidal ideation
- Exposure to suicide or suicide of a family member or friend
- One or more very stressful events, transitions or losses
- Detailed plan for a suicide attempt (e.g., when, where, how)
- Access to lethal means, especially a firearm

Warning signs associated with *increased suicide potential*:

- School performance problems; academic set backs; learning disability; likelihood of dropping out of school
- Serious family fights and conflict, outrageous, abusive, or unpredictable behavior by parents
- Alcohol or other drug use and abuse
- Isolation, alienation from family, peers (homeless, runaways)
- A conduct disorder -- always pushing to the edge and beyond
- Getting in trouble with the law

Precipitating Factors often *immediately and directly associated* with youth suicide include:

1. **Opportunity** such as access to a gun or other lethal means (especially dangerous for a vulnerable youth), inadequate supervision
2. **An altered or unbearable state of mind** such as hopelessness, shame, despair, rage, intoxication, intense self-criticism or perfectionism
3. **Very stressful life event(s)** recently experienced such as:
    - Interpersonal problems (family, boy/girlfriend); taunting or humiliation from peers
    - Intrapersonal issues (sexuality, morality, etc.)
    - Loss or death of friend/family member, or loss of an important relationship (boyfriend/girlfriend)
    - Loss of self-esteem or negative anticipated outcomes; actual, perceived, or anticipated humiliation, reprimand, parental disappointment or disapproval
    - Disciplinary crisis, loss of freedom (incarceration)
    - Anniversary of someone else's suicide
    - Pregnancy, fear of pregnancy
    - Physical or sexual abuse

Risk Factors

The following lists are representative of information found in suicide literature. While no list is all inclusive, those included below serve to summarize an enormous amount of information.

The Four Most Common Factors in Youth Suicide*

- Depression, mood disorder, anxiety
- Conduct disorder
- Alcohol and other drug use
- Isolation

*These do not cause suicide, but when many factors are present, these will make a difference.

Family Risk Factors

- ☐ Family history of suicide (especially a parent)
- ☐ Changes in family structure through death, divorce, re-marriage, etc.
- ☐ Family involvement in alcoholism
- ☐ Lack of strong bonding/attachment within the family, withdrawal of support
- ☐ Unrealistic parental expectations
- ☐ Violent, destructive parent-child interactions
- ☐ Inconsistent, unpredictable parental behavior
- ☐ Depressed, suicidal parents
- ☐ Physical, emotional, or sexual abuse

Behavioral Risk Factors

- ☐ One or more prior suicide attempt(s)
- ☐ Alcohol/drug abuse
- ☐ Aggression/rage/defiance
- ☐ Running away
- ☐ School failure, truancy
- ☐ Fascination with death, violence, satanism
- ☐ A detailed plan for how, when, where
- ☐ Kids not telling adults about friends who may be suicidal

Environmental Risk Factors

- ☐ Access to lethal means
- ☐ Frequent mobility
- ☐ Religious conflicts
- ☐ Social isolation/alienation or turmoil
- ☐ Exposure to suicide of a peer
- ☐ Anniversary of someone else's suicide
- ☐ Incarceration/loss of freedom
- ☐ High levels of stress; pressure to succeed
- ☐ Over-exposure to violence in mass media

Personal Risk Factors

- ☐ Mental illness/psychiatric condition
- ☐ Depression/anxiety
- ☐ Poor impulse control
- ☐ Confusion/conflict about sexual identity
- ☐ Loss of significant relationships
- ☐ Compulsive, extreme perfectionism
- ☐ Lack skills to manage decision-making, conflict, anger, problem solving, etc.
- ☐ Loss (or perceived loss) of identity, status
- ☐ Feeling powerless, hopeless, helpless
- ☐ Victim of sexual abuse
- ☐ Pregnancy or fear of pregnancy
- ☐ Fear of humiliation

Maine's Statewide Crisis Hotline -- 1-888-568-1112

Suicide Warning Signs and Clues

Early Warning Signs for Suicide/Classic Signs of Depression

- ☐ Difficulties in school
- ☐ Feeling sad, angry
- ☐ Drug / Alcohol abuse
- ☐ Sleep disturbances (too much, too little)
- ☐ Eating disturbances (weight gain or loss)
- ☐ Disinterest in usual activities
- ☐ Restless, agitated, anxious
- ☐ Feeling like a failure / worthless
- ☐ Hopeless, helpless, hapless
- ☐ Pessimistic
- ☐ "Roller Coaster" moodiness-more often & for longer periods than ususal
- ☐ Overly self-critical
- ☐ Persistent physical complaints
- ☐ Difficulty in concentration
- ☐ Preoccupation with death (often through music, poetry, videos)

Late Warning Signs

- ☐ Talk of suicide, death
- ☐ Neglect of appearance, hygiene
- ☐ Dropping out of activities
- ☐ Isolating self from friends, family
- ☐ Feeling life is meaningless
- ☐ Hopelessness, helplessness increases
- ☐ Refuses help, feels beyond help
- ☐ Puts life in order-may make a will
- ☐ Picks a fight, argues
- ☐ Gives away favorite possessions
- ☐ Verbal clues (see below)
- ☐ Sudden improvement in mood, behavior after being down or withdrawn*

**It is important to note that most suicidal people, no matter what their age, suffer from some degree of depression. In young people the depression often goes undiagnosed until a crisis occurs. Depression may leave a person feeling drained, "too tired" to carry out a suicide plan of action. When the depression begins to lift and you notice a sudden improvement, be warned that this could be a very dangerous time. Three months following a period of depression is a critical time of suicidal risk. The person has the energy to act, and may even appear cheerful and at peace with the world.*

Direct Verbal Clues

- I wish I were dead.
- I'm going to end it all.
- I've decided to kill myself.
- I believe in suicide.
- If such and such doesn't happen, I'll kill myself.

Less Direct Verbal Clues

- You will be better off without me.
- I'm so tired of it all.
- What's the point of living?
- Here, take this. I won't be needing it anymore.
- Pretty soon you won't have to worry about me.
- Goodbye. We all have to say goodbye.
- How do you become an organ donor?
- Who cares if I'm dead, anyway?

Maine's Statewide Crisis Hotline -- 1-888-568-1112

Common Themes, Depression Causes, and Death Conceptions

Motives for Youth Suicide

- To seek help
- To escape from an impossible situation
- To get relief from a terrible state of mind
- To try to influence some particular person
- To show how much they loved someone
- To make things easier for others
- To make people sorry
- To frighten someone or to get their own way
- To make people understand how desperate they were feeling
- To find out whether they are really loved
- To do something in an unbearable situation
- Loss of control
- Desire to die

Source: Shamoo, Tonia K., and Patros, Philip G. *Helping Your Child Cope with Depression and Suicidal Thoughts*. New York: Lexington Books, 1990.

Causes of Depression in Adolescence

- Maturational crisis
- Chemical imbalances
- Intensified introspection
- Imaginary audience watching one's every move
- Intensified sexuality
- Development of abstract thinking, ideals
- Family dysfunction
- Poor family communication
- Intense period of loss

Source: Adapted from *SOS Runaways and Teen Suicides: Coded Cries for Help*. Human Services Development Institute, Center for Research and Advanced Study, University of Southern Maine.

Common Notions of Adolescent Death

- Revenge
- Romance/admiration
- A test of immortality
- To end pain and make lives better
- Ultimate power trip

Source: Adapted from *SOS Runaways and Teen Suicides: Coded Cries for Help*. Human Services Development Institute, Center for Research and Advanced Study, University of Southern Maine.

Commonalities of Suicide

- Common purpose -- to seek a solution
- Common goal -- to stop the pain
- Common stimulus -- unbearable psychological pain
- Common stressor -- frustrated psychological needs
- Common emotion -- hopelessness/ helplessness
- Common internal attitude -- ambivalence
- Common cognitive state -- world is closing in
- Common action -- to escape
- Common interpersonal act -- communication of intention
- Common consistency -- life-long coping patterns

Source: Adapted from United Way of Connecticut/Infoline.

Masked Signs of Depression Include:

- Hostile, uncommunicative, rebellious behavior
- Running away from home
- Sexual promiscuity
- Truancy, delinquent or antisocial behavior
- Accident prone or reckless behavior
- Obsessive/compulsive behavior
- Temper tantrums
- Boredom, restlessness
- Somatic complaints

Source: Adapted from *SOS Runaways and Teen Suicides: Coded Cries for Help.* Human Services Development Institute, Center for Research and Advanced Study, University of Southern Maine.

(Student Handout taken from Lifelines Lessons)

Warning Signs

Warning signs can be organized around the word **FACT:**

Feelings:

- ❑ Hopelessness- "Things will never get any better." "There's nothing anyone can do." "I'll always feel this way."
- ❑ Fear of losing control, going crazy, harming self or others.
- ❑ Helpless, worthless, "Nobody cares about me." "Everyone would be better off without me."
- ❑ Overwhelming guilt, shame, and self-hatred.
- ❑ Pervasive sadness.
- ❑ Persistent anxiety or anger.

Action or Events:

- ❑ Drug or alcohol abuse.
- ❑ Themes of death or destruction in talk or written materials.
- ❑ Nightmares.
- ❑ Recent loss-through death, divorce, separation, broken relationship, loss of job, money, status, self-esteem.
- ❑ Loss of religious faith.
- ❑ Agitation, restlessness.
- ❑ Aggression, recklessness.

Change:

- ❑ Personality-more withdrawn, tired, apathetic, indecisive or more boisterous, talkative, outgoing.
- ❑ Behavior-can't concentrate on school, work, routine tasks.
- ❑ Sleep pattern-over sleeping or insomnia, sometimes with early waking.
- ❑ Eating habits-loss of appetite and weight or overeating.
- ❑ Loss of interest in friends, hobbies, personal grooming, or other activities previously enjoyed.
- ❑ Sudden improvement after a period of being down or withdrawn.
- ❑ Getting into trouble at school, or with the law.

Threats:

- ❑ Statements, e.g., "How long does it take to bleed to death?"
- ❑ Threats, e.g. " I won't be around much longer."
- ❑ Plans, e.g., putting affairs in order, giving away favorite things, studying drug effects, obtaining a weapon.
- ❑ Gestures or attempts, e.g., overdose, wrist cutting.

Of course, aside from the obvious gestures or threats, none of these signs is a definite indication that the person is going to commit suicide. Many people are depressed and never end their lives. Many experience losses or evidence changes in behavior or demeanor with no indication of suicide. However, if a number of these signs occur, they may be important clues.

Responses to Suicidal Behavior

Suicide is an Impulsive Act That Does Not Occur Spontaneously

It is important to remember that suicide is not usually considered a spontaneous act. That is, people do not suddenly decide to end their lives. They first find themselves in increasingly difficult circumstances, lacking adequate coping skills to deal with their problems. If someone does not intervene, eventually they are unable to cope and may see suicide as an option for solving their problems. Once the idea has been considered, they have to plan the time, place, and means to complete the act. The process may take ten minutes, two weeks, or a lifetime, but typically it takes a matter of days, weeks, or months. While some young people behave very impulsively and move quickly towards suicide, the average crisis period usually lasts about two weeks. Often there is time to intervene. The Gatekeeper's role is to intervene as early as possible.

As you begin your intervention, keep in mind the goals that you need to achieve and what you need to do. Safety is a primary concern, of the youth, for yourself.

The Gatekeeper must be able to:

- **Talk about suicide.** Talk in a direct, clear calm manner.
- **Ask about suicide.** Ask as directly as you can. Gather information.
- **Listen.** Listening shows you care. Listening saves lives.
- **Keep Safe.** Ask about and remove lethal means if possible.
- **Get Help.** Identify and access helpful resources.

Gatekeepers must not:

- **Judge, lecture, get angry**
- **Ignore or minimize the suicidal behavior**
- **Try to solve all the problems**
- **Promise secrecy**
- **Get over-involved or over-react**
- **Make promises that can't be kept**
- **Leave the suicidal person alone**

Initial Response to Suicidal Individuals

This reviews the appropriate initial response to someone who is either openly threatening or talking about suicide, or who is showing warnings signs, or is known to have risk factors, or to have experienced precipitating events. The most basic goal here is to engage the person and to assess the likelihood that they will try to harm or kill themselves. This risk may range from the fact that they are thinking a lot about it and need to talk with someone, or they seem to be resolved to try suicide or are unable to control the impulse to harm or kill themselves and need to be transported to a crisis center or hospital. These encounters all start in one of two ways: *the suicidal person* brings up suicide or *you* bring it up in response to the distress/warning signs that you are seeing, or because a third party has brought the individual to your attention.

They Bring Up Suicide: Direct Statements or Threats (if someone is talking directly about suicide)

- **Stay calm**: (at least outwardly) look at them directly and speak in a calm but clear and concerned tone.
- **Do not leave the person alone**, even to go to the bathroom. Let them know that you are not going anywhere.
- **Buy time**: encourage the person to talk and let him/her know you are hearing him/her. It almost doesn't matter what you talk about, because the more the two of you talk, the harder it is for them to maintain the energy necessary to take action.
- **Acknowledge** what you are hearing and convey that you are taking it seriously. Acknowledgement always precedes alternatives, directives:
  "I'm hearing that this feels hopeless to you and I'm thinking that there may be a way to deal with this that we haven't thought of yet."
  "I can see that you are very upset and I need for you to put the gun down so we can talk."
- **Listen** to what the person is saying and let him/her know that you are hearing him/her by reflecting back what you are hearing.
  "It sounds like you are having some very rough times and you don't see any way to deal with this."
- **Convey** that you hear that they see suicide as an only option and let them know that you believe that with help other possible options can be discovered.
  "I hear that you are thinking of (planning to) kill (or harm) yourself. Something must have gotten you very upset to reach this point. I'm concerned and I would like to help you find another way of handling this" or "I want to help you get to someone who can help you."

- **Ask for** any pills: **be directive** (ask that weapons should be put out of reach or with someone else).
  "Let me take those pills for now."
- **Note the time** any pills were taken so you can provide this information to the person(s) you may be handing off to.

You Bring Up Suicide: Responding to Warning Signs or a Referral

- **Review** your evidence--what is happening, what is the person doing that causes your concern?
  "Tom, I understand (or, other people have noticed) that since you didn't get your promotion, you haven't been going out with your friends, you haven't been eating much, and you've been drinking a lot more."
- **Inquire** about feelings or state what you have seen or heard:
  "It would be normal to be upset about the promotion--it seems as if you have been taking it pretty hard, is that right?"
- If you get denial, **persist**:
  "Well, you really have been down (or acting differently)--again, that's understandable, but I wonder (or I'm concerned about) how bad this has been for you."
- Use the "**sometimes**" approach:
  "Tom, sometimes when people feel as bad as you do they have thoughts of harming or killing themselves."
- **Ask directly**:
  "Have you had thoughts of harming or killing yourself?"
  "Are you thinking about suicide?"
- **Offer help**:
  "I'd like to try to help you come up with ways of handling this without hurting yourself."
- If you get **denial** and do not feel convinced, let them know:
  "Tom, you say you haven't thought about killing yourself, but I'm still concerned."

To Increase Safety:

- Don't leave the person alone or send the person away.
- Don't over-react--don't be shocked by anything s(he) says. You need to show your care, concern, and willingness to listen nonjudgmentally.
- Don't rush--remember, you are trying to establish contact and begin the process of resolving the crisis.

- Don't minimize the person's concerns--e.g., *"This is not worth killing yourself over."* Remember to acknowledge: *"I see this is very upsetting to you and I want to help you."*
- Don't discount or make light of the suicidal threat: e.g., *"You don't really want to kill yourself."*
- Don't argue whether suicide is right or wrong.
- Don't preach or moralize--e.g., *"You have everything to live for."* The issue is the problem or bind the person feels s(he) is in, not life and death per se.
- Don't challenge or get into a power struggle. You will do everything you can to get help right now, but ultimately s(he) has control over his/her decision.
- Don't think the person just needs reassurance. Take immediate steps that show you will be helpful.
- Don't promise to keep the conversation confidential. There is no confidentiality in life-threatening situations.

- **Do remember** that all persons who are at risk for suicide need help. It is always better to over-react (in terms of taking action) than to fail to take action. It is better to have someone angry with you or embarrassed than dead.
- **Do take care of yourself** by asking for a debriefing session. Professionals always do.

Used with permission from John Kalafat, Ph.D.

Three Steps to a Basic Suicide Intervention

1. Show You Care

- Take all talk of suicide seriously.
- Do whatever you can to create privacy.
- Be absolutely attentive, listen very carefully and reflect what you hear.
- Use language appropriate for the age of the person involved.
- Do not worry about doing/saying exactly the "right" thing…your genuine interest is what is most important.

2. Ask About Suicide

- Talking eases stress and tension and often allows the crisis to slow down.
- If you are even remotely wondering if you should ask about suicide, ASK.
- Stay calm, caring and non-judgmental.
- Ask as directly and clearly as possible (sample questions below):
  - ➤ *"Are you thinking about killing yourself?"*
  - ➤ *"Are you thinking about suicide?"*
  - ➤ *"You seem very unhappy, are you wishing you were dead?"*
  - ➤ *"Has the idea of suicide been on your mind?"*
  - ➤ *"Tell me what you have been thinking…"(and depending upon your comfort level and experience, ask how, when, where, who else knows about this…)*
- Remember, if the answer to your question about suicide is "yes," you do not have to solve all of his/her problems, but you must get help.

3. Get Help

- Reassure the person that help is available and that you will help them get help.
- Follow the protocols at your school or agency for getting help, calling parents or guardians, crisis providers or other appropriate resources.
- Encourage the suicidal person to identify helpful resources.
- Make arrangements for the helper(s) to come to you OR take the person directly to the source of help.
- Set up or provide referral resources as necessary for parents or guardians.
- Outline a plan for safety (see p. 36) and plan specifically for follow-up.
- Stay with the person until the immediate crisis has passed.

The Three Basic Steps to a Suicide Intervention*

1. **Show You Care – Listen Carefully – Be Genuine**
   "I'm concerned about you…about how you are feeling."

2. **Ask About Suicide – Be Direct, but Non-Confrontational**
   "Are you thinking about suicide?"

3. **Get Help – Do Not Leave the Person Alone**
   "You are not alone. I will help you."

* This three-step suicide intervention model is used with the permission of the Youth Suicide Prevention Program, Seattle, Washington. The Maine Youth Suicide Prevention Program is most appreciative.

Participant Notes:

The S.L.A.P. Scale

Having a suicide plan is a major indicator of the seriousness of suicidal ideas. A well-developed plan can be measured by the following factors, referred to as the S.L.A.P. Scale. This is not a foolproof risk assessment, but it can be a helpful tool for individuals who need to gather information from a potentially suicidal person. This tool is passed along, not so you will become a clinical expert in assessment, but merely to be used to assist you in organizing how you ask about and hear the plan. When you refer for more intensive help, this kind of information is very valuable to a crisis worker.

S = How SPECIFIC are the Details of the Plan?

- The greater the specificity, the higher the risk.
- Adolescents may, however, be impulsive and act without a plan.

L = How LETHAL is the Intended Method?

- The more lethal, the higher the risk.
- How reversible are the means?
- How intent is the adolescent on dying?
- Adolescents who have difficulty with the concept of the finality of death may use a more lethal means than they intend.

A = What is the AVAILABILITY of the Proposed Method?

- The more available the means, the higher the risk.

P = What is the PROXIMITY to Helping Resources?

- The greater the distance from rescue, the higher the risk.
- Proximity is measured in physical, geographical, and emotional terms.

Source: Developed by Dr. Marvin Miller (1986)

Safety Plans/Contracts for Safety

A contract, a promise, a "plan for safety" (verbal or written) all describe an agreement between yourself and a youth whom you feel is at risk for suicide, but not acutely suicidal. It is meant for low risk situations. While it is highly unlikely to cause any harm, it provides absolutely no guarantees. If the "helper" or clinician has the sense that creating a safety plan is the only intervention they need to do, it may even increase the risk. The young person may make a suicidal attempt whether or not they form such an alliance. However, planning for safety does allow you to:

- gain some sense of their impulse control and the seriousness of their suicidal ideation
- demonstrate that you care about them and are willing to work with them, listen to them, and help identify resources
- work with the youth to think through what to do and who to turn to when they feel suicidal
- clarify any steps taken to get help from others

Examples of Low Risk Situations
(Appropriate for a "Plan for Safety"or Contract)

- A youth who has had occasional thoughts of suicide, but none currently
- A youth who has several risk factors and feels under stress, but denies feeling suicidal

Examples of High Risk Situations
(Too risky to trust a Contract or "Plan for Safety")

- A youth who frequently thinks of suicide and has a detailed plan for how, when, and where, etc.
- A youth who has suicidal urges, appears agitated even though they deny having a plan to kill themselves
- A youth who reports suicidal thoughts and doesn't feel able to control the urge to kill himself/herself

Please Note:
Some people believe that contracting or planning for safety is a key step in suicide prevention. Others feel it has little, if any value. Some people believe that you need to have an already established trusting relationship in order for a contract or plan to mean anything, while others have found that it works well as a simple way of expressing care and concern even in the absence of a long term trusted relationship. You will have to make your own judgment about taking this step. You must consider the policies and procedures outlined by your school or

agency. It is always a good idea to document verbal and written conversations about the plan for safety, whether the youth agrees to it or not. Document and pass on to your supervisor all signed and verbal agreements and a summary of your interaction with the youth. If there are any questions at a later date, your memory is not to be trusted. Remember, there are no guarantees.

Factors That Increase the Likelihood That a Safety Plan or Contract will be Rendered Useless:

- Anything you plan with someone you don't know well.
- Any time the plan or contact is the only intervention.
- Any plan or contract that is limited to directives/promises to refrain from a particular behavior.
- Any time a person's ability to care for self depends upon unreliable others.
- May be of limited value with children especially if they are immature, impulsive, agitated, or anxious.
- Any time the person is using and/or abusing substances.

Factors That Contribute to a Potentially Useful Safety Plan or Contract:

- An existing friendship or trusting relationship with the individual.
- A prior history of a working relationship in which you have been helpful and directive.
- Specific, doable directives toward positive action that the individual has helped to construct and is capable of doing. Structure reduces anxiety.
- Confirmation that others involved in the plan are, in fact, available, informed of the situation, and willing to help.
- Follow-through and follow-up as promised!
- A promise or "agreement" not to die may appeal to the person's code of honor.

Supporting Parents Through Their Child's Suicidal Crisis

Family Support is Critical

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

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

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

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

Common Parental Reactions to Hearing that their Child is Suicidal

- Acute personal shock and distress
- Totally paralyzed by anxiety
- Very confused, puzzled, or in denial
- Embarrassed
- Blamed, stigmatized
- Angry, belligerent, threatening

Concerns of the Helper/Professional

- Safety of the youth
- Professional responsibilities
- Gaining cooperation from parent(s)

Concerns of the Parent

- Maintain some equilibrium
- The safety of the youth
- What to do; Where to turn for help

Parents May Need Support to:

- Overcome their emotional reactions
- Accept the seriousness of the situation
- Recognize their key role in helping their child
- Recognize the importance of finding (professional) help
- Understand the importance of removing firearms from their environment
- Identify personal coping mechanisms and support systems
- Understand their limits
- Establish some hope

How Gatekeepers Can be Helpful

- "Just be there" (through the immediate crisis)
- Reflective listening - acknowledge the impact, the fear, the anger ...
- Avoid judging, blaming
- Provide information and referrals
- Emphasize safety; strongly recommend removing lethal means from the home and provide information on how to do that
- Support any and all acceptance of responsibility and efforts to help
- Model limit setting and self care

Things you can ask—or say—once the immediate crisis has passed:

- How can I help?
- How are you coping?
- Who can you talk to? How are you in touch with these people? Would it help if I called them for you? (sometimes just picking up the phone is more than they can do for themselves)
- "I can appreciate how this has turned your world upside down. It is great that you have been willing to get help. None of us can do this alone."
- "How have we (professionals) been helpful? What has not been helpful? What could we do better?

Suggestions That May Help Enlist Parental Cooperation (offered by gatekeepers who have worked with parents of suicidal youth)

1. Invite the parents' perspective. State what you have *seen* (rather than the results of your assessment) and ask how that fits with what they have noticed going on.

2. Advise them to remove lethal means from the home while the child is vulnerable -- just as you would advise taking car keys from a youth who had been drinking. Include the fact that you had this conversation in your notes. Consider having them sign a form acknowledging the conversation.

3. Comment on how scary this behavior is and how it complicates the life of everyone who cares about this young person.

4. Acknowledge their emotional state, including anger, if present.

5. Ask, "What it would take to help you understand the seriousness of the situation?" (Develop a form for them to sign that outlines that you have discussed suicide as an issue for their child and steps to be taken.)

6. Acknowledge that none of us can do this alone - appreciate their presence.

7. Listen for myths of suicide that may be blocking the parent from taking action.

8. Explore reluctance to accept a mental health referral, address those issues, explain what to expect.

9. Align yourself with the parent if possible ... explore how and where these kids get this idea ... without in any way minimizing the behavior.

10. Other:

Five Minutes Can Save a Life
A Three Step Intervention to Use With Parents of Suicidal Adolescents

This is a very important Gatekeeping intervention. It is as sensible as taking the car keys away from an intoxicated individual. It may very well mean the difference between life and death for an adolescent.

1. **Inform the parents that their adolescent is at risk for suicide and why you think so.** For example, if you are working with an adolescent who is known to have made one attempt, it is important to inform the parent or caretaker that "Adolescents who have made a suicide attempt are at risk for another attempt. One attempt is a very strong risk factor for another."

2. **Tell parents or caretakers that they can reduce the risk of suicide by removing firearms from the house.** Research shows that the risk of suicide doubles if a firearm is in the house, even if the firearm is locked up. It is extremely important to help parents or caretakers understand the importance of removing access to firearms and other lethal means. Two-thirds of Maine's youth suicides are committed with a firearm. This is important information for all parents, even if they do not own a firearm. Access to lethal means may be readily available at the home of other family members, friends, or neighbors. Every effort must be made to remove all access to lethal means.

3. **Educate parents about different ways to dispose of, or at the very least, limit access to a firearm.** Officers from local police departments, sheriff's offices, or state police barracks are willing to discuss the disposal of firearms. The information on the following pages will inform you, as gatekeepers, on what to expect in terms of procedures for removing, storing, or disposing of firearms.

Source: Adapted for use by Maine "Gatekeepers" from CD-ROM -- *Team Up to Save Lives* -- *What Your School Should Know About Preventing Youth Suicide*, brought to you by the University of Illinois at Chicago and funded by Ronald McDonald House Charities (McDonald's Resource Center -- 1-800-627-7646).

Frequently Asked Questions About Firearm Disposal for Suicide Prevention

Six of ten youth suicide deaths are completed with a firearm. Removing lethal means can mean the difference between life and death for a vulnerable person.

1. What Advice Should Be Given to a Family in the Hospital Emergency Department?

- A careful, calm explanation of the critical importance of restricting access to lethal means must be given.
- Speak to the parent(s)/caretaker(s) in a room separate from the adolescent to avoid calling the adolescent's attention to the means of suicide.
- Advise families **NOT** to bring firearms to the hospital premises under any circumstances.

2. Who Can Help Dispose of a Firearm?

- Start with a phone call to your local police department, sheriff, or state police.
- Ask for the Officer on Duty, be sure to write down his/her name and the department's name.
- Identify yourself and explain your concern.
- Arrange with the officer a time and location for him/her to pick up the firearm.
- **DO NOT** bring the firearm to the police department, unless told to by the Officer on Duty.
- If asked to bring the firearm to the police station, explain who will bring it, what the person looks like, and schedule a time.

3. Are There Any Legal Issues Involved?

- In Maine you must have a permit to carry concealed weapons and/or a loaded weapon being carried in a vehicle.
- Some police departments, but not all, will overlook the registration status of a gun for the benefit of a well-meaning act.
- If you are a convicted felon, you must not have a gun at all. You could be convicted of another felony.
- Most police departments will run a ballistics check or trace on the weapon to see if it has been involved in a crime, so owners should be informed of that process.

4. How Do You Prepare a Firearm for Transport?

- If the owner knows how to safely unload the firearm, he/she should unload it.
- If the owner does not know how to unload the weapon, tell the Officer on Duty before he/she arrives to pick up the firearm.
- Follow the instructions the police provide to safely transport any firearm. For example, the police may advise that transport be in a storage case in the trunk of your car.

5. What Happens to the Firearm?

- The owner and the Officer on Duty will complete some paperwork. The owner puts the request for storage of the firearm in writing. The police officer will sign it and give the owner a receipt.
- The firearm will be stored by the police department.
- Upon the request of the owner, more paperwork will be processed and the firearm will be returned.

6. What if the Owner Does Not Want to Involve Law Enforcement in the Disposal of the Firearm?

- Remove the firearm from the house and store it somewhere else. Elsewhere may be the home of another family member or a trusted friend. Be sure the youth does not gain access to the firearm before or after it is removed from the home.

- Lock the firearm unloaded in a gun safe or storage box. This doesn't guarantee safety. Trigger locks are an option. These locks can be found in sporting goods stores and most stores where firearms are sold. The keys and combinations are kept away from the person at risk.
- **DO NOT** place the firearm in a bank safe deposit box. Most states have laws that prohibit carrying a weapon into federally insured buildings, such as banks.
- Sell the firearm. **BE SURE** to keep the firearm away from the person at risk.

7. Does This Intervention Apply to Suicidal People of All Ages?

- Yes. Rates of suicide in the elderly (those older than 65) are the highest for any age group.
- Limiting access to firearms and other lethal means is important for individuals of all age groups.

8. What About Restricting Access to Other Lethal Means?

- Limiting access to firearms, drugs, medicines, ropes, and all other lethal means can be helpful in decreasing suicide by adolescents.
- Alcohol is very often involved in a suicide.
- It is recommended that all prescription medications, over-the-counter medications, and alcoholic beverages be removed from or locked up in the house.
- Adults requiring prescription medications can carry their own supply.

9. What if a Family Member of a Suicidal Youth has to Carry a Firearm as Part of the Job?

- If it is impossible to remove all of the firearms from the household, remove all but the one required, and the person who is responsible for the firearm must keep it in his/her possession.
- Consider locking devices or locked storage. This does not guarantee absolute safety, but does present a barrier to impulsive use.

In Five Minutes or Less You Can Tell a Parent These Three Things:

1. Inform the parents that their adolescent is at risk for suicide and why you think so.
2. Tell parents they can reduce the risk of suicide by getting firearms and other lethal means out of the house.
3. Educate parents about different ways to dispose of, or at the very least, limit access to a firearm.

For More Information:

- If you are concerned about a loved one or friend who may be in crisis, call the Statewide Crisis Hotline at 1-888-568-1112.
- To learn more about Maine's Youth Suicide Prevention Program, call the Childhood Injury Prevention & Control Program at 1-800-698-3624 or 287-5356.
- To receive materials on youth suicide prevention call the Statewide Information and Resource Center at 1-800-499-0027.

Building School Readiness Steps to Prevent Youth Suicide

One in eleven Maine high school students report actually attempting suicide within the past twelve months on the Youth Risk Behavior Survey. The school role in preventing youth suicide is a limited, but crucial one. Youth suicide prevention is an important part of creating a safe climate within the school community.

A guiding principle of the Maine Youth Suicide Prevention Program (MYSPP) is *Do No Harm.* We strongly believe that it is extremely important to have prevention and crisis intervention systems in place to identify and help young people at risk of suicide before any direct suicide education is done with students!

Based on current research, the Maine Youth Suicide Prevention Program recommends the following components to aid school personnel in identifying and appropriately assisting students at risk for suicide.

1. **Administrative Procedures in Place** to guide school personnel in responding effectively to suicidal behavior in troubled students, in those who threaten or attempt suicide, and in others potentially at risk in the aftermath of a death by suicide. Procedures clarify for school personnel their role in suicide prevention and crisis intervention and lessen the burden on individual school employees.

2. **Agreements with Local Crisis Service Providers** that outline prevention and crisis intervention services to be provided to the school system such as:
    - Conducting student risk assessments.
    - Helping with crisis management.
    - Debriefing school staff in the aftermath of a crisis.

3. **Educational Programs to Increase Knowledge about Suicide Prevention:**

    - **Youth Suicide Prevention "Gatekeeper" Training** for designated school personnel who are available to each school building to intervene and refer a potentially suicidal youth.

- **Basic Suicide Prevention Information Awareness Sessions** for ALL school personnel including administrators, teachers, custodians, cafeteria workers, coaches, bus drivers, secretaries, aids, educational technicians, and other support staff.

- **Suicide Prevention Information and Resource Materials for Parents.**

- **Suicide Prevention Education for Students,** within a comprehensive school health education program. *Student education should only be done after procedures are established and school personnel are educated.*

4. **A Range of School and Community-based Support Services for At-risk Students.**

MYSPP Resources Include:

- Suicide Prevention, Intervention & Postvention Guidelines
- A variety of training programs for school staff and community members
- Technical Assistance

Guidelines for Schools

In response to many requests from Maine schools for help in managing suicidal behavior and/or death by suicide, the Maine Youth Suicide Prevention Program (MYSPP) developed **Youth Suicide Prevention, Intervention and Postvention Guidelines, A Resource for School Personnel**. This was a collaborative effort with the Maine School Management Association, the Maine Principals' Association, the Departments of Education and Human Services, the Maine Attorney General's Office and many others. Every school in Maine received a copy in the Spring of 2002.

Recognizing that each school community is unique, these guidelines are offered as an aid in discussion and planning for crisis response. The document recognizes and builds on the skills and resources inherent in school systems. Schools are exceptionally resilient and resourceful organizations whose staff members may be called upon to deal with a crisis on any given day. The likelihood of students, faculty or staff encountering a suicidal student is real, even at the elementary school level. Few events are more painful or potentially disruptive than the suicide of a student. Schools can be a source of support and stability for students and community members when such a crisis occurs. The Guidelines are available on the MYSPP website: http://www.state.me.us/suicide. The Table of Contents is included in this section of this book.

Maine Youth Suicide Prevention, Intervention, and Postvention Guidelines

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Guidelines for When a Student Returns to School Following Absence for Suicidal Behavior

This information is found in the Youth Suicide Prevention, Intervention & Postvention Guidelines published by the Maine Youth Suicide Prevention Program and mailed to all schools in May 2002.

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

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

Some suggestions to ease a student's return to school are as follows:

1. Prior to the student's return, a meeting between a) a designated liaison person (such as school nurse, guidance counselor, social worker, administrator or other adult designee trusted by the student), b) parents/guardian and c) the student should be scheduled to discuss possible arrangements for services and to create an individualized re-entry plan.

2. The designated liaison person is responsible to:
    a. Review and file written documents as part of a confidential health record.
    b. Serve as case manager for the student. Understand what precipitated the suicide attempt and be alert to what might precipitate another attempt. Be familiar with the practical aspects of the case, i.e. medications, full vs. partial study load recommendations.

c. Help the student through re-admission procedures as necessary, monitor the re-entry and serve as a contact for staff members who need to be alert to re-occurring warning signs.
d. Serve as a link with the parent/guardian, and with the written permission of the parent/guardian, serve as the liaison with any external agency staff providing support to the student.

3. Classroom teachers need to know whether this student is on a full or partial study load and be updated on progress. They do not need the clinical information or detailed student history. *Only the liaison needs to know what precipitated the suicide attempt so that s/he can be sensitive to what might precipitate another attempt.*

4. Discussion of case among school personnel directly involved in supporting the student should be specifically related to the student's treatment and support needs. Discussion of the student among other staff should be strictly on a "need to know" basis. That is, information directly related to what staff has to know in order to work with a student.

5. Discussion of any specific case in classroom settings should be avoided entirely since such discussion would constitute a violation of the student's right to confidentiality, and such discussion would serve no useful purpose to the student or his/her peers.

6. It is appropriate for school personnel to recommend to students that they discuss their concerns or reactions with an appropriate administrator or other designated school personnel. The focus should not be on the suicidal individual, but on building help seeking skills and resources for others who might be depressed or suicidal.

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

1. **Issue: Social and Peer Relations**

Options:

- ❑ Speak to student about how he/she wants to share information with peers and the type of support that will be most helpful.

- ❑ Schedule a meeting with friends prior to re-entry to discuss their feelings regarding their friend, how to relate and when to be concerned.
- ❑ Arrange for friends to visit the hospital or home with permission from the parent, student and therapist.
- ❑ Place the student in a support group.
- ❑ Refer the student to a peer helpers program or buddy system.
- ❑ Arrange for a transfer 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 home to begin the re-entry process.
- ❑ Obtain a signed release from the parents so the school can communicate with the therapist.
- ❑ Request permission to attend the discharge conference.
- ❑ Invite the therapist to attend the school re-entry planning meeting.
- ❑ Consider allowing the student to attend school on a part time basis before discharge from the hospital.

3. **Issue: Academic problems**

Options:

- ❑ Provide tutoring from peers or teachers.
- ❑ Modify the schedule and adjust the courses to relieve stress.
- ❑ Allow make-up work to be adjusted and extended without penalty.
- ❑ Monitor student's progress.

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

Options:

- ❑ Schedule a family conference with the school psychologist or home school coordinator to address their concerns.
- ❑ Include the parents in suicide awareness and parenting workshops.
- ❑ Invite parents to attend the re-entry planning meeting.
- ❑ Refer the family to an outside community agency for counseling services.
- ❑ Arrange for continuing support by the school's primary caregiver.

5. Issue: Behavior and attendance problems

Options:

- ❑ Meet with teachers to help them anticipate appropriate limits and consequences of behavior.
- ❑ Consult with discipline administrator.
- ❑ Request daily attendance report from attendance office.
- ❑ Make home visits or regularly schedule parent conferences to review attendance and discipline record.
- ❑ Provide counseling for student.
- ❑ Place the student on a sign in/out attendance sheet to be signed by the classroom teachers and returned to the attendance office at the end of the school day.

6. **Issue: Medication**

Options:

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

7. **Issue: On-going support**

Options:

- ❑ Assign a mentor to meet regularly at established times.
- ❑ Contact the therapist and parents frequently. If leaving a message, state your schedule/availability so it will be easier to connect.
- ❑ Ask the student to check in with the counselor daily/weekly.
- ❑ Make a no-suicide contract/safety plan with primary caregiver. Re-assess the suicide risk if necessary.
- ❑ 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.
- ❑ Assure that the family follows through with community referrals and has a resource available when school is not in session.

For more information call (822-0126 or 1 800-492-0846) and ask for Susan Lieberman. The "Psychiatric Facility and School Transition Initiative" is sponsored by the Regional Children Cabinets.

Checklist for the Aftermath of a Student Suicide

- ☐ **Keep the School Open.** The school community serves as the center of operations in times of crisis. It is a very important source of support and information.

- ☐ **Consult Your Crisis Plan.** Crisis Team planning and preparation allow the community to function and move forward, even when in a state of shock and consumed by sadness. Systems are in place and ready to serve students, staff, parents, and others. Each crisis presents some unique qualities and the plan can be adjusted as necessary.

- ☐ **Plan for Media Involvement.** Establish media control. Assign one school authority/spokesperson to interact with the media. A fine line needs to be walked to ensure honest reporting of the student's involvement in the school. Never speculate as to why the student committed suicide. Focus on the positive steps of the school's postvention plan to help students through the crisis. Also emphasize resources for help. (See Appendix B for more media guidelines.)

- ☐ **Contact the Family.** The principal, along with a selected member from the crisis team, should visit the victim's family at home. In addition to the expressions of sympathy and support, explain the school's plan for helping the grieving survivors. The family may assist in identifying friends and siblings in schools who may need assistance. Advice can be given with regard to contacts by the media. Contact and support from the school are usually greatly appreciated by the family.

- ☐ **Return Personal Belongings.** This can be a time to offer assistance in retrieving their child's personal belongings from lockers and other locations, such as desks. Parents may wish to do this in privacy or have someone else do it for them.

- ☐ **Provide Fact Sheets.** The death and the fact that it was a suicide should be acknowledged. Do not give details of the method. Keep parents informed on warning signs and resources for help for themselves, siblings, and friends as well as activities, services, and support available at school. Consult with local law enforcement as appropriate. A faculty fact sheet should include detailed information on schedules, debriefing meetings, crisis center activities.

- ☐ **Communicating the News.** Do not hold large school assemblies and public address announcements about any suicide. There is evidence to the effect that these actions tend to memorialize and romanticize suicide, thus extending the problem. It is better to address the situation on a smaller scale, for example, in drop-in locations and in homeroom discussions with trained personnel, which allow the opportunity for greater small group or individual contacts.

- ☐ **Determine Intervention Groups.** Identify those who might need assistance, i.e., the deceased student's classmates, friends, siblings (and their schools), teachers/other school staff, other parents, at-risk youth. Provide mental health counseling as appropriate. Provide relief for impacted staff. Provide daily staff and crisis team informational debriefing.

- ☐ **Offer Grief Counseling.** This may be a student's first experience with death. Grief counseling is extremely important. Students should be given every opportunity to express their grief within safe, comfortable settings such as: individually or in small groups; in classroom discussions with their teacher and a crisis facilitator/grief worker. Be prepared for ventilation of strong feelings. All expressions of grief need to be validated. No large group assemblies. Provide resource list for referrals to community agencies and other services. Be aware of the possibility of other students feeling suicidal and be ready to refer them for services.

- ☐ **Staff members need support and grief counseling.** Crisis workers and grief support professionals can be very helpful to and supportive of staff.

- ☐ **Emphasize that no ONE Person or Event is to Blame.** Suicide is the most complicated of human behavior. It cannot be simplified by blaming individuals, alcohol, drugs, music, the school, etc. Acknowledge how difficult it is to understand, but do not blame.

- ☐ **Consider Memorials Very Carefully.** One of the more delicate issues a school faces after a suicide is to decide on appropriate commemorative activities. All efforts must be made to avoid glamorizing or sensationalizing a suicide. Things such as dedicating athletic events or establishing permanent memorials have the potential of providing an invitation to other vulnerable youth to consider suicide. Grieving students may be very insistent that the memory of their deceased friend be honored. These energies are best channeled into constructive projects that help the living. Appropriate activities after a suicide include donations to the family, charity, or suicide prevention efforts; establishment of support programs at school. Schools need to provide guidelines for appropriate commemorative activities designed to honor and respect any student who dies for any reason, in a fair and equitable way. Design a memorial action plan that treats all deaths in the same fashion.

Teen Suicide Cluster Checklist

Watch for a series of similar suicides in terms of age and sex of the individual victims, methods used, closeness in time, schools attended, peer groupings, and residences. If a pattern develops, you probably have a suicide cluster in your community.

Identify the close friends and associates of the cluster victims. Whether or not a true suicide pact (one in which a group consciously agrees to mutually commit suicide) exists, all of the intimates of the person who committed suicide are at high risk.

Encourage, in a supportive fashion, the families of any teens who commit suicide to hold sittings, wakes, and funerals during after school hours or on weekends. Teens should not be given the message they can stop the world if they kill themselves. Grief work is important, but is best supported during nonschool times.

Avoid holding large school assemblies and public address announcements about a suicide. There is evidence to the effect that these actions tend to memorialize and romanticize the suicides, thus extending the problem. It is better to address the situation on a smaller scale, for example in drop-in locations and in homeroom discussions with trained personnel.

Involve all segments of the community, including the local press, in downplaying the suicides. The reports of the suicides should not be graphic or sensationalized. Sensationalized media reporting about suicide has been shown to increase the risk of contagion or "copycat" suicide and/or suicide clusters.

For more information: Consult this manual's Appendix E on the suicide clusters bibliography, and the guidelines on suicide contagion and the media in Appendix B.

Source: Coleman, Loren. *Suicide Clusters* (Boston: Faber and Faber, 1987).

Long-Term Effects and Follow-Up

The aftermath of a suicide can be among the most stressful and painful times a school will ever experience. The intense phase of the crisis may last only a few days or weeks, but some effects are ongoing for a year or more. Schools must be sensitive to how special events and the anniversary of the suicide may reawaken distress. Postvention efforts may need to be reintroduced during these times.

Remember, prevention efforts are important but do not substitute for postvention work. It is not appropriate to introduce new prevention initiatives until well after the crisis. Consider formalized six-month and one-year follow-up meetings with staff.

The period of time immediately following a crisis in not the time for prevention education. It is very important to help youth and adults to get through the crisis and process their feelings of grief.

Managing a suicidal crisis may leave a school a stronger, more resilient, and more caring system. Everyone can learn and grow from such an experience.

Source: Adapted from Solanto, Joseph. "The Days After: A School's Response in the Aftermath of Sudden Adolescent Death" in *Teenage Suicide: Prevention, Intervention, Response*. Cosad and Four Winds Hospital, c1984, pg. 10-12; and Carpussi, David. *Adolescent Suicide, Awareness-Prevention-Crisis Response*, Portland State University, Oregon, 1994; and the Los Angeles Unified School District's "Quick Reference Guide for School Crisis management," 1999.

"Suicide Survivors" and Suicide Bereavement

"Suicide Survivor" is a term used to describe someone who actually attempts and then survives a suicide attempt. The same term is also commonly used to describe family members and close friends of someone who has died by suicide. While the language may be confusing, in the section that follows outlining bereavement issues, the term survivor is used to describe individuals close to the person who died by suicide.

Personal stories, clinical reports, and public perception support the belief that grieving the loss of a loved one to suicide is one of the most burdensome forms of bereavement. During the 1990s research was done on grief as a result of suicide. Given the present state of knowledge about suicide bereavement, there is no definitive answer as to exactly how different and difficult suicide bereavement is compared to that following other kinds of sudden, unnatural, untimely traumatic death. It is clear that there are unique qualities to a suicide bereavement. It is important for survivors and their support system to be aware of the complicated mix of social and psychological factors that survivors face.

Survivors struggle to make meaning of the loss. Because suicide is self-inflicted, survivors struggle to make sense of the motives and the frame of mind of the deceased. They struggle to make some sense out of the death. They ask "why" over and over and over again until they finally understand that they will probably never know the answer. Survivors struggle with the loss of the physical presence of their loved one and how to transition into ways to remember this person. They search for something positive and reasonable to come out of the tragedy they have experienced. Over time, the survivor realizes that there was more to their loved one's life than his or her final decision...to die by suicide.

It is critical for the survivor to be able to tell their story, to talk about what has happened until it becomes real and until they come to some resignation, acceptance, and peace of mind. It takes time for survivors to understand that they will never be the same, but they can go on to have meaning and purpose in life. Healing is a long, slow process. In

summary, survivors face many unique tasks in their recovery. They spend much more time and energy trying to comprehend the complicated aftermath of the suicide than do other kinds of mourners. Whenever possible, suicide survivors should be offered the opportunity to interact with other suicide survivors. Their grieving process may take three to five times longer than the average period of grief. It is important for caring family members and friends to be supportive and patient.

Survivors suffer from feelings of guilt, blame, shame, responsibility, and in some cases, relief. They wonder why they didn't see it coming and what they might have done to prevent it. Frequently they blame themselves, are blamed by others, or wish to place the blame on others for the death. In some cases the survivors have suffered from the ordeal of living for a long time with an emotionally disturbed, self-destructive person. They may feel a complicated mixture of loss and relief. There is considerable evidence that the general stigma associated with suicide in our society spills over to the bereaved family members. Caring individuals who genuinely wish to be helpful may feel uncomfortable about how to go about it. The survivor may misinterpret that awkwardness as rejection. It is also possible that the survivor reflects the negative attitude toward suicide in our culture. They may assume or fear that others are judging them negatively and withdraw from the genuine support that is offered. When grieving after any kind of death, it is important to have the opportunity to express one's wide range of emotions, no matter how conflicted. In summary, research shows that interpersonal interaction and social support after a death by suicide is almost always different and more problematic than most other kinds of deaths. Because there is an elevated risk of suicidality associated with loosing a loved one to suicide, survivors need support for their grief and proactive monitoring of their own risk of suicide.

Survivors experience feelings of rejection and/or abandonment, and possibly anger toward the deceased. "How could they do this to me?" "...to us?" It is quite possible that nothing will ever make this death acceptable...or understandable. There is very little research on how different kinds of death effect family functioning. However, there is clinical evidence that suicide is particularly difficult for families no matter what their level of function is, especially if it was the suicide of a child or adolescent. The suicide has the potential to warp patterns of communication and contribute to the development of serious problems in surviving family members. Increased distance between family members is reported far more often than closeness. Other issues include information/communication distortion (hiding the truth about the circumstances of the death), guilt, and identification with the deceased. The fact that

one member of the family modeled suicide as a way to solve problems has a powerful influence, particularly on other children. Bereavement following suicide is a very complicated process.

Feelings are Overwhelming

- **Shock:** Sudden, untimely, unexpected, unnatural loss.
- **Stigma:** Investigations by police and reporters can heighten stigma.
- **Shame:** What do I tell people? Do I have to tell them at all?
- **Blame:** School, spouse, parent, employer, therapist (suicide malpractice is the number-one claim brought against psychiatrists, psychologists, social workers, and nurses).
- **Disbelief:** How could things have been "that bad?"
- **Guilt:** How did I contribute to this? Could I have prevented it?
- **Puzzlement/Rejection/Desertion:** How could he do this to me? To our family? I just don't understand, etc.
- **Fear:** What about me? What about other family members? Will we do the same thing? Is this behavior inherited?
- **Anger:** What a stupid thing to do! Why didn't he talk to me? He didn't have to do this.

What Survivors Find Helpful and Healing

- Acknowledgement of the loss...and that it was a suicide
- Information about suicide and the grief process
- Sharing of memories using the name of the deceased
- Support groups especially designed for suicide survivors
- Individual (and family) work with a mental health professional
- Psychoeducational presentations, reading materials, group discussions
- Discussion of specific coping skills and interpersonal tactics for dealing with stigma and shame, anniversaries and other special events
- Help in establishing formal rituals to honor the deceased person's life
- Identification of personal strengths and positive coping skills from other difficult times
- Reading, writing, and expressing grief in a comfortable time, place, and manner
- Patience from loved ones for the time it takes to heal after suicide
- Thoughtful, sometimes unexpected, offers of support from others
- Sensitivity to difficult times: holidays, birthdays, anniversary dates

What Hinders the Healing of Survivors?

- Hiding or denying that the cause of death was suicide
- Blaming themselves or others for the suicide
- Internal or external pressure to "finish" or "stop" grieving and "get on with their life"
- Self-destructive behaviors, e.g., dependency on drugs/alcohol, isolation, refusal of help for depression
- Thoughtless judgmental comments from others
- Lack of supportive, good listeners

A Combination of Individual and Family Psychotherapy and Group Care is Most Helpful (just a few reasons listed below).

- Time limited, individual therapy is often very helpful in sorting through the above list of feelings, events prior to death, questions about the mental health of the deceased.
- Group support comes because members identify with other survivors and allow strong emotions and feelings to be expressed.
- The grieving person sees others who got through this experience and feels understood. Close bonding occurs through shared experiences.
- Ideas are shared on how to deal with everything from legal issues, telling others, to dealing with holidays and anniversaries.
- Group therapist or facilitator recognizes disturbed reactions, depressions, etc.

How to Support Grieving Youth

Avoid:

- Giving a lot of advice
- Arguing over trivial matters
- Making moralistic statements about the behavior of the person who died
- Minimizing the loss
- Discouraging or time-limiting the grieving process
- Assigning new responsibilities right away.

Do:

- Learn about the grief process
- Be absolutely genuine and truthful
- Demonstrate love and respect by being attentive
- Encourage talking about feelings and about the deceased friend

- Listen, no matter what!
- Offer to attend the visitation or funeral with a youth
- Allow crying--perhaps lots of crying
- Expect laughter--a sign of happy memories
- Follow the lead of the "survivor" with patience and kindness
- Offer opportunities for remembering; i.e., special events, anniversaries, birthdays
- Expect that your presence may be important, while talking may be limited ("Silence is Golden")
- Share some of your experience with loss, but keep the focus on the person you are supporting
- Help to identify others to talk to (i.e., minister, priest, rabbi or counselor)
- Understand that memorials can be very comforting (i.e., writing a poem, a song, a letter, recording a tape, making a scrapbook, buying a bouquet; writing a letter)
- Believe in healing and growth

Maine and Exeter, New Hampshire, Grief Support Centers

The Center for Grieving Children
P.O. Box 1438
Portland, ME 04104
207-775-5216
Fax: 207-773-7417
Contact: Ann Lynch, Executive Director
Linda Kelly, Program Director
Patricia Ellen, Assistant Program Director

The Children & Teens Program
Hospice Volunteers of Kennebec Valley
ME General Medical Center
150 Dresden Avenue
Gardiner, ME 04345
207-626-1779
Fax: 207-582-6819
Contact: Tina DeRaps, Bereavement Coordinator
Barbara Bell

Pathfinders-Hospice of Eastern Maine
885 Union Street, Suite 220
EM Healthcare Mall
Bangor, ME 04401
207-973-8269 or 1-800-350-8269
Fax: 207-973-6557
Contact: Linda Boyle, Bereavement Coordinator
Vicki Trundy, Pathfinders Consultant

Seacoast Hospice-Bridges
10 Hampton Road
Exeter, NH 03833
603-778-7391
Fax: 603-418-0040
Contact: Meg Kerr, Bridges Coordinator
Donna Theobold, Bereavement Coordinator

Pete's Place, A Center for Grieving Children & Families
Wentworth Douglass Hospital
Seacoast Cancer Center
1 Webb Place
Dover, NH 03820
603-740-2689
Fax: 603-742-7210
Contact: Jan Arsenault, Program Manager

Hospice Volunteers of Somerset County
P.O. Box 3069
Skowhegan, ME 04972
207-474-7227 or 1-800-794-6224
Contact: Laurie Magee, Coor. of Volunteer Services

Program for Grieving Children and Teens
Androscoggin Home Care and Hospice
15 Strawberry Avenue
Lewiston, ME 04240
207-777-7740 or 1-800-482-7412
Fax: 207-777-7748
Contact: Mary Heath (ext. 273)
Sally Brochu (207-777-8520 - St. Mary's)

Transitions Midcoast Grieving Children's Program - Hospice Volunteers
45 Baribeau Drive
Brunswick, ME 04011
207-721-9702
Fax: 207-729-2721
Contact: Margaret Pelletier

Maine Medical Center
Department of Patient & Family Services
22 Bramhall Street
Portland, ME 04102
207-871-4226
Contact: Connie Korda
Meet 2nd and 4th Monday @7 pm

Hospice Volunteers of the Waterville Area
304 Main Street, P.O. Box 200
Waterville, ME 04901
207-873-3615
Contact: Dale Marie Clark, Executive Director

Camp Ray of Hope, Hospice Volunteers of Waterville Area
304 Main Street, P.O. Box 200
Waterville, ME 04901
207-873-3615
Contact: Dale Marie Clark (dmclark@mint.net)
web site: www.hvwa.org

Home Health and Hospice of St. Joseph
St. Joseph Healthcare Park
900 Broadway
Bangor, ME 04401
207-262-1810
Fax: 207-262-1928
Contact: Reita Abbott

Hospice Volunteers of Waldo County
P.O. Box 772
Belfast, ME 04915
207-930-2677
Contact: Connie Woitowitz
Lindsay McGuire, Bereavement Coordinator

Hospice Volunteers in Midcoast
45 Baribeau Drive
Brunswick, ME 04011
207-729-3602 or 1-888-486-0340
Fax: 207-729-2721
Contact: Marie Badger

Down East Hospice
c/o Calais Regional Hospital
22 Hospital Lane
Calais, ME 04619
207-454-7521, ext. 126
Fax: 207-726-5087
Contact: Barbara Barnett, Director

Pine Tree Hospice
895 Main Street
Dover-Foxcroft, ME 04426
207-564-8401, ext. 346
Greenville Satellite Office: 207-695-5283
Contact: Theresa Boettner

New Hope Hospice, Inc.
P.O. Box 757
Holden, ME 04429
207-843-7521
Fax: 207-843-6645
Contact: Patricia Eye
Nancy Burgess

Hospice of Hancock County
14 McKenzie Avenue
Ellsworth, ME 04605
207-667-2531
Fax: 207-667-9406
Contact: Mary-Carol Griffin, Bereavement Coordinator

Hospice Volunteers of Kennebec Valley
150 Dresden Avenue
Gardiner, ME 04345
207-626-1779
Fax: 207-582-6819
Contact: Barbara Bell

Community Health Services Hospice
901 Washington Avenue, Suite 104
Portland, ME 04103
207-775-7231 or 1-800-479-4331
Fax: 207-775-5520
Contact: Deb Wood

Hospice of Aroostook
P.O. Box 688, 14 Carroll Street
Caribou, ME 04736
207-498-2578 or 1-800=439-1685
Fax: 207-493-3111
Contact: Robin Holmes

Kno-Wal-Lin Home Care and Hospice
170 Pleasant Street
Rockland, ME 04841
207-594-9561 or 1-800-540-9561
Fax: 207-594-1461
Contact: Sara Swelley
Frank Magrogan

Visiting Nurse Service
15 Industrial Park Road
Saco, ME 04072
207-284-4566 or 1-800-660-4867
Fax: 207-282-4148
Contact: Susan Detullio

VNA Home Health Care
50 Foden Road
South Portland, ME 04106
207-780-8624 or 1-800-757-3326
Fax: 207-756-8676 or 207-756-8677
Contact: Colleen Hilton

Family Therapy Association
Cottage Place, 433 US Rt. 1, Suite 110
York, ME 03909
207-363-4000
Fax: 207-363-1034
Contact: Bobbi Gray

For the Bereavement Support Group in your location, call Luanne Crinion, RN, MSN, at DHS, Lewiston -- 1-800-482-7517, ext. 4450 or Barbara Wilkinson, MD, Maine Medical Center -- 207-773-5219.

Generally speaking, if you call your local hospice, they will help you identify grief support resources.

Taking Care of Ourselves

Dealing with a suicidal youth is one of the more difficult challenges with which we may be faced in our lives. In addition to our responsibilities to young people, we also have responsibilities to ourselves and to other professionals, parents, and community members.

Here are some tips for self-care:

Acknowledge Your Own Feelings and History

A suicidal crisis will always bring out intense feelings in caregivers. Sometimes feelings from the caregiver's own past experience are displaced onto the suicidal individual. The caregiver may feel angry or may resent the individual because he or she reminds the caregiver of personal unresolved conflicts. If you have these intense feelings, acknowledging their existence may help you understand the root causes. It may be helpful to talk to your peers or other staff members. If you don't think you can deal with an individual effectively without interference from these feelings, you should try to get another person to handle the suicidal individual. In any case, it is important to know your own limits and capabilities. No one is expected to be perfect.

Sometimes dealing with a suicidal individual can arouse suicidal feelings in the caregiver. It is essential that you gain a clear and comfortable understanding of your own feelings and seek professional counseling, if necessary.

Avoid Over-Involvement

Teamwork works! You must be able to resist the desire to be omnipotent. An intensely dependent individual can attribute tremendous power to you as a potential rescuer. But this power gives you too much responsibility for another's life. Emotional over-involvement of caregivers in an emergency is unhelpful and at times destructive. Sometimes there is a fine line between being involved and over-involved. When we are over-involved we don't always know it. It is the responsibility of other staff members to confront the person who they sense has become over-involved. One person alone cannot provide all of the necessary support a suicidal individual will need.

Understand the Role of Responsibility in Suicides

Although involvement in a life-saving situation carries a lot of responsibility, you cannot be fully responsible for another individual's life. You must try to prevent a suicide, but the ultimate decision rests with the individual.

Debrief the Incident With the Whole Staff

A suicidal incident is such an emotionally charged situation that it will always leave you with leftover feelings. Taking time to debrief is critically important for all involved. Go over the incident in detail to confirm that you dealt with the situation as best you could and to consider with others what might be done in the future. It is important for your co-workers to support the notion that no one is expected to be perfect. We need each other as resources and for support. Outside resources, such as a mental health crisis worker or a staff member from a survivor's group or grieving center, may also be very helpful. We tend to be very critical of ourselves following a suicide prevention or crisis intervention. It is common for us to question our judgment when we are assessing and intervening in a suicidal situation. The best way to deal with that is to share the responsibilities of decision-making. Involve your pre-designated school crisis team members and community-based helping professionals, if available.

Think of the Special Ways to Take Care of Yourself

It is often extremely important to set up a routine, almost ritualized but familiar ways to "unwind" after a suicidal intervention. Consider what you like to do to take care of yourself after a semi-difficult day, and find comfort in that routine after an especially intense suicide intervention. Connect with something you love (e.g., walking your dog, taking a peaceful bath, having a nice dinner with your partner, going to a light-hearted movie). And definitely make contact with someone that evening after a stressful day. Avoid being alone with your feelings about the interaction that is filling your thoughts.

APPENDICES

STATEWIDE HOTLINE – 1-888-568-1112

CRISIS INTERVENTION SERVICES

Licensed by Department of Behavioral and Developmental Services (formerly DMHMRSAS)

	Walk-in Crisis and Triage Services/Mobile Outreach Services
Region 1 Cumberland County York County	**Cumberland County Crisis Service** Ingraham, Inc. Department of Behavioral and Developmental Services (formerly DMHMRSAS) Maine Medical Center Sweetser Children's Services **York County Crisis Services** Counseling Services, Inc. Department of Behavioral and Developmental Services (formerly DMHMRSAS) Southern Maine Medical Center
Region 2 Kennebec and Somerset Counties Sagadahoc, Lincoln, Knox, & Waldo Counties, plus Brunswick/Freeport Area Androscoggin, Oxford, & Franklin Counties	**Ken-Som Crisis Services** Kennebec Valley Mental Health Center Crisis & Counseling Center Maine General Medical Center **Coastal Crisis Response Services** Shoreline Care Systems, Inc. Mid-Coast Mental Health Center **Western Maine Crisis Services** Tri-County Mental Health Services Evergreen Behavioral Health Services GRAMI/Oxford County Crisis Response Rumford Group Homes
Region 3 Aroostook County Penobscot, Piscataquis, Hancock, & Washington Counties	**Aroostook Crisis Response** Aroostook Mental Health Center **Northeast Crisis Response** Community Health & Counseling Services Washington County Psychotherapy Associates

SUICIDE PREVENTION SUPPORT SYSTEM

Statewide Crisis Hotline -- 1-888-568-1112

Statewide Emergency Numbers:

1. 911
2. Poison Control Center -- 1-800-442-6305
3. Maine State Police -- 1-800-432-7381
4. Child Abuse & Neglect -- 1-800-452-1999

Local Numbers:

Hospital Emergency Room _____

School Contact(s) _____

_____

_____

_____

Referrals (Practitioners/Therapists) _____

_____

Child & Adolescent Specialists _____

Family Systems Therapists _____

_____

Drug & Alcohol Specialists _____

_____

Interpreters (Deaf, Spanish, Hmong, Etc.) _____

_____

_____

For more informational materials call:

Maine Office of Substance Abuse Information and Resource Center
1-800-499-0027

Featuring Suicide in the Media: Avoiding Contagion -- Promoting Help

Suicide has for many years been a taboo subject. This shroud of secrecy has helped foster misleading myths about suicide and made constructive, informed community discussions about suicide more difficult. However, public discussion of suicide in the media must also consider research findings about media coverage and contagion that highlight the need for considerable caution and care.

The key issue is the potentially harmful impact of a prominent media suicide story on those in the community who are already vulnerable. The specific concern arises from research evidence that prominent news stories about suicide have been followed by an increase in suicides in areas impacted by these stories. Adolescents and young adults appear to be particularly susceptible to repetitive coverage of suicide stories in the media which can strengthen their preoccupation with self-harm and suicide. The challenge is to ensure that any public discussion of suicide promotes the safety of those at risk. A key aim is to emphasize the help and support that is available in the community for any person struggling with painful circumstances in their life.

What Evidence is There for this Concern?

Studies indicating the need for care and caution in media reporting of suicide have emerged from the United States, Europe, and Australia. David Phillips and his colleagues from the University of California at San Diego have characterized concerns about contagion as 'the Werther effect,' named after Geothe's fictional hero whose suicide was seen by some contemporaries as instrumental in precipitating subsequent suicidal behaviour. Their review of literature on this subject identified substantial circumstantial evidence that prominently publicized news stories about suicide were followed by a rise in completed suicides in communities likely to have been impacted by the report. Similar findings have been reported by Columbia Univeristy's Madelyn Gould and Riaz Hassan at Flinders University, Adelaide.

Much of this research is based on measuring numbers of suicides immediately following a media story. There is no way of knowing how many of those individuals who died by suicide immediately following the story read the account or were influenced by it. However, the repeated finding that prominent media stories have often been followed by significant increases in suicides highlights a problem that cannot be lightly dismissed.

There is also some evidence that changes in media policy can make a difference. One Austrian study indicated that changes in media policy could have beneficial effects. A 1987 media policy decision to discontinue reporting subway suicides in Vienna was followed by a subsequent reduction in these deaths, even though suicide rates from other means remained relatively unchanged.

Some Guidelines to Consider

Stories about suicide are sometimes considered newsworthy and will be reported. Few want to return to a situation where suicide is considered a taboo topic that cannot be discussed. *How* we talk about it is what deserves careful attention. The American Foundation for Suicide Prevention, working with others, recently conducted a thorough review of the media guidelines produced by the Centers for Disease Control and Prevention in 1994. *These guidelines and those proposed by others in the field suggest that authors of any media story on suicide need to consider its potential impact on people in their audience or readership who may be vulnerable to suicidal behavior.*

Key Themes

- Recognize complexity. Suicide usually has complex causes. Stories which imply simplistic cause and effect relationships such as *'study pressures lead to teenager's suicide'* convey a misleading impression.

- Acknowledge the pain and suffering behind any life story ending in suicide. Suicide is a tragic, potentially avoidable outcome arising from troubled circumstances. Consider the impact of the story on the grief of those mourning this loss or on those whose grief from earlier losses may be aroused.

- Avoid idealizing suicide or romanticizing people who take their own lives which might present them as possible role models to be imitated.

- Avoid giving suicide stories undue prominence, sensational treatment or repetitive attention. Do not provide detailed descriptions of methods of the suicide.

- Feature stories about people who adopted life-affirming options. Media stories can provide role model alternatives to readers by featuring stories of people who found a way through their suicidal crisis.

- Publicize sources of help. Ensure that a story always features information about where people can receive help. This works to ensure that people at risk, or those concerned about friends at risk, have somewhere to go immediately with their concerns.

Above all, public discussion about suicide needs to emphasize that suicide can be prevented and that help is available to those in the community seeking to find a way through painful circumstances in their lives.

Source: Turley, Bruce. *Featuring Suicide in the Media: Avoiding Contagion - Promoting Help*. Suicide Inforrmation and Education Centre Current Awareness Bulletin, Vol. 8, No. 2, Summer 1998.

Bruce Turley, MA, is a Counselling Psychologist and Director of Lifeline Australia Youth Suicide Prevention Project, a national network of crisis lines based in Melbourne, Victoria, Australia.

References for this article can be found in Appendix F, "Credits," under Media.

Selected Resources

In an age of the Internet, website resources on suicide prevention are an important new tool. The following resources and websites are potentially useful in your suicide prevention work. All updated as of August 2003.

Suicide Prevention & Related Information Resources

Maine Youth Suicide Prevention Web Site
http://www.state.me.us/suicide
This site is created through a joint effort of the Maine Injury Prevention Program in the Bureau of Health, Department of Human Services and the Office of Substance Abuse in the Department of Behavioral and Developmental Services. It includes information about prevention efforts in Maine, resources available, Maine and National data, and a new searchable database of all IRC resources.

Maine Office of Substance Abuse Information Resource Center (OSA/IRC)
http://www.state.me.us/bds/osa
The OSA/IRC maintains a variety of suicide prevention resources. Print materials, books, and videos may be obtained by calling 1-800-499-0027, 207-287-8900 or by e-mail at osa.ircosa@state.me.us

National Alliance for the Mentally Ill (NAMI) of Maine
http://www.me.nami.org
NAMI of Maine is a membership organization dedicated to improving the quality of life for people living with mental illness. They provide information and referral to services for mental illness, local support groups, education and systems advocacy.

(Maine) Teen Yellow Pages
http://www.ingraham.org/needhelp/yellow.html
The pocket-size Teen Yellow Pages explores topics such as Alcohol, Employment, Eating Disorders, Education, Suicide, Depression, Abuse and Neglect, Teen Dating Violence, and Volunteering. It is designed to provide facts and resources to help teens make wise choices. It is a resource guide written with the help of teens for teens that contains information about where to find help for specific problems and how to help others.

A Comprehensive Approach to Suicide Prevention — Lollie McLain
http://www.lollie.com/suicide.html
This energetic website jumps at whoever comes near. The take control, feel-good approach to suicide prevention is broadcast with different inspirational posters, humorous brochures, lists of action, and stories. The navigating of the site is tricky at first, but highly creative with the use of dual menu bars.

American Academy of Child and Adolescent Psychiatry (AACAP)
http://www.aacap.org/
A leading national professional medical association dedicated to treating and improving the quality of life for children, adolescents, and families affected by mental, behavioral, or developmental disorders. AACAP, 3615 Wisconsin Ave., N.W., Washington, D.C. 20016-3007. Phone: (202)966-7300; Fax: (202)966-2891. This site provides public information through fact sheets including one on teen suicide.

American Academy of Pediatrics (AAP)
http://www.aap.org/
An organization of 55,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. National headquarters at 141 Northwest Point Boulevard, Elk Grove, IL 60007-1098. Phone: (847)228-5005; Fax: (847)228-5097. This site provides family oriented fact sheets including one on adolescent depression and suicide.

American Association of Suicidology (AAS)
http://www.suicidology.org/
A United States organization of concerned persons and agencies working in suicide prevention. American Association of Suicidology, Central Office, Suite 310, 4201 Connecticut Avenue, N.W., Washington, DC, 20008, Phone: (202)237-2280, Fax: (202)237-2282. The American Association of Suicidology (AAS) promotes research, public awareness programs, and education and training for professionals and volunteers. In addition, it serves as a national clearinghouse for information on suicide. This site provides information you should know about suicide, membership information, a listing of AAS publications, and conference information.

American Foundation for Suicide Prevention (AFSP)
http://www.afsp.org/
The American Foundation For Suicide Prevention is dedicated to advancing our knowledge of suicide and our ability to prevent it. AFSP, 120 Wall Street, 22nd Floor, New York, NY 10005, Phone: (212)410-1111; Fax: (212)363-6237. This site is very easy to navigate and is updated regularly. It contains some very interesting articles on the subject of suicide and the issues surrounding it.

American Psychiatric Association (APA)
http://www.psych.org/
The American Psychiatric Association is a medical specialty society recognized world-wide. Its 40,500 U.S. and international physicians specialize in the diagnosis and treatment of mental and emotional illnesses and substance abuse disorders. American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005. Phone: (202)682-6000; Fax: (202)682-6850.

Center for School Mental Health Assistance
http://csmha.umaryland.edu
This center at the University of Maryland at Baltimore provides leadership and technical assistance to advance effective interdisciplinary school-based mental health programs. It strives to support schools and community collaboratives in the development of programs that are accessible, family-centered, culturally sensitive, and responsive to local needs. CSMHA offers training, a forum for the exchange of ideas, and promotes coordinated systems of care that provide a full continuum of services to enhance mental health, development, and learning in youth.

Center for Substance Abuse Prevention Prevline
http://www.health.org
This site contains substance abuse prevention resources for teachers across the nation. It lists a comprehensive set of links to substance abuse resources worldwide, including sites for youth.

Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov/
The CDC is an agency of the U.S. Department of Health and Human Services. In addition to health statistics, this website provides access to publications, health information, and funding announcements. Centers for Disease Prevention and Control, 1600 Clifton Road, NE, Atlanta, GA 30333. Phone: (404)639-3311.

Gay, Lesbian, and Straight Education Network
http://www.glsen.org
121 West 27th Street #804
New York, NY 10001
phone: 212-727-0135 • fax: 212-727-0245
GLSEN strives to assure that each member of every school community is valued and respected, regardles of sexual orientation, by teaching the lesson of respect for all in public, private, and parochial K-12 schools.

International Association for Suicide Prevention (IASP)
An international association of concerned persons and organizations working in suicide prevention. International Association Suicide Prevention, Central Administrative Office, Dr. David Clark, Rush Presbyterian, St. Lukes's Medical Center, Rush University, 1725 West Harrison Street, Suite 955, Chicago, IL, 60612-3824, USA Email: IASP@aol.com

KidsHealth.org
http://www.KidsHealth.org/
A website for children's health information sponsored by the American Medical Association and the Nemours Foundation. Provides parents with children's health information on such topics as childhood infection, emergencies and first aid, safety and injury prevention, child development, and understanding and preventing teen suicide.

Light for Life Foundation of America
http://www.yellowribbon.org/
Provides information on the Yellow Ribbon Program for preventing youth suicide. Also included are suicide facts and statistics. Frequently updated.

National Mental Health Association (NMHA)
http://www.nmha.org/
The National Mental Health Association is dedicated to promoting mental health, preventing mental disorders, and achieving victory over mental illness through advocacy, education, research, and service. National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314-2971. Phone: (703)684-7722; Fax: (703)684-5968.

National Strategy for Suicide Prevention
http://www.mentalhealth.org/suicideprevention
This site provides the Surgeon General's National Strategy for suicide prevention and links to suicide information, research, and data.

Ronald McDonald House Charities - *"Team Up to Save Lives"*
1-800-627-7646
A training CD-Rom for educators is available for $1.10 per copy plus a shipping fee of $3.95. Must be pre-paid. Call for details.

SA\VE -- Suicide Awareness\Voices of Education (SAVE)
http://www.save.org/
Includes a helpful Frequently Asked Questions (FAQ) file, general information on suicide and some common statistics, symptoms of depression, a book list, and much more in an easy-to-read format. Frequently updated.

Schools Mental Health Project (SMHP) at UCLA
http://smhp.psych.ucla.edu
SMHP works closely with school districts, state agencies, organizations, and colleagues across the country. The Center offers leadership training, capacity building, resources, and technical assistance with school base mental health initiatives. Sister site to University of Maryland site.

Self-Injury Page — Llama Central
http://www.palace.net/~llama/psych/injury.html - 30 Apr 1998
This page comes out of the author's own experience with self-mutilation. It contains frequently asked questions about self-injury, the bodies-under-siege mailing list, and a comprehensive review of treatment modalities by theoretical orientation. Information is presented in a very organized manner.

SPAN (Suicide Prevention Advocacy Network)
http://www.spanusa.org/
A U.S. network of persons working to raise national awareness and advocate for a National suicide prevention policy. 5034 Odin's Way, Marietta, Georgia, 30068, Phone: (770)998-8819.

Suicide Information and Education Centre (SIEC)
http://www.siec.ca/
Suicide Information and Education Centre (SIEC) is a library and resource center. They do not do crisis intervention or counseling; instead, this site gives recommendations on where to get help, in both Canada and the U.S. Located on this site is a comprehensive list of suicide prevention resources, crisis support information, and links to other helpful suicide prevention sites. This site is very user friendly and would be very helpful to someone who is thinking about suicide or knows of someone that may be suicidal.

Suicide: Read This First
http://www.metanoia.org/suicide/
This site contains conversations and writings for suicidal persons to read and a few simple prevention materials. "It grows out of my 14 years work with online (and telephone) crisis counseling and online support groups on depression and suicide." Includes links as well as lots of helpful information.

The Samaritans — U.S. Mirror Site
http://www.samaritans.org.uk/
A non-religious charity that has been offering emotional support to the suicidal and despairing for over 40 years by phone, visit, and letter. Callers are guaranteed absolute confidentiality and retain the right to make their own decisions including the decision to end their life. The service is available via E-mail, run from Cheltenham, England, and can be reached from anywhere with Internet access. Trained volunteers read and reply to mail once a day, every day of the year.

Western Washington University Suicide Prevention
http://www.ac.wwu.edu/~hayden/spsp
This web site lists all states with state plans for suicide prevention. It provides many links to useful information on suicide prevention.

Depression

National Depression Screening Day
http://www.mentalhealthscreening.org/depression.htm
During the first week of October, Thursday is set aside as National Depression Screening Day as part of Mental Illness Awareness Week activities. Call the number above to locate a free anonymous site for screening in your local area.

National Foundation for Depressive Illness, Inc.
http://www.depression.org/
The National Foundation for Depressive Illness (NAFDI) provides public and professional information about Affective Disorders, the availability of treatment, and the need for further research. The Foundation is committed to an extensive, ongoing public information campaign addressed to this pervasive, costly, and hidden national emergency. This site provides an overview of depression as well as information on the Foundation.

Reading/Video List

Books About Childhood & Adolescent Depression

No One Saw My Pain - Why Teens Kill Themselves by Andrew Slaby, M.D., and Lili Frank Garfinkel
Helping Your Depressed Child - A Reassuring Guide to the Causes & Treatments of Childhood & Adolescent Depression by Lawrence L. Kerns, M.D.
It's Nobody's Fault - New Hope and Help for Difficult Children and Their Parents by Harold S. Koplewicz, M.D.
The Suicide of My Son - A Story of Childhood Depression by Trudy Carlson
Children & Adolescents with Mental Illness - A Parent's Guide edited by Evelyn McElroy, Ph.D.
Sad Days, Glad Days by DeWitt Hamilton (a storybook for children about adult depression)
Helping Your Depressed Teenager – A Guide for Parents and Caregivers by Gerald D. Oster, Ph.D., and Sarah S. Montgomery, MSW
Perfectionism – What's Bad About Being Too Good? by Miriam Adderholdtt-Elliott, Ph.D.
The Power to Prevent Suicide – A Guide for Teens Helping Teens by Richard E. Nelson, Ph.D., and Judith C. Galas
A Parent's Guide for Suicidal & Depressed Teens by Kate Williams
Understanding Your Teenager's Depression: Issues, Insights & Practical Guidance for Parents by Kathleen McCoy
When Nothing Matters Anymore, A Survival Guide for Depressed Teens by Bev Cobain

Books to Share with Small Children

Let's Talk About Feelings: Ellie's Day by Susan Conlin and Susan Friedman
Sad Days, Glad Days, A Story About Depression by DeWitt Hamilton
Feelings by Aliki
Glad Monster, Sad Monster, A Book About Feelings by Ed Emberley and Anne Miranda
How Do I Feel? by Norma Simon
When Dinosaurs Die - A Guide to Understanding Death (a storybook for children) by Laurie Krasny Brown and Marc Brown

Books About Suicide and Suicide Prevention

Suicide Clusters by Loren Coleman
Suicide: Why? by Adina Wrobleski
Suicide: The Forever Decision - For Those Thinking About Suicide, and For Those Who Know, Love, or Counsel Them by Paul G. Quinnett
Suicide: Intervention & Therapy - Undoing the Forever Decision by Paul G. Quinnett
Choosing to Live - How to Defeat Suicide Through Cognitive Therapy by Thomas E. Ellis, Psy.D., and Cory F. Newman, Ph.D.
Preventing Youth Suicide - A Handbook for Educators & Human Service Professionals by Marcia L. McEvoy and Alan W. McEvoy
An In-Depth Look at Why People Kill Themselves by David Lester, 1997, Charles River Press
Why Suicide? by Eric Marcus
A Parent's Guide for Suicidal and Depressed Teens by Kate Williams
Adult Children of Suicide – Characteristics and Risk Factors by Frank Campbell, MSW
Night Falls Fast, Understanding Suicide by Kay Redfield Jamison

Autobiographies

Darkness Visible - A Memoir of Madness by William Styron
The Beast - A Reckoning with Depression by Tracy Thompson
A Brilliant Madness by Patty Duke
An Unquiet Mind by Kay Redfield Jamison
Night Falls Fast, Understanding Suicide by Kay Redfield Jamison

Books About Finding Your Way Through Grief After a Suicide

A Grief Observed by C.S. Lewis
My Son, My Son by Iris Bolton
Companion Through the Darkness: Inner Dialogues on Grief by Stephanie Ericsson
Giving Sorrow Words by Candy Lightner
Life is Goodbye Life is Hello: Grieving Well Through All Kinds of Loss by Alla Bozarth-Campbell, Ph.D.
The Grieving Child: A Parent's Guide by Helen Fitzgerald
Helping Children Grieve by Theresa Huntley
Talking about Death: A Dialogue between Parent & Child by Earl A. Grollman
Remembering with Love by Liz LeVang and Sherokee Isle

Singing Lessons by Judy Collins
His Bright Light by Danielle Steel
Breaking the Silence by Mariette Hartley
Suicide: Survivors - A Guide for Those Left Behind by Adina Wrobleski
Child Survivors of Suicide: A Guidebook for Those Who Care for Them by Rebecca Parkin with Karen Dunne-Maxim
Suicide Survivors' Handbook by Trudy Carlson
After Suicide by John Hewitt
No Time To Say Goodbye by Carla Fine
The Caregiver as Survivor by Iris Bolton, the Link Counseling Center, Atlanta, GA
Treatment of Survivors by Sam Heilig, MSW, Private Practice, Los Angeles, CA
The Suicide of My Son - A Story of Childhood Depression by Trudy Carlson
Prayers for Bobby: A Mother's Coming to Terms with the Suicide of Her Gay Son by Leroy Aarons

Videos

Depression: On The Edge (#429). Produced by "In the Mix," 114 E. 32nd Street #903, New York, NY 10016. 1-800-597-9448 or 212-684-3940
Fatal Mistakes: Families Shattered By Suicide. Produced by American Foundation for Suicide Prevention, 120 Wall Street, 22nd Floor, New York, NY 10005. 212-363-3500 ($19.99)
Day for Night: Recognizing Teenage Depression. Produced by DRADA (Depression & Related Affective Disorders Association), Meyer 3-181, 600 Wolfe Street, Baltimore, MD 21287-7381. 410-987-7445 ($60.00)
SOS – Runaways and Teen Suicides: Coded Cries for Help by Sally Brown, Loren Coleman, Robert Schroff, and Carol Buggis
SOS: Coded Cries for Help (video) produced by Dan Porter, Loren Coleman, Ted Miles, and Mara Janelle
A Preventable Tragedy: First Response to Suicidal Youth. Produced by Center for Educational Media, Portland, Maine, for the Maine Youth Suicide Prevention Program. Available on loan at Information and Resource Center -- 1-800-499-0027.
Suicide: A Guide to Prevention. Produced by the NoodleHead Network, 107 Intervale Avenue, Burlington, Vermont 05401. 1-800-639-5680. e-mail: steve@noodlehead.com • www.noodlehead.com

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Credits

In producing a manual such as this, several reference sources, websites, brochures, and routine suicide prevention materials were consulted. In general, many authorities and authors use and recycle commonly repeated information that is freely shared to benefit our goal of saving young people's lives. The following is a list of sources that were used as the building blocks for this manual. Any organization or individual that was not credited was omitted as an oversight, and a correction and credit will appear in future editions.

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Language
For the purpose of clarity in this manual and training session, we are using the language as adopted by the *Centers for Disease Control and Prevention,* the *American Association of Suicidology,* the *Center for Mental Health Services,* and the *National Institute of Mental Health.*

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"Survivors" of Suicide Information
Bolton, Iris, Executive Director of the Link Counseling Center in Atlanta, Georgia and author of *My Son...My Son, A Guide to Health After Death, Loss or Suicide*.

Teen Suicide Cluster Checklist
The Teen Suicide Cluster Checklist is a 1998 revision of the one in Loren Coleman's *Suicide Clusters* (Boston: Faber and Faber, 1987).

The S.L.A.P. Scale
The S.L.A.P. Scale was developed by Dr. Marvin Miller (1986).

Warning Signs
Light for Life Foundation of America
http://yellowribbon.org/warning.html
http://www.yellowribbon.org

Web Resources
Mental Health Net & CMHC Systems
http://www.cmhc.com/

Why do people kill themselves?
http://www.montana.edu/wwwcc/suicide-prev.html

Youth Suicidal Thoughts and Feelings
David Clark, Ph.D., Rush Medical College, Chicago (The Three Most Common Factors in Youth Suicide).

Glossary

Adolescent Suicide – A term that encompasses the suicide of individuals between the ages of 13 and 19. Youth suicide is a more general term to describe any suicide of a child, teen, or young adult through age 24.

Ambivalence – Conflicting feelings or thoughts; uncertainty or indecisiveness as to what course to follow.

Asphyxiation – To kill or make unconscious by lack of oxygen.

Bereavement – Global term encompassing both the feelings of grief and the process of mourning in reaction to the death of a loved one.

Bipolar Disorder – A mood disorder characterized by manic episodes and major depressive episodes.

Caregiver – A person providing direct care to children.

Caretaker – A person providing physical or emotional care and support.

Community Referral – A recommendation to obtain additional services to be provided by hospitals, mental health agencies, organizations, consultants, and/or mental health professionals in the local area.

Conduct Disorder – A repetitive and persistent behavior pattern during which the basic rights of others or major age-appropriate norms or rules are ignored and often violated.

Continuum – A whole characterized as a collection, sequence, or progression of elements varying by degrees.

Crisis Intervention – The immediate response to an individual who is at moderate or high risk for suicide. Intervention includes the response and medical or psychiatric emergency services for the individual.

Crisis Intervention Training – Education designed to provide specific information and development of skills necessary to prepare individuals who will intervene during a crisis.

Crisis Plan – A written document that addresses the school and community response following a crisis. In the event of a suicide, the plan addresses the school and community response to suicide and also the needs of at-risk students.

Crisis Team – A group of individuals trained and assembled for the purpose of responding to the needs of others during and after a crisis event/situation.

Debriefing – Facilitated session to provide staff intervening in a crisis with an opportunity to discuss and process crisis related events. Purpose is to provide support, recognition, and information.

Detoxifying – Counteracting or destroying the poisonous properties of a substance; for example, the carbon monoxide content of the coal gas supplied to homes.

Etiology – All of the causes of a disease or abnormal condition.

External Supports – External supports may include community health professionals, mental health agencies, personnel from neighboring schools, parent organizations, clergy, funeral directors, police, and families of the community. External supports are needed to brace the school's internal resources, share responsibility in assisting grieving survivors, and increase the availability of support to all impacted survivors.

Internal Supports – Internal supports are those resources schools traditionally use, such as administrators, the crisis team, faculty/staff, students, and students' parent(s)/caretaker(s).

Lethal Means of Suicide – Most dangerous and successful methods of taking one's life, such as the use of firearms, cutting tools, or medications.

Lethality – The degree of danger that a person will probably kill himself or herself.

Lethal Means Restriction – The interruption of and/or prevention of access to deadly methods of suicide. Removing lethal means is a means restriction.

Mood Disorders – Disorders that have a disturbance in mood as the predominant feature. These disorders include depressive disorders, bipolar disorders, and mood disorders due to etiologies such as a medical condition or substance abuse.

Morbidity – The relative incidence of disease or injury.

Mortality – Incidence of death in general or due to a specific cause.

National Institute of Mental Health – Federal organization structured to provide technical assistance, research, and support on issues related to mental health.

Nomenclature – A system or set of terms, names, or definitions.

Post-traumatic Stress Disorder – Intense fear, helplessness, or horror brought about through exposure to an extreme stressor or other threat to oneself.

Postvention – A sequence of planned support and interventions carried out with survivors in the aftermath of a suicide.

Prevention – A coordinated and comprehensive set of specific interventions strategically linked to target populations at risk for the development of specific disorders and dysfunctions.

Protective Factors – The positive conditions, personal and social resources that promote resiliency, protect and buffer the individual, and reduce the potential for high-risk behaviors, including suicide.

Psychiatric Illness – Mental disorder of the brain or "mind." See the American Psychiatric Association's Diagnostical and Statistical Manual for Mental Disorders for a list of disorders.

Psychoeducation – Methods or approaches for educational purpose that are based on foundations of psychological theory.

Psychological Autopsy – In-depth study of the elements that may have led to a completed suicide.

Psychopharmacology – The study of the effect of drugs on the mind and behavior.

Reliability – The degree to which an individual's test score remains relatively consistent over repeated administration of the same test or alternate test forms.

Risk Factors – Stressful events, situations, and/or conditions that may increase one's likelihood of attempting or completing suicide.

Serotonin – A neurotransmitter. Diminished serotonin activity has been associated with suicide in adults.

Sociocultural – Involving a combination of social and cultural factors.

Somatic Complaints – An expression of grief, pain, or discontent relating to or affecting the human body.

Stressor – A situation or action that increases stress.

Substance Abuse – Maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.

Suicide – Death from injury, poisoning, or suffocation where there is evidence (either explicit or implicit) the injury was self-inflicted and the decedent intended to kill himself or herself. (Note: The term "completed suicide" can be used interchangeably with the term "suicide.")

Suicide Watch – Around-the-clock observation and direct supervision of client activities initiated by hospital staff to protect the life of a suicidal patient.

Surveillance – A mechanism for identifying and characterizing selected problems. The mechanism is the collection, analysis, interpretation, and dissemination of health-related information used for planning, implementation, and evaluation of public health programs.

Validity – The extent to which a measuring instrument corresponds to its concept.

Witnessed Suicide – Personal or direct cognizance of a suicide. A witness may be visibly or audibly present, may discover the victim, be informed by telephone of the intent, be advised in advance of suicidal ideation or a suicidal plan, or have secret knowledge of a suicide attempt or rehearsal.