TeachME PROFESSIONAL DEVELOPMENT
CEUs for Teachers and Educators

Suicide Prevention Guide for Schools

Introduction

Suicide is the second leading cause of death among 10 to 24-year-olds, only behind accidental or unintentional injuries, in the United States (Prinstein, 2022). While this statistic is grim, with the proper programs in place, schools have the potential to change it. Schools have a unique opportunity to address the behavioral health of young people and take proactive steps for prevention. For educators, this means implementing awareness and skills training for students, understanding and identifying risk factors, warning signs, and protective factors, and knowing the appropriate steps to take to help a suicidal student.

Section 1: Youth Mental Health Crisis

In 2021, the American Academy of Pediatrics (AAP) declared a state of emergency regarding the mental health of children and adolescents (Charpignon et al., 2022). This occurred in the midst of the covid-19 pandemic, which of course had detrimental effects on mental health, but the rise in youth suicide rates was happening before then. While the term "youth" is relatively subjective, this course discusses school-age children, 5-12 years old, as well as adolescents from 13-20 years old. "Young people are by nature vulnerable to mental health problems, especially during the years of adolescence" (Bilsen, 2018).

Statistics

Between 2000 and 2007, the suicide rate among young people aged 10 to 24-years-old stayed around 6.8 deaths per 100,000 people; by 2019, the rate trended upward to 10.7 deaths per 100,000 people, which is a 57.4% increase in a little over a decade's time (Curtin, 2020). While youth suicide is a major public health concern, both within the United States and globally, even more young people attempt suicide or have suicide ideations. For example, "during 2018, according to data from a nationally representative sample of emergency departments (EDs), approximately 95,000 youths aged 14–18 years visited EDs for self-harm injuries" (Ivey-Stevenson et al., 2020).

Ivey-Stevenson et al. (2020) reports on the findings of the 2019 Youth Risk Behavior Survey (YRBS), "regarding suicidal ideation and behaviors among high school students and presents trends in suicide attempts among this population during 2009–2019." During the year before the survey took place, 18.8% of students across the country

“reported seriously considered attempting suicide,” among these students, “15.7% of students had made a plan about how they would attempt suicide,” and “8.9% of students had attempted suicide ≥1 time” (Ivey-Stevenson et al.). For all three of these categories, prevalence was higher amongst female students than male students. While reporting attempted suicide and suicide ideation is more prevalent for adolescent girls, actually succeeding in committing suicide is consistently higher for males; “in 2017, the rate of suicides was 17.9 per 100,000 in males and 5.4 per 100,000 in females among” 14-19 year olds (Jones, 2019).

The Youngest Group

Typically, youth suicide rates peak during mid-adolescence, but it’s important to note that the prevalence of suicide for kids aged 5-11 has also risen an average of 15% per year from 2013 to 2020 (Sparks, 2022). John Ackerman, clinical pediatric psychologist and the suicide-prevention coordinator with the Center for Suicide Prevention and Research at Nationwide Children’s Hospital, explains, “A lot of adults view elementary school-aged kids as incapable of experiencing the level of emotional distress that could lead someone to consider suicide, but we know very objectively that’s not true” (as cited in Sparks). Further, “Research shows now that young kids . . . understand that killing oneself leads to death, but they don’t always understand the permanence of that . . . We know that young kids absolutely can be in deep, emotional pain. They can have a desire to die but not always fully understand the implications of that” (Sparks). As such, discussing mental health and having difficult conversations with younger kids is essential because while they are capable of feeling suicidal, they do not understand that death means that they will never come back. They simply don’t understand the implications of their actions. Signs of mental health struggles in young children may also be more difficult to identify. “A lot of times they’re left with intense feelings that they’re not able to communicate, or potentially the parts of the brain that do a good job of helping manage and find out solutions on how to deal with those don’t have as much practice” (Gans, 2022).

Groups with Increased Risk

In 2019, “one out of every five youth reported seriously considering attempting suicide, and one out of every eleven actually made a suicide attempt” (Youth.gov, 2022). For some groups of youth, the prevalence of suicidal behavior is even higher. Such groups include youth involved in juvenile justice and welfare systems, LGBTQ+, and American Indian/Alaska Native (AI/AN) (Youth.gov). These groups with increased risk are discussed below, along with key risk factors and protective measures that are unique to each

group. “Risk factors are characteristics that potentially increase an individual’s level of suicide risk, whereas protective factors are factors that mitigate against risk” (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). Risk factors and protective measures for the general youth population will be discussed in detail in Section 2.

Youth in Juvenile Justice and Welfare Systems. Suicide among kids and teens in the juvenile justice system occurs about four times more than it does for youth in the general population (Youth.gov, 2022). Similarly, “children in foster care were almost four times more likely to have considered suicide and almost four times more likely to have attempted suicide than those who had never been in foster care” (Youth.gov).

Key Risk Factors. Children in the juvenile justice and welfare systems have a high prevalence of risk factors for suicide, such as mental, emotional, and behavioral disorders (Youth.gov). Difficult life situations and risk factors are more prevalent for youth in the juvenile and welfare systems, and they typically have less access to positive support systems and resources. For youth in confinement, there are additional high risk periods and factors to consider, including withdrawal from drugs and/or alcohol, legal hearings, personally significant dates (e.g. birthday), bad news, and and impending release or transfer (Illinois Public Health Institute & The Suicide Prevention/Juvenile Justice Curriculum Ad Hoc Committee, 2018).

Key Protective Factors. “While protective factors that stem from adults in youth’s lives cannot necessarily change existing risk factors, the following are protective factors that may minimize youth’s likelihood to engage in suicidal ideation or behavior” (Youth.gov, 2022). These protective factors include having a safe school and feeling connectedness at school, strong and open communication with trusted adult/s, physical activity and participation in sports, reduced access to lethal means, learning effective coping skills, academic achievement, and consistent academic support (Youth.gov). Unsurprisingly, many of the protective factors for youth in the juvenile justice or welfare systems are associated with a supportive, stable environment and having a trusted adult, which are often scarce for kids in the system. Sometimes youths in the system have positive relationships with foster parents or case managers, but oftentimes it is teachers, coaches, and other school personnel that play this important role.

LGBTQ+. LGBTQ+ youth are more than four times as likely to attempt suicide as their peers, with an estimated 1.8 million per year seriously considering suicide, and at least one suicide attempt occuring every 45-seconds in the United States (The Trevor Project, 2021). LGBTQ+ youth “are not inherently prone to suicide risk because of their sexual

orientation or gender identity but rather placed at higher risk because of how they are mistreated and stigmatized in society" (The Trevor Project). Although there is some degree of increased awareness and acceptance in the United States today, LGBTQ+ still deal with "harassment, discrimination, and bias enacted by peers, family, colleagues, workplaces, houses of worship, schools, places of public accommodation, and health care settings" (National LGBT Health Education Center).

For the youth LGBTQ+ population, intersectionality is also a factor. Intersectionality is "a framework for understanding how interdependent and multidimensional social identities at the individual level, such as race/ethnicity, gender, and sexuality, are shaped by interlocking systems of privilege and oppression at the societal level, such as heterosexism, cisgenderism, and racism" (The Trevor Project, 2021). Intersectionality presents distinct stressors for LGBTQ+ youth that also identify with additional marginalized groups. While research is limited, the existing research shows "increased disparities for bisexual youth, transgender and nonbinary youth, and LGBTQ youth of color" (The Trevor Project).

Key Risk Factors. Some unique risk factors for LGBTQ+ youth include isolation from family and peers, history of mental health issues, substance use disorders, and victimization, including bullying and abuse (National LGBT Health Education Center, 2018). The Minority Stress Model "suggests that experiences of LGBTQ-based victimization — and the internalization of these experiences and anti-LGBTQ messages — can compound and produce negative mental health outcomes and increase suicide risk among LGBTQ individuals" (The Trevor Project, 2021). LGBTQ+ that experienced four specific types of minority stress, including "LGBTQ-based physical harm, discrimination, housing instability, and change attempts by parents," were 12 times more likely to attempt suicide than LGBTQ+ youth that did not have such experiences (The Trevor Project).

Rejection, a lack of social support, and a lack of affirming spaces are also unique risk factors for LGBTQ+ youth. Research shows that "only one-third experience parental acceptance, with an additional one-third experiencing parental rejection, and the final one-third not disclosing their LGBTQ identity until they are adults'' (The Trevor Project, 2021). Meanwhile, youth with high levels of parental rejection are eight times more likely to attempt suicide, and six times more likely to experience severe depression (The Trevor Project). Many LGBTQ+ youth do not have access to affirming, safe spaces. Only 55% of LGBTQ+ youth reported that their school is an affirming space, and only 37% reported that their home is affirming (The Trevor Project). This is even more drastic for

transgender and nonbinary youth, in which less than ⅓ found their homes to be gender-affirming, and about 51% found their schools to be (The Trevor Project).

LGBTQ+ youth experience bullying and physical harm at a higher rate than their straight, cisgender peers. 36% of LGBTQ+ youth reported being physically threatened or harmed, and 52% of LGBTQ+ youth enrolled in middle and high school experienced in-person or online bullying in the last year (The Trevor Project, 2021). Individuals that experienced bullying or physical harm were three times more likely to attempt suicide than those who did not (The Trevor Project). Further, "73% of LGBTQ youth report that they had experienced discrimination based on their sexual orientation or gender identity at least once in their lifetime," and those who did were more than two times as likely to attempt suicide (The Trevor Project).

Key Protective Factors. Social support and acceptance from adults and peers are key for LGBTQ+ youth. Having at least one supportive adult can reduce the risk of a suicide attempt among LGBTQ+ youth by 40% (The Trevor Project, 2021). This means that teachers have the unique opportunity to be that one supportive adult for an LGBTQ+ youth, making their life and experiences better. Further, "LGBTQ youth who felt high social support from their family reported attempting suicide at less than half the rate of those who felt low or moderate social support" (The Trevor Project). A supportive community also makes a big difference for LGBTQ+ youth.

Affirming spaces, particularly schools, is also a protective factor for the LGBTQ+ community. "LGBTQ youth who report the presence of trusted adults in their school have higher levels of self-esteem and access to supportive peers is protective against anxiety and depression, including among those who lack support from their family" (The Trevor Project, 2021). Essentially, a supportive school environment can actually combat the negativity of an unsupportive home environment. Schools that offer extracurricular activities and clubs, particularly Gender and Sexualities Alliances (GSA), have been found to "significantly reduce the risk for depression and increase well-being among LGBTQ youth and young adults'' (The Trevor Project).

Policies and practices that support transgender and nonbinary youth are also necessary protective factors. Transgender and nonbinary youth experience better mental health outcomes "when their pronouns are respected, when they are allowed to officially change the gender marker on their legal documents, and when they have access to spaces (online, at school, and home) that affirm their gender identity" (The Trevor Project, 2021). Further, gender-affirming healthcare, including "gender-affirming

hormone therapy is significantly related to lower rates of depression, suicidal thoughts, and suicide attempts among transgender and nonbinary youth" (The Trevor Project).

AI/AN. "Suicide rates among American Indian/Alaska Native (AI/AN) individuals are the highest among any racial or ethnic group in the United States, thus suicide rates among AI/AN youth are significantly higher than among youth overall" (Youth.gov, 2022). 34% of AI/AN high school youth had seriously considered suicide in the past year compared to 18% of the overall population, and the percentage of AI/AN high school youth that made an actual suicide plan was 9% higher than non-native youth of the same age (Youth.gov). Suicide risk for this population is at its highest during adolescence and young adulthood, between ages 15-34. "Although suicide rates vary widely among individual tribes, it is estimated that 14 to 27 percent of AI/AN adolescents have attempted suicide" (Youth.gov).

Key Risk Factors. Alcohol and drug use have been found to be high risk factors for AI/AN youth. "AI/AN populations had the highest rate of current illicit drug use (13.4%) among those ages 12 or older compared to any other single racial/ethnic group, and illicit drug use is a risk factor for suicide" (Education Development Center). Drug and alcohol use are often seen as an outlet for AI/AN youth that have depression, or have gone through a traumatic experience. "AI/AN youth are 2.5 times more likely to experience trauma than non-AI/AN youth" (Education Development Center, 2020). A lot of this trauma involves victimization from non AI/AN people, as well as family violence and abuse.

AI/AN youth often have limited access to mental health services, or they do not utilize them. "Only 10% to 35% of American Indian adolescents and young adults use professional health services during a suicidal episode" (Education Development Center, 2020). There are many different reasons that AI/AN youth cite for not seeking help. One study reported that "internal factors, such as embarrassment, not realizing they had a problem, a belief that nobody could help, and self-reliance, affected their decisions not to seek help" (Education Development Center). In addition, many AI/AN people live in isolated rural areas, making it difficult to access healthcare professionals even if they wanted to. As such, there is a significant need for mental health services and suicide prevention programs in rural areas with a large AI/AN youth population. Mental health services are not only needed for therapeutic purposes but also "to identify and diagnose youth struggling with mental disorders that put them at higher risk for suicide early on" (Youth.gov, 2022).

Acculturation is another unique risk factor that AI/AN youth experience. "In some American Indian tribes, there is more pressure to acculturate, greater conflict regarding

traditional cultural practices, and a high suicide rate among adolescents and young adults" (Education Development Center, 2020). Tribal members with "greater adaptation to the mainstream culture" report increased psychosocial stress, less happiness, and increased drug and alcohol use to cope with balancing two cultures (Education Development Center).

AI/AN youth also experience frequent discrimination. "Studies of American Indian youth found that discrimination was as important a predictor of suicidal ideation as poor self-esteem and depression" (Education Development Center, 2020). This association is more prevalent for AI/AN youth in reservations than it is for youth in urban areas. LGBTQ+ AI/AN individuals experience "even more prejudice and discrimination and have higher rates of suicide deaths, attempts, and ideation than heterosexual AI/AN people and LGBT people of other racial/ethnic backgrounds" (Education Development Center).

Key Protective Factors. "Two large studies found that for AI/AN youth, strengthening protective factors may be more important than reducing risk factors in addressing suicide risk" (Education Development Center, 2020). In a study of data from the British Columbia Coroner's Office, tribes with no suicides showed more cultural continuity. Cultural continuity is defined as "having infrastructure, such as the presence of cultural facilities; sovereignty, such as self-government; having title to their traditional lands; and the provision of services within the community, including education, police, and fire, health care delivery, and child and family services" (Education Development Center).

Cultural identity and spirituality are protective factors for AI/AN youth. Two studies of Native American youth in the midwest found "that those who had a stronger ethnic/cultural identity were better able to cope with acculturative stress and less likely to have suicidal thoughts" (Education Development Center, 2020). Additionally, "people with a high level of cultural spiritual orientation have a reduced prevalence of suicide compared with those with low levels of cultural spiritual orientation" (Education Development Center). Family connectedness also serves as a protective factor for AI/AN youth.

Possible Causes for the Rise in Youth Suicides

Public health experts do not have a definitive reason for the rise in youth suicide rates, but only speculation. The CDC attributed some of the rise in suicide and suicide ideation rates among adolescents to "increases in social media use, anxiety, depression, and self-inflicted injuries," but wish to examine more data points as well (Miron et al., 2019). Youth.gov (2022) expresses that these increasing rates of suicide ideation should be a

call for action regarding the need for “high quality comprehensive support” and “suicide prevention” services, particularly for groups of youth that are at an increased risk. Likewise, inefficient mental health screenings and stigma surrounding mental health create obstacles for individuals that might need help (Dastagir, 2020). “Fear of school shootings and the prohibitive cost of college may also be factors. Many children, experts say, are struggling to imagine their futures” (Dastagir). Each of these factors, or a combination of multiple, most likely contribute to the rise in suicide rates among young people.

Effects of the Covid-19 Pandemic

During the summer and winter of 2020, following the announcement of the Covid-19 pandemic and mitigation measures being put into place, emergency room visits for adolescent suicide attempts increased significantly (Li, 2021). According to reports from the CDC, “There was a 22.3 percent spike in ER trips for potential suicides by children aged 12 to 17 in summer 2020 compared to 2019” (Li). During the Covid-19 pandemic, young people might “represent a group at high risk because they might have been particularly affected by mitigation measures, such as physical distancing (including a lack of connectedness to schools) . . . barriers to mental health treatment; increases in substance use; and anxiety about family health and economic problems, which are all risk factors for suicide” (Li). While experts cannot say for sure that these increases were a direct effect of the pandemic, it seems likely that losing loved ones, isolation, and fear is related to suicide attempts.

Myths About Youth Suicide

The more educators understand about suicide and suicide prevention, the better prepared they are to help students that are at-risk. As a result, it is important that teachers can differentiate between facts and myths when it comes to youth suicide.

Myth 1: Talking about suicide will encourage/trigger the act

Many adults believe that if they ask a teen if they are suicidal or discuss suicide, then it will give them the idea to commit suicide. This belief is not only false but it is also a barrier to potentially helpful conversations for at-risk youth. “Asking at-risk individuals if they are suicidal can help lower anxiety, open up communication, and lower the risk of an impulsive act” (Nevada Division of Public and Behavioral Health [DPBH] Office of Suicide Prevention, 2021). In addition to opening a line of non-judgmental communication, discussing suicide with young people who might be at-risk can help the

teacher gauge whether or not they are seriously considering suicide. “Opening this conversation helps people find an alternative view of their existing circumstances,” and also increases the likelihood that they will seek help (Sharma, 2021). Still, suicide should not be discussed casually or without precaution. Section 3 discusses evidence-based ways to approach such a discussion, and additional steps to follow.

Myth 2: Young people that talk about suicide don’t actually follow through or are just seeking attention

When a young person talks about feeling suicidal, it should ALWAYS be taken seriously. In fact, talking about suicide is a warning sign, which will be further discussed in section 2. “Talking about suicide can be a plea for help and it can be a late sign in the progression towards a suicide attempt” (DPBH, 2021). Educators should never assume that kids are not serious, just seeking attention, or being dramatic. In fact, if a child is seeking this kind of attention, then receiving the attention could save that young person’s life. If a child talks about death or suicide, it is important to listen without judgment and then take the appropriate next steps (e.g. contact the school psychologist for a suicide assessment).

Myth 3: Suicide attempts and deaths happen without warning

There are almost always warning signs before a suicide attempt, but oftentimes the warning signs are not recognized (DPBH, 2021). In most cases of death by suicide, such signs are evident in the individual’s behavior or conversations prior (Camber Children’s Mental Health, 2021). Research also shows that kids often share their thoughts and plans with peers at school, and “adolescents are more likely to 'ask' for help through non-verbal gestures than to express their situation verbally to others” (DPBH). Being able to identify suicide warning signs (discussed in section 2) and acting quickly are keys to early intervention. Therefore, when both kids and adults are taught the warning signs and encouraged to speak up about mental health issues, it is more likely that suicide attempts can be prevented.

Myth 4: If a person really wants to commit suicide, there’s no way to stop them

Suicide is often preventable. Suicidal ideation can be short-lived and situational. For example, stressful events like the death of a loved one, end of a relationship, or trouble with the law can trigger suicidal thoughts in a vulnerable person; however, people can get help. “Early identification and intervention make it possible to help someone before they attempt suicide” (Camber Children’s Mental Health, 2021). By knowing risk factors and warning signs, as well as having open communication (discussed more in sections 2

and 3), teachers can help suicidal students get the help that they need. “Professional counseling, medications, and other treatment approaches have proven to be very successful in helping people reduce and overcome suicidal thoughts” (Camber Children’s Mental Health).

Myth 5: There is a specific profile for youth that commit suicide

“Suicidal thoughts and attempts can happen to anyone regardless of gender, race, age, upbringing, education level, ethnicity, or other demographic, lifestyle or socio-economic factors” (Camber Children’s Mental Health, 2021). While there are risk factors that can indicate a higher risk for suicide, anybody can have suicidal thoughts, including people that don’t have any risk factors. “Youth are in very influential, developmental phases and may be experiencing a range of pressures and stress that overwhelm them and lead to suicidal thoughts” (Camber Children’s Mental Health). There is no one profile for someone who is suicidal or might have suicidal thoughts. “By removing assumptions that certain people should or should not have suicidal thoughts, we further help reduce the stigma around suicide and mental health overall” (Camber Children’s Mental Health).

Myth 6: If a person attempts suicide and survives, they won’t try again

Attempting suicide is a key risk factor for further attempts and “it is likely that the level of danger will increase with each further suicide attempt” (DPBH, 2021). In the three months following a suicide attempt, a young person is most at risk for dying by suicide (DPBH). As such, if a suicide attempt has already been made, a child is considered at an increased risk for suicide and monitored appropriately.

Section 1 Key Terms

Cultural Continuity - Having infrastructure, such as the presence of cultural facilities; sovereignty, such as self-government; having title to their traditional lands; and the provision of services within the community, including education, police, and fire, health care delivery, and child and family services

Intersectionality - The interconnected nature of social categorizations such as race, class, and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.

Minority Stress Model - A relationship between minority and dominant values and resultant conflict with the social environment experienced by minority group members

Protective Factors - Factors that mitigate against risk

Risk Factors - Characteristics that potentially increase an individual's level of suicide risk

Suicidal Ideation - Thoughts of engaging in suicide-related behavior

Section 1 Reflection Questions

1. While researchers suggest a number of reasons for the rise in youth suicide rates, there's not necessarily one specific cause for the increase. What individual factors and societal factors do you think most contribute to the increased youth suicide rates?
2. Which suicide myth do you think is most widely believed among educators? Why is it important for teachers to differentiate between myths and facts about suicide?
3. Why do you think certain groups are at a statistically higher risk for suicide? What can educators do to provide additional support for children in these groups without singling them out?

Section 1 Activities

1. Research some of the available supports (clubs, support groups, organizations, etc.) and resources for youth in the high-risk groups discussed above that are available in your community. Create a document of available resources that you can save to share with students or parents.

Section 2: Risk Factors, Protective Measures, and Warning Signs

As stated in section 1, "Risk factors are characteristics that potentially increase an individual's level of suicide risk, whereas protective factors are factors that mitigate against risk" (SAMHSA, 2020). Understanding risk factors and protective factors allows educators to be proactive in identifying students that may be at risk, and providing additional support when possible. "Understanding the dynamics of resilience, and the intricate interchange of risk and protective factors, has been shown to bolster intervention and prevention efforts in various situations, including adolescent suicide"

(National Association of Social Workers, 2022). At the end of this section, suicide warning signs will be discussed. Warning signs are different from risk factors in that if they are present, it means that an individual might be at immediate risk for suicide.

Risk Factors

"Findings from recent research have shown that most youth suicides are the result of an interaction between biological, psychological, socio-cultural, and family factors" (DPBH, 2021). As such, risk factors occur at an individual, relational, community, or societal level. Further, an individual's age, gender, or ethnicity can increase the impact of certain risk factors (DPBH). Nevada DPBH explains, "A suicidal act can be seen as the result of an interaction between background personal and family factors, current emotional state and recent significant life event which lead to an intolerable mental anguish in the young person." However, suicide is not typically a random act or a result of stress alone. Understanding common risk factors can help educators be proactive in suicide prevention.

Individual

Previous Suicide Attempts. "The most powerful predictor of completed youth suicide is a past history of attempted suicide" (DPBH, 2021). About 25–33% of youth suicide cases came after an earlier suicide attempt, and this was more prevalent among boys than girls (Bilsen, 2018). Research shows that boys with a previous suicide attempt have a "30-fold increase in suicide risk" than boys without a previous suicide attempt, while girls with previous attempts have a "threefold" increase (Bilsen). The more times that individuals attempt to commit suicide, the higher the likelihood is that they will succeed. Self-harm, such as cutting, is also common after a suicide attempt, which creates additional risks. Studies show that the stigma and shame people feel after an attempted suicide may cause them to try to do it again (American Academy of Pediatrics [AAP], 2022). A person is considered at a high risk for one year after a suicide attempt, so follow-up care and support is pertinent (AAP).

Mental Health Conditions. Mental health conditions that can put young people at a greater risk for suicide include (but may not be limited to) depression, anxiety disorders, bipolar disorder, conduct disorder, and schizophrenia (American Foundation for Suicide Prevention [AFSP], 2022). Mental health disorders contribute to 47-74% of suicide risk, and about 90% of individuals that commit suicide have at least one known mental health disorder (Bilsen, 2018). Many youth that struggle with mental health disorders

experience a comorbidity of conditions, which also "substantially increases suicide risk" (Bilsen, 2018).

Depression. Depression is a "health condition that causes someone to be in a sad or irritable mood for an unusually long period of time" (Miller, 2021). Depression is not uncommon in adolescents and teens. "In 2020, 12% of U.S. children ages 3 to 17 were reported as having ever experienced anxiety or depression, up from 9% in 2016" (VanOrman, 2022). Depression can affect youth of any sex and gender identity, but studies show by age 15, females were twice as likely to have experienced depression as males, and the likelihood is even higher for individuals "who identify with a gender minority, such as transgender, genderqueer, and nonbinary" (Washington, 2021). Unfortunately, due to lack of access, stigma, and other various reasons, many children and teens do not seek treatment for their depression. According to Mental Health America (MHA), 60% of adolescents with depression did not seek treatment from 2017 to 2018, and "more than two-thirds of adolescents diagnosed with depression did not continue with consistent treatment" (Washington).

It is important to note that mood changes, and even occasional irritability or sadness, is normal for children, adolescents and teenagers, but ongoing, debilitating, low moods can indicate serious depression. As educators, it is important to be able to recognize some of the common signs of depression:

- Low mood
- Loss of interest in activities
- Social withdrawal and isolation
- Loss of energy and motivation
- Frequent crying or outbursts
- Fatigue
- Loss of enjoyment in activities
- Sleep disturbance (sleeplessness or excessive sleeping)
- Change in appetite (increased or decreased)
- Physical complaints (stomachaches, headaches) that don't improve with treatment

- Sense of hopelessness and/or helplessness
- Thoughts of death or suicide (DPBH, 2021; WebMD, 2022)

Not all children and teens will exhibit all of these symptoms, and they can vary at different times and in different settings. “Although some children may continue to do reasonably well in structured environments, most kids with significant depression will have a noticeable change in social activities, loss of interest in school, poor academic performance, or a change in appearance” (WebMD). Since teachers see these children everyday, it is important that they are cognizant of drastic changes in short periods, or even major changes over time. Children that experience depression are also at an increased risk for drug and alcohol use, particularly if they are over 12-years-old (WedMD). Since 20% of adolescents and teens will face depression at some point in their lives, the AAP recommends that all kids aged 12 and over be screened for depression and suicide risks during their yearly checkups, as a sort of universal screening preventative measure (AAP, 2022).

Bipolar Disorder. Like depression, bipolar disorder is a mood disorder. With bipolar disorder, episodes alternate between depression and mania (or feeling “up,” or overly happy) (National Institute of Mental Health, 2020). These ups and downs of bipolar disorder are not the typical up and down feelings that all children exhibit. Symptoms of mania include: talking more than usual, talking too fast or loud, inflated self esteem, distractibility, excessive interest in pleasurable but risky activities, and extreme irritability (National Institute of Mental Health). The National Institute of Mental Health explains, “Although bipolar disorder is less common than depression in both teens and adults, those with the illness are at particular risk for suicide.”

Conduct Disorders. Conduct disorders refer to a cluster of behavioral and emotional problems characterized by antisocial behavior. Children with a conduct disorder have a “difficult time following rules and behaving in a socially acceptable way,” and can exhibit behaviors that are “hostile and sometimes physically violent” (Nationwide Children’s Hospital, 2022). When they’re young, children with conduct disorders might engage in aggressive behaviors like pushing, hitting and biting; as they get older, more serious behaviors might emerge, like bullying, hurting animals, picking fights, theft, vandalism and arson (Nationwide Children’s Hospital).

Individuals with conduct disorders are believed to have an impairment in the frontal lobe of their brain, which causes impulsivity, and interferes with their ability to “plan, avoid harm, and learn from negative experiences” (Nationwide Children’s Hospital).

Other risk factors that lead to conduct disorder include having experienced "abuse, parental rejection, or neglect," living in poverty, exposure to violence, lack of parental involvement, and inconsistent or overly harsh discipline (Nationwide Children's Hospital).

"Youths with a history of conduct disorder have a much higher risk of suicide because they tend to act out their feelings in a destructive manner" (DPBH, 2021). Many individuals with conduct disorders are in a constant state of emotional crisis and unable to manage such strong emotions. Likewise, they are impulsive and do not consider the consequences of their actions, making suicide ideation particularly dangerous for this population. Kids with a conduct disorder are at a higher risk for suicide if they are "isolated, angry, aggressive, impulsive and they are abusing drugs and alcohol" (DPBH).

Drug & Alcohol Abuse. "It is estimated that substance abuse occurs in 1/3 of youth suicides" (DPBH, 2021). Many young people that suffer from depression or simply have difficulty coping with problems turn to alcohol or drugs for relief. Because drugs and alcohol feel like a temporary escape, usage continues and often increases. "With increased use, the youth may become emotionally and physically dependent on the drugs to the point where he/she has to keep taking them to avoid withdrawal symptoms" (DPBH). While young people might take excessive amounts of drugs to purposely commit suicide, drug use can also lead to accidental death, either by overdosing or engaging in dangerous behaviors (e.g. intoxicated driving). Furthermore, "drugs, including the so called 'recreational drugs,' can bring on psychotic episodes with resultant hallucinations and delusions which may then lead to suicide" (AAP, 2022). Drugs and alcohol also have a tendency to exacerbate symptoms of depression, anxiety, and paranoia, which creates a lethal combination for individuals that already suffer from mental health disorders.

Relational

Negative Peer Relationships & Bullying. For an adolescent, social influence and peer groups are extremely important. Therefore, it is not surprising that "interpersonal losses" such as "relationship break-ups, the death of friends and peer rejection may have a great impact in youth, and are found in one fifth of youth suicide cases" (Bilsen, 2018). Typically an otherwise mentally healthy individual will not become suicidal due to issues in their peer group, but social problems combined with other factors can increase the risk.

Bullying increases the risk for suicide ideation and suicide attempts for youth. Bullying is defined as “an aggressive behavior that involves an imbalance of power or strength,” and is “repeated over time” (Megan Meier Foundation, 2022). Bullying can be physical (hitting, punching, shoving), verbal (teasing, taunting, name-calling, sexual remarks), or psychological/social (intimidation, spreading rumors, or social exclusion) (Megan Meier Foundation). Unfortunately, bullying is not at all uncommon. The National Center for Education Statistics reported that 20% of middle and high school students reported being bullied each year (Megan Meier Foundation). Kids who are bullied are at an increased risk for “depression, anxiety, sleep difficulties, lower academic achievement, and dropping out of school”; further, kids who bully are at an increased risk for “substance use, academic problems, and experiencing violence later in adolescence and adulthood” (National Center for Injury Prevention and Control [NCIPC], 2019). Largely due to the feelings of depression, anxiety, and helplessness, youth who are bullied are almost two times more likely to attempt suicide than individuals who aren’t bullied (Megan Meier Foundation). It is also alarming to note that while one in five youth in America experience serious mental concerns associated with trauma, bullying, and social isolation, only 20% of them get the help that they need (Megan Meier Foundation).

Negative Family Experiences. There are multiple family experiences that are associated with increased suicide risk. “It is estimated that in 50% of youth suicide cases, family factors are involved” (Bilsen, 2018). One important family factor is history: history of mental health disorders, substance abuse, and suicidal behavior of the immediate family. “Research shows that when one family member dies by suicide, others in the same family are more likely to take their own lives” (AAP, 2022). While this might seem like imitation behavior, “adoption studies have reported a greater concordance of suicidal behavior with biological relatives than adoptive relatives, which points more toward a genetic explanation” (Bilsen).

Traumatic events within the home are also related to suicide. “Kids who live with abuse, violence, and other forms of trauma are also at greater risk of suicide” (AAP, 2022). Abuse does not necessarily have to be against the child for it to affect that child’s mental health. “Violence at home often seems to be found in the background history of young suicide cases, not only specifically against the child, but more as a way of dealing with problems between family members” (Bilsen, 2018). When children see violence in their home, it automatically ignites fear, as their biological fight or flight system turns on, creating excessive stress responses. Sexual and emotional abuse are “associated with subsequent suicide attempts . . . with sexual abuse and emotional abuse playing an important role in adolescent suicidal behavior” (Wasserman et al., 2021). Disruptions

within a child or teen's family life can have detrimental effects as well. Separation from caregivers or family members due to death, deployment, divorce, incarceration, deportation, or other means, "can cause mental health struggles that may contribute to suicide risks, as can the loss of stable housing" (AAP).

Conflicts or poor communication with family can also be a trigger. Family support is important at any age, particularly for adolescents during a time of rapid changes, and inconsistent or unavailable support can have negative consequences. "Acute conflicts with parental figures precede 40% of suicide cases" (Bilsen, 2018). Children who don't have support from the important adults in their lives, or support from other family members, can experience extreme isolation, which can lead to suicidal feelings. Other family risk factors include new family relationships (e.g. blended families, parental significant others), geographic and social mobility, and poverty (AAP, 2022).

Community & Societal

Suicide Imitation. Some studies have indicated "that when young people learn about the suicide of someone they know, they are more likely to consider or attempt suicide" (AAP, 2022). When a suicide occurs, especially if it involves a family member, friend, close adult, or peer at school, it's important that caregivers and educators pay close attention to the mental states of the children. Kids and teens will most likely need extra support (e.g. grief counseling, peer support groups, et cetera) to cope with the confusion and feelings that arise from such a loss. Likewise, while imitation of suicide is more likely in a situation of direct contact (e.g. friends, family, school), it can also "be evoked at a macro level (e.g., by mass media reports)" (Bilsen, 2018). Suicide imitation is dependent on additional factors. First, the "characteristics of the model" are important factors, and imitating effects are stronger when "there are similarities between the young person and the model" (e.g. age, gender, background story), "there is a strong bond between them," or "the model is someone they admire" (Bilsen). Second, whether or not the behavior is validated and reinforced makes a difference. "The more this behavior is condoned, regarded as positive, understandable, sometimes even admirable and brave, the more young people are likely to imitate it" (Bilsen). Lastly, "the frequency and manner of presentation of the model's behavior is important, e.g., the size and number of headlines, number of repetitions, real story or fiction" (Bilsen).

Racism & Discrimination. Racism, discrimination, and other "related systemic bias" are detrimental to an individual's mental health (AAP, 2022). This is particularly true for adolescents because there is so much individual change and uncertainty occuring, that additional community conflicts make them a more vulnerable population. One study of

“Black and Latinx youth showed that even subtle discrimination is linked with suicidal thinking” (AAP). Discrimination is also the factor that puts LGBTQ+ at a higher risk for suicide.

Lack of Access to Healthcare. Some youth, due to their geographical location, do not have access to healthcare services. Therefore, even if they wanted to seek professional mental help, it is not an easy option for them. For example, “youth living in rural areas are at greater risk of suicide than those living in urban areas. Suicide rates are also growing at a faster pace among rural youth” (National Institutes of Health [NIH], 2020). Despite these higher rates of suicide, rural areas have fewer mental health facilities that offer support for suicide prevention.

Stigma. Unfortunately, there is a stigma associated with mental health conditions, particularly when it comes to seeking help. Stigma regarding mental health is dangerous because it not only causes individuals with mental health issues to internalize negative feelings, but it also prevents them from seeking help when they need it the most. “Stigma towards mental illness may be a significant contributor to the emergence of suicidal ideation, to the progression from thoughts of suicide to suicidal behavior, and, in some cases, to dying by suicide” (Salvatore, 2022). Mental health stigma effects that increases the risk of suicide include:

- Internalization of negative beliefs
- Social exclusion and isolation
- Reduced social connection and support
- Hopelessness
- Shame
- Avoiding treatment of health and behavioral symptoms
- Exacerbation of mental illness symptoms (Salvatore)

The internalization of such stigma, combined with the refusal to seek help, puts suffering individuals in a very precarious and dangerous position.

Access to Lethal Means. “The transition from suicidal ideation to actual suicide often occurs impulsively as a reaction to acute psychosocial stressors, especially among young people” (Bilsen, 2018). So while suicide ideation can occur for longer periods of time, the decision to actually do it is often quick and impulsive, meaning that access to lethal

means plays a key role. In a study of 153 survivors, aged 13-34, of nearly-lethal suicide attempts, when asked how much time passed between when they decided to commit suicide and when they attempted it, one in four deliberated for less than 5 minutes (Harvard Injury Control Research Center, 2022). As such, availability of lethal means in those minutes of impulsivity, as well as the lethality of the chosen method, can make a difference.

Children often commit suicide via hanging, running into traffic, jumping from a high surface, or poisoning with a stash of prescription drugs; adolescents vary their methods and in addition to hanging and poisoning, particularly young men, use firearms (Bilsen, 2018). Not so surprisingly, "Firearms are the top cause of death for teens 15-19 years old who die by suicide" (AAP, 2022). One of the reasons for this is that guns are more lethal than almost any other method of suicide. Using a gun is quick and the damage is usually irreversible. "Attempters who take pills or inhale car exhaust or use razors have some time to reconsider mid-attempt and summon help or be rescued," whereas once a trigger is pulled, there's no rethinking the decision (Harvard Injury Control Research Center, 2022). Because we know that the "fatal transition from suicidal ideation and suicide attempts to an actual completed suicide often occurs suddenly, unexpectedly and impulsively, especially among adolescents," it is crucial that lethal means, especially firearms, are not so readily accessible to kids and young adults (Bilsen, 2018).

Poverty. Higher poverty rates are linked to increased suicide risks. A study of almost 21,000 deaths over a decade's time showed that "U.S. counties with poverty rates of at least 20%, people 5 to 19 years old were 37% more likely to die by suicide than people in counties where less than 5% of residents lived in poverty" (Galvin, 2020). While it's difficult to pinpoint the exact reasons for this correlation, Galvin suggests that kids living in high-poverty homes experience more stress, and their communities "may lack the neighborhood infrastructure for children to grow up healthy, such as safe parks, good schools or high-quality mental health care." In addition, poverty often results in a lack of health insurance, which makes healthcare inaccessible. "Disparities exist among some adolescents, particularly youths of color, who often lack adequate health insurance, and thus are not seen regularly by physicians" (NASW, 2022).

Protective Factors

Protective factors, which can reduce the risk of suicide by as much as 70%-85% when present, also occur at the individual, relationship, community, and societal levels (Wasserman et al., 2021; CDC, 2022). Although leading researchers in youth suicide note

the need for more research on specific protective factors for children and teens, they have identified the following: 1) Resilience (good coping and problem-solving skills), 2) strong family and community support, 3) positive peer relationships, and 4) interests and activities (DPBH, 2021).

Individual

Intrapersonal Skills & Resilience. Self-regulation, coping, and problem-solving skills are protective factors against suicide. The reason for this is because when an individual has healthy coping strategies and good problem-solving skills, they are able to better deal with stressful situations. "A person who is coping well may see a stressful situation as a challenge and an opportunity for change rather than as an occasion for despair" (Nevada DPBH, 2021). In addition, the way that children view themselves increases or decreases their risk. "Positive self-esteem also acts as a protective factor, especially when the interaction with perceived social support is considered" (Wasserman et al., 2021).

Relationship

Connectedness. "The stronger the connections kids have to their families, to their friends, and to people in the community, the less likely they are to harm themselves" (Kaslow, 2022). Positive relationships, particularly with a trusted adult, can make all the difference for a young person's mental health, even those in higher risk populations. This person can be a parent, teacher, youth worker, friend's parent, et cetera, as long as the individual is a positive influence on the child. The reason why this mitigates suicide ideation is partly "because they feel loved and supported, and partly because they have people to turn to when they're struggling and feel really challenged" (Kaslow). "As long as there is an emotionally significant person in the youth's life to whom the youth can relate, this will decrease the likelihood of suicide" (DPBH, 2021).

Family connectedness, specifically, is also a protective factor. "Firm guidance, good communication, family stability and an ability to 'grow' with the child are important ingredients for a well functioning family" (DPBH, 2021). In addition, when children have a supportive family at home, they always have someone that they can turn to in times of distress. Positive family relationships are also often associated with security and stability, which aid in positive mental health as well.

Community & Societal

Interests and Activities. Having interests and developing a passion for something gives a young person purpose. Further, group activities and team sports learn to "channel their energy and frustration in a socially acceptable manner" (DPBH, 2021). Taking part in activities can also help build stronger school and community connectedness, which are also protective factors (Kaslow, 2022). When children feel like they are a part of something, or they are good at something, they also have increased self esteem.

Access to Healthcare. "Promoting overall physical health has been shown to aid in reducing the prevalence of adolescent suicidal behaviors" (NASW, 2022). Having access to physicians, as well as mental health professionals as needed, provides an additional protective layer for kids. However, while access to healthcare is a protective factor, there is still "a need for training to assist primary care physicians in screening for risk factors, such as depression and other psychiatric illnesses, substance abuse, and behavior problems" (NASW).

Restricted Access to Lethal Means. Obviously, it is impossible to prevent access to every lethal means available, but there are proactive measures that can be taken to limit access. For example, "A key protective factor in reducing suicide among teen girls is to be aware of the methods commonly used by this population, including asphyxiation, cutting arteries, overdosing on prescription or other drugs, carbon monoxide poisoning, and firearms" (NASW, 2022). Particularly for youth that are considered at-risk, it is necessary to take all measures to ensure that they do not have lethal means readily available to them.

Warning Signs

While the presence of risk factors put people at a higher risk for suicide, warning signs indicate that they may be at an immediate risk, and intervention is needed. If teachers or other school officials witness any suicide warning signs, they should contact the school health professional and administration, and follow the school's risk assessment protocol. The Jason Foundation (2022) reports that "four out of five individuals considering suicide give some sign of their intentions, either verbally or behaviorally." Though not an exhaustive list, some warning signs include:

- **Ideation:** Talking about wanting to die, being a burden on others, or dealing with great shame or guilt are all verbal warning signs that someone might be considering suicide (NIH, 2022). Expressing these feelings verbally, in writing,

throughout artwork, or on social media, are all serious warning signs and should never be ignored.

- **Suicide Plan:** "Having a plan for suicide and/or obtaining the means to follow-through on a suicidal attempt" is a serious sign of immediate danger for the individual (Hughson, 2020).

- **Feelings of Unbearable Pain:** Expressing feelings of hopelessness, emptiness, or having no reason to live are also serious indicators (NIH). Even if these feelings are the result of a tragic event in the child's life, they are still warning signs and indicate that the child needs help.

- **Threats:** Sometimes an individual will make suicide threats or comments about death that should also not be ignored. Examples of these are, "I would be better off dead," "I won't be bothering anyone much longer," "You/they would be better off without me," and "I am going to kill myself" (NIH). Threats might come in off-color comments as well, such as an individual stating that they hate their life, or wish that they could sleep and never wake up.

- **Mood/Behavioral Changes & Depression:** The Jason Foundation explains that depression is also one of the leading causes of suicide. Depression can manifest differently in different people, including: sudden changes in personality, expressions of despair, loss of interest in activities, lack of hygiene, withdrawal from family and friends, aggression, changes in eating and sleeping habits, and declining grades and school performance (The Jason Foundation).

- **Self Destructive Behaviors:** Taking dangerous risks and being reckless are behavioral warning signs. This can include driving at high speeds, using drugs or alcohol, or risky sexual behavior. This can also include non-lethal self-harm, such as cutting.

- **Making Final Arrangements:** Some young people will choose to make final arrangements when they have decided to commit suicide. This might include "giving away prized possessions, putting their affairs in order," and "saying goodbye to family and friends" (The Jason Foundation).

Individual warning signs in isolation might not mean that a person is going to commit suicide, but it means that help is needed. When these issues and warning signs are not addressed they can result in suicide attempts.

Section 2 Key Terms

Comorbidity - When a person has two or more conditions (e.g. anxiety and depression)

Mania - Excessive happiness or enthusiasm; feeling “up”

Warning Signs - Indicate an imminent risk of suicide and may require prompt intervention

Section 2 Reflection Questions

1. Think about a student that you have worked with that exhibits signs of a mental illness. Besides some of the symptoms discussed above, how else did the illness manifest in the classroom?
2. As an educator, what do you think your role is in helping students access protective factors? How can you do this at the classroom level?
3. Have you ever experienced a child exhibiting suicidal warning signs? How did you handle the situation?
4. How can you reduce the stigma of mental health needs in your classroom? How can your administration do this at the school level?

Section 2 Activities

1. In a doc, create a table with two columns: Risk Factors and Mitigating Risk Factors. In the risk factors column, list some of the risk factors discussed above. In the mitigating column, list specific strategies that you can do as an educator to mitigate each risk factor.
2. Similar to the activity for section 1 but for the general population of students (not specific to high-risk populations), create a doc with community resources and groups that students can contact for support. Keep it student friendly and post it on a classroom or hallway bulletin board.

Section 3: The Role of Schools in Suicide Prevention

Children and adolescents spend a significant amount of their young lives at school. As such, school staff are in a key position to recognize the risks and warning signs of suicide, and determine the best ways to help; further, schools have the opportunity to take a proactive role in preventing suicide and suicide ideation through staff and student training/education, positive programming, and universal screening methods.

Knowledge of the Referral Process

Teachers do not typically have the training to provide counseling to a student in crisis, and are not expected to do so at most schools. Teachers must be familiar with their school's protocol for identifying and referring students for mental health evaluations. Likewise, most schools have a process for supporting a student that is suicidal. At the very least, if teachers determine that a student is suicidal, they should always contact the school's mental health professional, as well as a member of the administration. From there, parents and outside help will be contacted. Ensuring the child's safety is first and foremost, and following the school's procedure for dealing with a mental health crisis should support that.

Universal Strategies

Universal strategies target everyone in a defined population, such as students within a school, regardless of their risk status. Universal strategies for suicide prevention "promote well-being and prevent the probability of any suicide attempts by providing a safe and supportive environment for all students and staff" (Illinois State Board of Education, 2017). Universal strategies also often include parent support components, as well as school-improvement initiatives aimed at school climate (Wasserman et al., 2020). For universal suicide prevention strategies to be effective, institutions must practice a whole-school approach. A whole school approach "attempts to foster a school in which all adults and students are knowledgeable about suicide and prevention resources" (Committee for Children, 2019). One study showed that "students in schools with universal, schoolbased interventions showed a significant decrease in suicidal ideation and attempts in comparison to the control groups" (Committee for Children). Universal strategies include having a positive school climate, providing student awareness and skills training, implementing an early identification process, providing staff training,

having open communication regarding suicide and mental health, and using trauma-informed pedagogy.

Positive School Climate

The National School Climate Center [NSCC] (2021) defines school climate as, "the quality and character of school life," and is based on the key stakeholders' (students, parents, school personnel) "experience of school life, and reflects norms, goals, values, interpersonal relationships, teaching and learning practices, and organizational structures." Strong school climates can increase connectedness for students and give them a positive perception of school and learning, while poor school climates can have the opposite effect. A positive school climate also promotes diversity and actively opposes bullying. Many schools have a clear anti-bullying statement in their disciplinary policies and "are initiating programs that seek to change the school culture to be more inclusive and supportive of differences among students" (Carlton, 2020). Research shows "that safe and welcoming school environments and the presence of supportive adults are key to student well-being," while the opposite is "closely linked with levels of student anxiety, depression, rule-breaking, and substance use" (Serving and Accrediting Independent Schools [SAIS], 2022).

Student Awareness & Skills Training

Awareness and skills-based training for students is one of the common, and seemingly effective, universal strategies for suicide prevention that takes place in a school setting. Awareness training provides "reliable information about mental health and suicide, aiming to decrease stigma related to these issues and facilitate help-seeking behaviors," while "skills training is aimed at strengthening protective factors such as coping and problem-solving strategies, emotional awareness, and decision making." (Wasserman et al., 2020). There is an abundance of schoolwide intervention programs that cover suicide prevention, SEL skills, and overall mental health awareness.

Universal Suicide-Awareness and Education Programs. Suicide-awareness and education programs are usually implemented at the middle and high school levels, but there are also some programs available for elementary schools. "School-based suicide prevention programs that make use of education or awareness curricula teach students to recognize signs of suicide within themselves and others" (Committee for Children, 2019). There is "some" evidence that universal suicide-awareness and education programs reduce suicide attempts among middle and high school students, which means

that the “strategies have been tested more than once and results trend positive overall,” but still require additional research (County Health Rankings, 2017).

Some specific goals of awareness and education programs are to “increase knowledge and healthy attitudes about depression, encourage help-seeking behaviors, reduce stigma, engage parents and educators, and encourage school and community partnerships to support student mental health“ (Committee for Children, 2019). Oftentimes, discussing these heavy topics in age-appropriate ways can help young people to better understand and be able to identify serious mental health struggles. Since young people often turn to their peers to discuss suicidal feelings, educating children to identify warning signs can lead to better prevention.

Specific Programs. There are a handful of programs that have studies backing their effectiveness. Signs of Suicide (SOS) is a “a curriculum designed to raise awareness of suicide and a screening for depression and other risk factors associated with suicidal behavior” (Committee for Children, 2019). SOS has been evaluated in randomized control trials (RCTs) with U.S. high school students, and at the 3-month followup, “participants in the program were considerably less likely (40%–64%) to report a suicide attempt than those in the control group” (Committee for Children). Further, “increased knowledge about depression and suicide and more adaptive attitudes toward these problems were reported” (Committee for Children).

The Youth Aware of Mental Health (YAM) is a mental health promotion and suicide prevention program for kids in middle school and high school. With YAM, “mental health is explored through discussion and role-plays guided by two trained adult instructors and drawing on pedagogical materials (slides, posters, and a booklet for each participant to keep)” (Committee for Children, 2019). YAM has also been evaluated in an RCT involving over 11,000 European high school students; at the 12-month followup, “YAM participants showed half the incidence of suicide attempts and suicidal ideation compared to the students in the control condition” (Committee for Children). Committee for Children reports that “In a meta-analysis on youth suicide prevention, among the few included studies evaluating school-based and workplace interventions, YAM and SOS appeared to be promising even if requiring further evaluation.”

SEL Programs. SEL programs, sometimes referred to as skills training, develop “students’ problem-solving, coping, cognitive, communication, and social skills,” leading to improved relationships and overall well-being (Committee for Children, 2019). SEL programs cover five major competencies: self-awareness, self-management, social awareness, relationship skills, and positive decision making (Collaborative for Academic,

Social, and Emotional Learning [CASEL], 2022). The idea is that by developing these five core skills, young people will experience better individual, social, and academic outcomes, as well as better overall mental health. These programs can, but do not always, focus specifically on suicide prevention, but rather "promote problem-solving or self-regulation" skills, which are protective factors for youth suicide (Committee for Children). Some common themes across SEL programs include "building self-esteem, identifying emotions and stress, increasing communication and problem-solving skills, and recognizing and eliminating self-destructive behavior" (Committee for Children).

The benefits of SEL programs have been researched in depth. In 2011, a meta-analysis looking at 213 studies involving over 270,000 students found that "students participating in SEL programs showed improved classroom behavior, an increased ability to manage stress and depression, and better attitudes about themselves, others, and school" (CASEL, 2022). More recently, a 2021 study found that "universal SEL interventions enhance young people's social and emotional skills and reduce symptoms of depression and anxiety in the short term" (CASEL). In the long-term, studies show "a positive correlation between strong social emotional assets (measured at the end of intervention) and higher levels of well-being up to 18 years later" (CASEL). Again, while some of these programs might not directly discuss suicide, they give young people the tools that they need to deal with adversity, which is a key protective factor against suicide.

Provide Ways to Report. Sometimes young people will not approach adult with their problems, but rather they will go to a peer. Children and adolescents might not feel comfortable openly reporting their struggling friends to a parent, teacher, or other adult, so other accessible reporting methods must be available. Some districts have started to implement school wide hotlines that are accessible via phone or text. Called the "Text-a-Tip" hotline, it allows students, or anyone concerned about a student, to text for help at any time, and have "licensed mental health counselors text back, providing short-term crisis management and connections to community resources" (Kim, 2020).

Teacher & Personnel Training

"In 90% of cases suicide is thought to be the result of treatable conditions (e.g., depression, substance use disorders, etc.)," and "warning signs were identified in 80% of fatal suicides" (Hughson, 2020). As such, if teachers and other school personnel (who spend significant amounts of time with children), are trained to recognize warning signs and know how to intervene, then youth suicides should be preventable. It is important

to note that most school personnel are not expected or qualified to completes a suicide assessment or provide counseling, but rather "they are responsible for taking reasonable and prudent actions to help at-risk students, such as notifying parents, making appropriate referrals, and securing outside assistance when needed." (Hughson).

Gatekeeper Training. Gatekeeper programs aim to teach individuals in close contact with kids and teenagers, like teachers and other school personnel, to "recognize signs and symptoms of a suicidal crisis and refer identified 'at risk' subjects to appropriate help resources" (Committee for Children, 2019). Gatekeepers are trained to effectively:

- Identify risks and warning signs
- Reduce an individual's immediate risk through dialogue
- Keep an individual at imminent risk safe until necessary help arrives
- Facilitate referrals and assist in finding appropriate professional help (Illinois State Board of Education [ISBE], 2017).

School personnel have the opportunity to be the ultimate gatekeepers, as they often spend the most time with the kids. School staff need to be able to recognize and hear the warning signs and effectively intervene. "If a student comes up and has suicidal ideation or is talking about self-harm, [staff] are not really doing the counseling, but it's for the staff to recognize some of the language and the concerns and then refer to a counselor or a school psychologist" (Sparks, 2022). "All school staff must be prepared not only to thwart suicide attempts but also to address the conditions under which students develop suicidal thinking" (Hughson, 2020). With the proper training, school staff should be able to identify warning signs, and make the proper referrals accordingly.

QPR is a widely used gatekeeper training program. Individuals trained in QPR "learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help" (QPR Institute, 2020). The Committee for Children (2019) reports, "Several studies have shown a positive change in knowledge and attitudes toward suicide among trained teachers," but effectiveness in reducing suicide ideation and attempts among youth has not been proven.

Safe Communication with Students

While teachers should not provide counseling to students, they might be the ones that students approach with a problem, or the ones who notice warning signs. When this

happens, teachers should always contact the school's mental health professional immediately after the conversation. However, since teachers are often the trusted adult that students come to, they also need to be aware of a safe way to communicate with someone who might be suicidal. The 988 Suicide & Crisis Lifeline (2022) has identified five action steps for talking to individuals who might be suicidal: Ask, be there, keep them safe, help them connect, and follow up.

Ask. Asking the question, "Are you thinking about suicide?" "communicates that you're open to speaking about suicide in a non-judgmental and supportive way," and "can open the door for effective dialogue about their emotional pain" (988 Suicide & Crisis Lifeline, 2022). It is important that teachers never indicate or promise confidentiality when it comes to a student's feelings about suicide, as the promise cannot be kept, and breaking such a promise can cause the student to lose trust. After asking comes active listening. "Listening to their reasons for being in such emotional pain, as well as listening for any potential reasons they want to continue to stay alive, are both incredibly important when they are telling you what's going on" (988 Suicide & Crisis Lifeline, 2022). As teachers listen, it's important to keep the focus on the individual's reasons for living.

Importance. Many people are under the false impression that discussing suicide increases suicidal thoughts and risks, but that is not the case. 988 Suicide & Crisis Lifeline (2022) says that "findings suggest acknowledging and talking about suicide may in fact reduce rather than increase suicidal ideation." Using a straightforward line of dialogue like the one discussed above communicates support and eliminates stigma around suicide.

Be There. In general, being there can mean being physically present, talking on the phone, text messaging, or just showing support; however, for teachers, being there will typically fall into the categories of being physically present and providing support in the school setting. "An important aspect of this step is to make sure you follow through with the ways in which you say you'll be able to support the person – do not commit to anything you are not willing or able to accomplish" (988 Suicide & Crisis Lifeline, 2022). Not committing to anything unrealistic is especially important for teachers to maintain boundaries with students; for example, many schools discourage teachers from sharing their personal cell phone numbers with students and parents, so committing to talk any time the student needs to would be unrealistic. However, helping students make a list of people that they can contact for support in various settings and at different times is helpful.

Importance. Being there for someone who is suicidal can be life changing for that person. "Increasing someone's connectedness to others and limiting their isolation (both in the short and long-term) has shown to be a protective factor against suicide" (988 Suicide & Crisis Lifeline, 2022). In fact, many theories consider relationships to be more than a protective factor, but rather a key in suicide prevention. In Klonsky and May's Three-Step Theory, also known as Ideation-to-Action Framework, they explain that connectedness "is a key protective factor, not only against suicide as a whole, but in terms of the escalation of thoughts of suicide to action. Their research has also shown connectedness acts as a buffer against hopelessness and psychological pain" (988 Suicide & Crisis Lifeline). Being there for those who are experiencing depression or feelings of hopelessness can alleviate some of the negativity and show them that they are not alone.

Keep Them Safe. This step is important for determining the next course of action. After a teacher has "asked" the question and has determined that the student is contemplating suicide, "it's important to find out a few things to establish immediate safety" (988 Suicide & Crisis Lifeline, 2022). This means finding out if the child has already made suicide attempts, if there is a plan in place, and how detailed that plan is. Knowing the answers to these questions helps to determine if the student is in imminent danger or not. "The more steps and pieces of a plan that are in place, the higher their severity of risk and their capability to enact their plan might be" (988 Suicide & Crisis Lifeline). After expressing feelings of suicide, the child should not be left alone until a mental health professional completes an assessment and deems it safe; this means that the child should not be sent home where there might be access to lethal means, until the evaluation is done.

Importance. This step "is really about showing support for someone during the times when they have thoughts of suicide by putting **time** and **distance** between the person and their chosen method, especially methods that have shown higher lethality (like firearms and medications)" (988 Suicide & Crisis Lifeline, 2022). The Harvard T.H. Chan School of Public Health reports that reducing a suicidal person's access to lethal means, or their method of choice, is actually critical in suicide prevention (988 Suicide & Crisis Lifeline).

Help Them Connect. Helping individuals with suicidal thoughts connect with consistent, ongoing support, "can help them establish a safety net for those moments they find themselves in a crisis" (988 Suicide & Crisis Lifeline, 2022). In addition to connecting students with the school social worker, this step might include helping form connections

to resources in their community. Helping them connect might also include aiding in developing a safety plan, including "ways for them to identify if they start to experience significant, severe thoughts of suicide along with what to do in those crisis moments," and forming a list of people to contact if they are in crisis (988 Suicide & Crisis Lifeline). Further, writing the numbers for suicide hotlines in a permanent place, such as on an assignment notebook or ID badge, provides them with a 24/7 lifeline. Depending on the school and the specific situation, this step might fall under the responsibilities of a social worker or other mental health professional, but it's still important for teachers to be aware and a part of the team.

Importance. Studies find that youth that called the hotline and were connected with mental health professionals "were significantly more likely to feel less depressed, less suicidal, less overwhelmed, and more hopeful by the end of calls handled by Applied Suicide Intervention Skills Training-trained counselors" (988 Suicide & Crisis Lifeline, 2022). Such improvements were linked to Applied Suicide Intervention Skills Training (ASIST) strategies, including "listening without judgment, exploring reasons for living and creating a network of support" (988 Suicide & Crisis Lifeline). Helping students connect with mental health specialists and programs in their community aids in building a resilience toolbox with resources that they can turn to when they are in crisis.

Follow Up. After the initial discussion and determining a plan of action, teachers should always follow up and see how a student is doing. Although teachers and social workers are often in contact regarding students in crisis, it's important that teachers follow up specifically with these students, so that they know they have a "team" at school that cares for them.

Importance. When teachers show that they care it increases feelings of connectedness for the student. Likewise, "there is evidence that even a simple form of reaching out . . . can potentially reduce their risk for suicide" (988 Suicide & Crisis Lifeline, 2022). For many students, teachers are the only consistent and supportive adults in their lives. As such, it's important that students are constantly reminded that they are loved, supported, and cared about.

Trauma-Informed Pedagogy

The Substance Abuse and Mental Health Services Association (SAMHSA) defines trauma as: "An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting

adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (Barnard College, 2022). Trauma changes the way the brain functions and can have negative implications on a student's ability to learn; likewise, it increases a child's risk for suicide. The National Child Traumatic Stress Network (NCTSN) (2022) reports that one out of every four children in school has been exposed to a traumatic event that can affect learning and behavior. As such, it is safe to say that most, if not all, teachers will work with students affected by trauma. Trauma-informed pedagogy refers "to using the knowledge of trauma to adapt our pedagogy to best support the well-being and success of both teachers and learners" (Elmagraby, 2021). Trauma-informed teaching leads to increased empathy, which leads to overall more effective teaching and learning.

Principles of a Trauma-Informed Approach. The CDC (2020), in collaboration with SAMHSA, has established six principles to a trauma-informed approach: Safety, trustworthiness and transparency, peer support, collaboration & mutuality, empowerment & choice, cultural, historical & gender issues.

Safety. When kids don't feel safe, learning is difficult if not impossible. The reason for this is that the brain is wired for survival; as a result, when a person feels unsafe, the brain enters "fight or flight" mode, which basically disconnects the parts of the brain that make learning possible. "Because trauma can unpredictably violate students' physical, social, and emotional safety," a trauma-informed classroom aims "to increase stability and minimize stress reactions in order to encourage focus on wellness" (Barnard, 2022). This means that "efforts are made to create an atmosphere that is respectful of the need for safety, respect, and acceptance for all class members in both individual and group interactions, including feeling safe to make and learn from mistakes" (Carello, 2020).

Trustworthiness & Transparency. "A focus on creating and maintaining trust can mitigate the adverse effects of uncertainty and help students find meaning and connections in your class" (Imad, 2020). For a teacher, this means establishing clear expectations for students, displaying consistency in your practice, and creating and following class routines and rituals. Trauma can cause feelings of isolation and mistrust for students, but "compassionate and dependable relationships can help reestablish trusting connections with others that foster mutual wellness" (Barnard, 2022).

Peer Support & Connections. "All class members are connected with appropriate peer and professional resources to help them succeed academically, personally, and professionally" (Carello, 2020). This includes but is not limited to providing information

for community resources (counseling, health, tutoring, etc.), announcing social events, and facilitating peer groups and team-building opportunities. Most importantly, teachers can create a classroom culture that relies on empathy and peer support. Teaching can "invite . . . students to share their own stories and strategies to help each other cope and progress academically," as well as share their own struggles and coping mechanisms (Imad, 2020).

Collaboration & Mutuality. While fostering and accepting individuality, teachers must also treat students in the classroom as a team. Teachers should "make the classroom a place that is life-sustaining and mind-expanding, a place of liberating mutuality where teacher and student together work in partnership" (as cited in Imad, 2020). The classroom should provide opportunities for success for all students, and students should try to empower and encourage one another. Strategies that encourage collaboration and mutuality include "involving students in creating or revising policies, assignments, and grading," "doing with rather than doing for students [e.g. grading math homework]," and "facilitating student-led discussions and activities" (Carello, 2020).

Empowerment & Choice. Teachers can "empower voice and choice by identifying and helping build on student strengths" (Imad, 2020). Because trauma often results in a loss of power and feelings of helplessness, "reestablishing a sense of agency can help students feel empowered in and outside of the classroom" (Barnard, 2022). This can be done by providing opportunities for choice in the classroom, including seating, readings, assignment format (e.g. essay, presentation, one pager, et cetera), and having policies influenced by empathy (e.g. flexible test retakes, flexible turn-in policies). Class discussions can also aid in empowerment. Teachers can "validate and normalize" student concerns by discussing "fear, stress, anxiety and trauma" (Imad).

Cultural, Historical, & Gender Issues. It is crucial that teachers "understand and use an intersectional lens when considering the challenges" that students are facing (Imad, 2020). Some students are facing a multitude of struggles simply due to their identities and the communities that they are a part of. Likewise, "students come from diverse social and cultural groups that may experience and react to trauma differently," and teachers need to be aware of these differences and respond sensitively (Barnard, 2022). Teachers can foster respect in this area by using correct pronouns, pronouncing names correctly, "being aware of personal and disciplinary biases and how they impact teaching and learning," and addressing microaggressions (Carello, 2020). A microaggression is defined as a "subtle verbal or nonverbal behavior, committed consciously or not, that is directed at a member of a marginalized group, and has a harmful, derogatory effect"

(Cuncic, 2021). While this may seem like “no big deal,” microaggressions can actually have detrimental effects on individuals that they are aimed at. Teachers must also identify and work against their own biases. Teachers should “commit to learning about and implementing accessible, equitable and antiracist teaching and learning strategies” (Imad, 2020). One example of this is utilizing an assessment framework “that is less focused on grading and more focused on improving learning or that celebrates students’ creativity” for some assignments (Imad).

Section 3 Key Terms

Microaggression - Subtle verbal or nonverbal behavior, committed consciously or not, that is directed at a member of a marginalized group, and has a harmful, derogatory effect.

Social-Emotional Learning / Skills programs - Programs that develop “students’ problem-solving, coping, cognitive, communication, and social skills,” leading to improved relationships and overall well-being.

Student Awareness programs - Schoolwide programs where students learn reliable information about mental health and suicide, aiming to decrease stigma related to these issues and facilitate help-seeking behaviors.

Trauma - An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

Section 3 Reflection Questions

1. Do you think it is appropriate for schools to implement student awareness programs regarding suicide and mental health? Why or why not?
2. What has your experience been with SEL or skills training programs for students?
3. What do you feel is the connection between trauma-informed pedagogy and suicide prevention?
4. Do you feel that teachers receive adequate training in suicide prevention or trauma-informed pedagogy? What type of training have you received and has it been efficient?

Section 3 Activities

1. Research and familiarize yourself with your school's referral process for student mental health evaluations, as well as the process for reporting suicidal thoughts of a student. Create a cheat sheet of steps and who to contact for what.
2. Create a list of classroom policies (class discussions, homework completion, test retakes) that reflect trauma-informed practices.
3. If your school does not currently use a student awareness or SEL skills program for students, do some research on some of the evidence-based programs available for the ages that you serve. Write down some pros and cons of each and consider sharing the information with your school administrators.

Conclusion

Between 2007 and 2019, the suicide rate among youth increased by over 50%, causing the American Academy of Pediatrics (AAP) to declare a state of emergency regarding the mental health of children and adolescents. Despite this alarming statistic, schools are in a position to play a proactive role in youth suicide prevention. Educators can do their part by implementing awareness and skills training for students, understanding and identifying risk factors, warning signs, and protective factors, and knowing what steps to take to get students the proper help they need. By providing a safe and affirming space and being a consistent and reliable mentor, teachers have the opportunity to save students' lives.

Case Study

Mrs. Plant is a 7th grade teacher at Homewood Middle School. Homewood is undergoing a mental health improvement and suicide prevention initiative and Mrs. Plant has been named the chairperson. The school has recently adopted the Signs of Suicide (SOS) program to implement with students, as well as grade specific SEL practices. Mrs. Plant wants to help other teachers to make changes in their teaching practices that will aid in the suicide prevention work, as well as help students to become part of the mission. She is starting by sending out surveys to staff to gauge their knowledge and comfort level on the topic of suicide, and wishes to do the same for students once teachers are ready for the discussion. The next step will be to provide

staff with adequate training so that they can successfully implement suicide prevention strategies and be there for their students as they address their personal struggles.

References

American Academy of Pediatrics. (2022). *Teen suicide risk: What parents should know.* Healthychildren.org. https://www.healthychildren.org/English/health-issues/conditions/emotional-problems/Pages/Which-Kids-are-at-Highest-Risk-for-Suicide.aspx

American Foundation for Suicide Prevention [AFSP]. (2022). *Risk factors, protective factors, and warning signs.* https://afsp.org/risk-factors-protective-factors-and-warning-signs

Barnard College. (2022). *Trauma-informed pedagogy.* Columbia University. https://barnard.edu/trauma-informed-pedagogy

Bilsen, J. (2018, October 30). Suicide and youth: Risk factors. *Frontiers in Psychiatry, 9.* DOI: 10.3389/fpsyt.2018.00540

Camber Children's Mental Health. (2021, September 29). *5 myths about teen suicide.* KVC Health Systems. https://www.cambermentalhealth.org/2021/09/29/myths-about-teen-suicide/

Carello, J. (2020). *Examples of trauma-informed teaching and learning in college classrooms.* Trauma-Informed Teaching & Learning. https://traumainformedteachingblog.files.wordpress.com/2020/03/examples-of-titl-in-college-classrooms-3.2020-color-3.pdf

Carlton, M.P. (2020, May 5). *Empowering schools to change behavior and attitudes.* Stopbullying.gov. https://www.stopbullying.gov/blog/2020/05/05/empowering-schools-change-behavior-attitudes

Centers for Disease Control and Prevention [CDC]. (2020, September 17). *Infographic: 6 guiding principles to a trauma-informed approach.* https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm

Collaborative for Academic, Social, and Emotional Learning [CASEL]. (2022). *What does the research say?* https://casel.org/fundamentals-of-sel/what-does-the-research-say/

Charpignon, M., Ontiveros, J., Sundaresan, S., Puri, A., Chandra, J., Mandl, K.D., & Majumder, M.S. (2022, April 25). *Evaluation of suicides among US adolescents*

during the covid-19 pandemic. JAMA Pediatrics, 176(7): 724–726. DOI:10.1001/jamapediatrics.2022.0515

County Health Rankings. (2017). *Universal school-based suicide awareness & education programs*. University of Wisconsin Population Health Institute. https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/universal-school-based-suicide-awareness-education-programs

Cuncic, A. (2021, February 26). *What are microaggressions?* VeryWellMind. https://www.verywellmind.com/what-are-microaggressions-4843519

Curtin, S.C. (2020, September 11). State suicide rates among adolescents and young adults aged 10–24: united states, 2000–2018. *National Vital Statistics Reports, 69(11)*. CDC. https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-11-508.pdf

Dastagir, A.E. (2020, September 11). *More young people are dying by suicide, and experts aren't sure why.* USA Today. https://www.usatoday.com/story/news/health/2020/09/11/youth-suicide-rate-increases-cdc-report-finds/3463549001/

Elmagraby, N. (2021, March 4). *Trauma-informed pedagogy*. Wake Forest University. https://cat.wfu.edu/2021/03/trauma-informed-pedagogy/

Galvin, G. (2020, January 27). *Study: Higher poverty tied to increased youth suicide risk*. U.S. News. https://www.usnews.com/news/healthiest-communities/articles/2020-01-27/higher-poverty-tied-to-increased-youth-suicide-risk-study-shows

Gans, A. (2022, April 5). *Preventing suicide among young children: 5 key takeaways*. EducationWeek. https://www.edweek.org/leadership/preventing-suicide-among-young-children-5-takeaways-for-educators/2022/04

Harvard Injury Control Research Center. (2022). *Means Matter.* https://www.hsph.harvard.edu/means-matter/means-matter/

Hughson, J. (2020). *Response to student risk of suicide.* Molalla River School District. https://cdn5-ss4.sharpschool.com/

Illinois Public Health Institute and The Suicide Prevention/Juvenile Justice Curriculum Ad Hoc Committee. (2018, November). *Suicide prevention for juvenile justice populations*. https://dph.illinois.gov/content/dam/soi/en/web/idph/files/publications/publicationsohpmspjj-training-content.pdf

Illinois State Board of Education [ISBE]. (2017). *Illinois youth suicide prevention toolkit*. https://www.isbe.net/Documents/Suicide-Prevention-Procedures.pdf

Imad, M. (2020, June 3). *Leveraging the neuroscience of now*. Inside Higher Ed. https://www.insidehighered.com/advice/2020/06/03/seven-recommendations-helping-students-thrive-times-trauma

Ivey-Stephenson, A.Z., Demissie, Z., Crosby, A.E., Stone, D.M., Gaylor, E., Wilkins, N., Lowry, R., & Brown, M. Suicidal ideation and behaviors among high school students — Youth Risk Behavior Survey, United States, 2019. *Morbidity and Mortality Weekly Reports Supplements*, *69*(1), 47–55. DOI: http://dx.doi.org/10.15585/mmwr.su6901a6

The Jason Foundation. (2022). *Warning Signs*. https://jasonfoundation.com/youth-suicide/warning-signs/

Kaslow, N. (2022, September 12). *Teen suicides: What are the risk factors?* Child Mind Institute. https://childmind.org/article/teen-suicides-risk-factors/

Megan Meier Foundation. (2022). *Bullying, cyberbullying, & suicide statistics*. https://www.meganmeierfoundation.org/statistics

Miller, C. (2021). *What are the kinds of Depression?* Child Mind Institute. https://childmind.org/article/what-are-the-kinds-of-depression/

Miron, O., Yu, K-H., Wilf-Miron, R., & Kohane, I. (2019, June 18). Suicide rates among adolescents and young adults in the United States, 2000-2017. *Journal of American Medical Association*, *321*(23), 2362-2364. DOI:10.1001/jama.2019.5054

National Center for Injury Prevention and Control [NCIPC]. (2019). *Preventing bullying*. Center for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/yv/bullying-factsheet508.pdf

National Institutes of Health [NIH]. (2020, November 10). *Rural youth often lack access to suicide prevention services*. https://www.nih.gov/news-events/nih-research-matters/rural-youth-often-lack-access-suicide-prevention-services

National Institutes of Mental Health. (2020). *Bipolar disorder in children and teens*. NIH. https://www.nimh.nih.gov/health/publications/bipolar-disorder-in-children-and-teens

National LGBT Health Education Center. (2018, September). *Suicide risk and prevention for LGBTQ people*. Fenway Institute. https://www.lgbtqiahealtheducation.org/wp-content/uploads/2018/10/Suicide-Risk-and-Prevention-for-LGBTQ-Patients-Brief.pdf

National School Climate Center [NSCC]. (2021). *What is school climate?* https://schoolclimate.org/about/our-approach/what-is-school-climate/

Nevada Division of Public and Behavioral Health [DPBH] Office of Suicide Prevention. (2021). *Prevention of youth suicide*. https://suicideprevention.nv.gov/Youth/Suicide_Prevention/

O'Donnell, J. (2020, June 7). *'We're losing our kids': Black youth suicide rate rising far faster than for whites; coronavirus, police violence deepen trauma*. USA Today. https://www.usatoday.com/story/news/health/2020/06/07/coronavirus-police-violence-boost-risks-rising-black-youth-suicide/2300765001/

Prinstein, M.J. (2022, February 7). *US youth are in a mental health crisis—we must invest in their care*. American Psychological Association. https://www.apa.org/news/press/op-eds/youth-mental-health-crisis

Salvatore, T. (2022, July 14). *How mental health stigma drives suicide risk*. Behavioral Health News. https://www.behavioralhealthnews.org/how-mental-health-stigma-drives-suicide-risk/

Sandy Hook Promise. (2022). *Prevention youth suicide*. https://actionfund.sandyhookpromise.org/issues/mental-health-and-wellness/prevent-youth-suicide/

Santhanam, L. (2019, October 18). *Youth suicide rates are on the rise in the U.S.* PBS News Hour. https://www.pbs.org/newshour/health/youth-suicide-rates-are-on-the-rise-in-the-u-s

Serving & Accrediting Independent Schools [SAIS]. (2022, May 2). *School climate and student well-being*. https://sais.org/resource/school-climate-and-student-well-being/

Sharma, P. (2021, December 20). *8 common myths about suicide*. Mayo Clinic Health Systems. https://www.mayoclinichealthsystem.org/hometown-health/speaking-of-health/8-common-myths-about-suicide

Sparks, S.D. (2022, March 1). *Suicide is rising amongst younger students. Here's how schools can prevent tragedy.* EducationWeek. https://www.edweek.org/leadership/suicide-is-rising-among-younger-students-heres-how-schools-can-prevent-tragedy/2022/03

Strauss, V. (2018, June 8). *Suicide: How schools should approach the subject with students.* The Washington Post. https://www.washingtonpost.com/news/answer-sheet/wp/2018/06/08/suicide-how-schools-should-approach-the-subject-with-students/

Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). *Treatment for suicidal Ideation, self-harm, and suicide attempts among youth*, No. PEP20-06-01-002. Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-06-01-002.pdf

The Trevor Project. (2021, December 15). *Facts about LGBTQ suicide.* https://www.thetrevorproject.org/resources/article/facts-about-lgbtq-youth-suicide/

VanOrman, A. (2022, August 8). *Anxiety and Depression increase among U.S. youth, 2022 kids counts data book shows.* PRB. https://www.prb.org/resources/anxiety-and-depression-increase-among-u-s-youth-2022-kids-counts-data-book-shows/

Washington, N. (2021, May 9). *Teenage depression facts: All you need to know.* PsychCentral. https://psychcentral.com/depression/teenage-depression-facts

Wasserman, D., Carli, V., Losue, M., Javed, A., Herrman, H. (2021, February 14). *Suicide prevention in childhood and adolescence: a narrative review of current knowledge on risk and protective factors and effectiveness of interventions.* Asia-Pacific Psychiatry, 13. DOI: https://doi.org/10.1111/appy.12452

WedMD Editorial Contributors. (2022, April 24). *Depression in children.* https://www.webmd.com/depression/guide/depression-children

Youth.gov. (2022). *Groups with increased risk.* https://youth.gov/youth-topics/youth-suicide-prevention/increased-risk-groups