Suicide Prevention for Students:

A Comprehensive School Counseling Program Perspective

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Introduction

Each and every year, countless students are lost to suicide. As a school, we have the duty to protect, educate, and serve all students. This duty includes suicide awareness, prevention, intervention, and follow-up. In response to this dire need, we have developed a comprehensive school counseling program that encapsulates all four components of the American School Counseling Association (ASCA) National Model: foundation, management, delivery and accountability. Specifically, an in-depth focus will occur throughout the delivery component. All direct and indirect components of the delivery systems will be discussed with a strategy for each: comprehensive school counseling curriculum, individual counseling, responsive services, referrals, consultation, and collaboration. Following each strategy will be a means for assessment, an integral part of the process that allows for reflection, adjustment, and outcome measurement.

Statistics

Many statistics support the importance of a school counseling program focusing on suicide prevention and intervention. According to the Centers for Disease Control and Prevention (CDC) (as cited in Substance Abuse and Mental Health Services Administration, 2012), the following statistics exist:

- Suicide is the third leading cause of death among teenagers.
- One out of every 53 high school students (1.9 percent) reported having made a suicide attempt that was serious enough to be treated by a doctor or nurse.
- For each suicide death among young people, there may be as many as 100-200 suicide attempts.
- Approximately 1 out of every 15 high school students attempt suicide each year.
- The toll among some groups is even higher. For example, the suicide death rate among 15-19-year-old American Indian/Alaska Native males in 2.5 times higher than the overall rate for males in that age group. (p. 10)

Indiana statistics mimic some of the national statistics mentioned above. According to the Indiana State Department of Health (2017), the following statistics specific to Indiana exist:

- The suicide rate in Indiana has increased nearly every year since 1999 with a total increase of 72% from 1999-2015.
- From 2011-2015, suicide was the second-leading cause of death in the 15–34 age group, the third leading cause of death among those 10–14 years of age, fourth among those 35–54 years of age and eighth for the 55-64 age group.
- National statistics indicate males die by suicide more frequently than females, and this is also true in Indiana.
- In 2015, the overall suicide death rate for Hoosiers was 14.4 per 100,000, 23.8 per 100,000 among males and 5.6 per 100,000 among females.
- From 2011 to 2015, 93.4% of suicide deaths in Indiana occurred among White Hoosiers. Whites (15.2 per 100,000) surpassed African Americans (6.4 per 100,000) and Asian/Pacific Islanders (6.4 per 100,000) in numbers of suicides during 2011-2015 (Figure 12). More suicide deaths were reported among White males compared to all other race/gender categories. (p. 13-14)

Throughout the United States, differences in suicide rates exist for various races. According to Jiang, Mitran, Minino, and Ni (2015), the following statistics exist:

- In 2012-2013, young adult males were more likely than young adult females to commit suicide. This relationship was true for the five race and ethnicity groups studied (non- Hispanic white, non-Hispanic black, Hispanic, Asian or Pacific Islander [API], and American Indian or Alaska Native [AIAN])
- The suicide rate was highest in the AIAN population for both males and females (34.3 and 9.9 deaths per 100,000 population, respectively).
- AIAN males were more than twice as likely to commit suicide as most other gender and racial and ethnic subgroups.
- Based on combined data from 2009 through 2013 for non-Hispanic black and non- Hispanic white young adults who committed suicide, firearms were the most common method used, followed by suffocation. For Hispanic, API, and AIAN young adults who committed suicide, suffocation was the most common method used, followed by firearms. Poisoning and falls were more common methods among API young adults who committed suicide (12.6% and 8.1% of suicide deaths, respectively) than among other race and ethnicity groups. (p. 1)

See Appendix A (Indiana State Department of Health, 2017) for graphic information.

Rationale

Schools should be concerned with the increasing risk of suicide for a variety of reasons. A non-exhaustive list is included below:

- One mission of each and every school is to provide a safe and nurturing environment for students. A child's safety must be protected. This can be done through a variety of methods including improving school climate, promoting connectedness, and beneficial delivery activities.
- Students' emotional health is connected to academic achievement. Depression, thoughts of suicide, and other negative thoughts can impede a child's ability to learn.
- Attempted or successful suicides can greatly impact many of those inside and outside the school. Suicide clusters and contagion can be extremely detrimental.
- It is the school's duty to inform others if a student is expressing suicidal thoughts and/or behaviors. Failure to do so can result in negligence. (Substance Abuse and Mental Health Services and Administration, 2012, p. 10-11)

Comprehensive School Counseling Program Component One: Foundation

Program Focus:

1. Beliefs

- Thoughts of suicide are understandable, complex, and personal.
- Suicide is preventable.
- Help-seeking is encouraged by open, direct, and honest talk about suicide.
- Interventions are known and can be learned.

2. Values

- All students have value.
- Intervention strategies are most successful when students are viewed holistically.
- Advocacy is a primary component for which social justice can be pursued.

3. Vision Statement

- The vision of our comprehensive school counseling program is all students will achieve personal/social, academic, and career success through meaningful and thoughtful intervention strategies in a safe and welcoming environment.

4. Mission Statement

- The mission of our comprehensive school counseling program is to provide academic, career, and personal/social growth through proactive interventions. This will be accomplished through school counseling curriculum, individual counseling, responsive services, referrals, consultation, and collaboration with students, staff, parents, and community members.

5. Program Goals

- Students will come to understand how to identify and express feelings, identify signs and symptoms of suicide ideation, and understand support systems in place through classroom lessons.
- Students will be able to identify and discuss feelings, make healthy decisions, and achieve desirable results through individual and small group counseling.
- Counselors will respond appropriately to exhibited suicidal ideation.
- Parents and/or guardians will understand the resources available in the community.
- School staff members will understand the signs of suicide as a result of Question, Persuade, Refer (QPR) training.
- Administrators will understand the need for a comprehensive team of mental health professionals to assist with student needs.

6. Student Competencies Addressed (throughout the following CSCP)

- PS:A1.1 – Develop positive attitudes toward self as a unique and worthy person.
- PS:A1.5 – Identify and express feelings.
- PS:A1.8 – Understand the need for self-control and how to practice it.
- PS:A1.10 – Identify personal strengths and assets.

- PS:A2.3 – Recognize, accept, respect and appreciate individual differences.
- PS:A2.4 – Recognize, accept, and appreciate ethnic and cultural diversity.
- PS:A2.6 – Use effective communication skills.
- PS:B1.3 – Identify alternative solutions to a problem.
- PS:B1.4 – Develop effective coping skills for dealing with problems.
- PS:C1.5 – Differentiate between situations requiring peer support and situations requiring adult professional help.
- PS:C1.6 – Identify resource people in the school and community, and know how to seek their help.
- PS:C1.7 – Apply effective problem-solving and decision-making skills to make safe and healthy choices.
- PS:C1.11 – Learn coping skills for managing life events (American School Counselor Association, 2014).

7. Professional Competencies Exhibited (throughout the following CSCP)

- ASCA's position statement, The Professional School Counselor and School Counseling Preparation Programs, states that school counselors should articulate and demonstrate an understanding of:
    - I-A-4. Leadership principles and theories
    - I-A-5. Individual counseling, group counseling, and classroom instruction ensuring equitable access to resources promoting academic achievement, career development, and personal/social development for every student
    - I-A-7. Legal, ethical, and professional issues in pre-K-12 schools
    - I-A-8. Develop mental theory, learning theories, social theory, multiculturalism, counseling theories, and career counseling theories
    - I-A-9. The continuum of mental health services, including prevention and intervention strategies to enhance student success
- An effective school counselor is able to accomplish measurable objectives demonstrating the following abilities and skills:
    - I-B-1. Plans, organizes, implements, and evaluates a school counseling program aligning with the ASCA National Model
    - I-B-1a. Creates a vision statement examining the professional and personal competencies and qualities a school counselor should possess
    - I-B-1b. Describes the rationale for a comprehensive school counseling program
    - I-B-1h. Demonstrates multicultural, ethical, and professional competencies in planning, organizing, implementing, and evaluating the comprehensive school counseling program
    - I-B-2c. Identifies and demonstrates professional and personal qualities and skills of effective leaders
    - I-B-2d. Identifies and applies components of the ASCA National Model requiring leadership, such as an advisory council, management tools, and accountability
    - I-B-4e. Understands how to facilitate group meetings to effectively and efficiently meet group goals
- School counselors believe:

    - I-C-4. Every student should have access to a school counseling program
    - I-C-5. Effective school counseling is a collaborative process involving school counselors, students, parents, teachers, administrators, community leaders, and other stakeholders
    - I-C-7. The effectiveness of school counseling programs should be measurable using process, perception, and outcome data
- School counselors should articulate and demonstrate and understanding of:
    - II-A-6. District, state and national student standards and competencies, including ASCA Student Standards and other student standards that may complement and inform the comprehensive school counseling program
- An effective school counselor is able to accomplish measurable objectives demonstrating the following abilities and skills:
    - II-B-3. Uses student standards, such as ASCA Student Standards and other appropriate student standards such as district or state standards, to drive the implementation of a comprehensive school counseling program
    - II-B-4a. Practices ethical principles of the school counseling profession in accordance with the ASCA Ethical Standards for School Counselors
- School counselors demonstrate their attitudes and beliefs that all students deserve access to a comprehensive program that:
    - II-C-1. Has an impact on every student rather than a series of services provided only to students in need
    - II-C-3. Promotes and supports academic achievement, career planning, and personal/social development for every student
- School counselors should articulate and demonstrate an understanding of:
    - III-A-3. Presentation skills for programs such as teacher in-services, parent workshops and presentation of results reports to school boards
- An effective school counselor is able to accomplish measurable objectives demonstrating the following abilities and skills:
    - III-B-2. Establishes and convenes an advisory council for the comprehensive school counseling program
    - III-B-3. Accesses or collects relevant data, including process, perception, and outcome data, to monitor and improve student behavior and achievement
    - III-B-3a. Reviews and disaggregates student achievement, attendance, and behavior data to identify and implement interventions as needed
    - III-B-3c. Uses student data to demonstrate a need for systemic change in areas such as course enrollment patterns; equity and access; and achievement, opportunity, and/or information gaps
    - III-B-5. Develops calendars to ensure the effective implementation of the school counseling program
    - III-B-6. Designs and implements action plans aligning with school and school counseling program goals
    - III-B-6a. Uses appropriate academic and behavioral data to develop school counseling core curriculum, small-group and closing-the-gap action plans and determines appropriate students for the target group for interventions

    - III-B-6b. Identifies ASCA domains, standards, and competencies being addressed by each plan
    - III-B-6c. Creates lesson plans related to the school counseling core curriculum identifying what will be delivered, to whom it will be delivered, how it will be delivered, and how student attainment of competencies will be evaluated
    - III-B-6d. Determines the intended impact on academics, attendance and behavior
    - III-B-6e. Identifies appropriate activities to accomplish objectives
    - III-B-6f. Identifies appropriate resources needed
    - III-B-6g. Identifies data-collection strategies to gather process, perception and outcome data
- School counselors believe:
    - III-C-3. Management of a school counseling program must be done in collaboration with administrators
- School counselors should articulate and demonstrate an understanding of:
    - IV-A-7. Principles of working with various student populations based on characteristics such as ethnic and racial background, English language proficiency, special needs, religion, gender and income
    - IV-A-8. Principles of multi-tiered approaches within the context of a comprehensive school counseling program
- An effective school counselor is able to accomplish measurable objectives demonstrating the following abilities and skills:
    - IV-B-1a. Identifies appropriate curriculum aligned to ASCA Student Standards
    - IV-B-1d. Develops materials and instructional strategies to meet student needs and school goals
    - IV-B-1g. Understands multicultural and pluralistic trends when developing and choosing school counseling core curriculum
    - IV-B-2. Facilitates individual student planning
    - IV-B-2g. Understands methods for helping students monitor and direct their own learning and personal/social and career development
    - IV-B-3. Provides responsive services
    - IV-B-4a. Understands how to make referrals to appropriate professionals when necessary
    - IV-B-5b. Applies appropriate counseling approaches to promoting change among consultees within a consultation approach
    - IV-B-6b. Conducts in-service training or workshops for other stakeholders to share school counseling expertise
    - IV-C-1. School counseling is one component in the continuum of care that should be available to all students
    - IV-C-4. School counselors should refer students to district or community resources to meet more extensive needs such as long-term therapy or diagnosis of disorders
- School counselors should articulate and demonstrate an understanding of:

    - V-A-3. Use of data to evaluate program effectiveness and to determine program needs
    - V-A-4. School counseling program assessments and results reports
- An effective school counselor is able to accomplish measurable objectives demonstrating the following abilities and skills:
    - V-B-1c. Uses formal and informal methods of program evaluation to design and enhance comprehensive school counseling programs
    - V-B-1g. Analyzes and interprets process, perception, and outcome data
    - V-B-1j. Reports program results to the school counseling community
- School counselors believe:
    - V-C-1. School counseling programs should achieve demonstrable results (American School Counselor Association, 2012)

8. **Ethical Standards** include the following, but are not limited to (throughout the following CSCP)

- A.1.a. Have a primary obligation to the students, who are to be treated with dignity and respect as unique individuals.
- A.1.e. Are concerned with students' academic, career, and social/emotional needs and encourage each student's maximum development.
- A.2.e. Keep information confidential unless legal requirements demand that confidential information be revealed or a breach is required to prevent serious and foreseeable harm to the student. Serious and foreseeable harm is different for each minor in schools and is determined by students' developmental and chronological age, the setting, parental rights and the nature of the harm. School counselors consult with appropriate professionals when in doubt as to the validity of an exception.
- A.3.b Provide students with a comprehensive school counseling program that ensures equitable academic, career and social/emotional development opportunities for all students.
- A.6.a. Collaborate with all relevant stakeholders, including students, educators and parents/guardians when student assistance is needed, including the identification of early warning signs of student distress.
- A.6.b. Provide a list of resources for outside agencies and resources in their community to student(s) and parents/guardians when students need or request additional support. School counselors provide multiple referral options or the district's vetted list and are careful not to indicate an endorsement or preference for one counselor or practice. School counselors encourage parents to interview outside professionals to make a personal decision regarding the best source of assistance for their student.
- A.7.a. Facilitate short-term groups to address students' academic, career and/or social/emotional issues.
- A.9.a. Inform parents/guardians and/or appropriate authorities when a student poses a serious and foreseeable risk of harm to self
  or others. When feasible, this is to be done after careful deliberation and consultation with other appropriate professionals. School counselors inform students of the school counselor's legal and ethical obligations to report the

concern to the appropriate authorities unless it is appropriate to withhold this information to protect the student (e.g. student might run away if he/she knows parents are being called). The consequence of the risk of not giving parents/guardians a chance to intervene on behalf of their child is too great. Even if the danger appears relatively remote, parents should be notified.

- A.9.b. Use risk assessments with caution. If risk assessments are used by the school counselor, an intervention plan should be developed and in place prior to this practice. When reporting risk-assessment results to parents, school counselors do not negate the risk of harm even if the assessment reveals a low risk as students may minimize risk to avoid further scrutiny and/or parental notification. School counselors report risk assessment results to parents to underscore the need to act on behalf of a child at risk; this is not intended to assure parents their child isn't at risk, which is something a school counselor cannot know with certainty.
- A.9.c. Do not release a student who is a danger to self or others until the student has proper and necessary support. If parents will not provide proper support, the school counselor takes necessary steps to underscore to parents/guardians the necessity to seek help and at times may include a report to child protective services.
- B.2.a. Develop and maintain professional relationships and systems of communication with faculty, staff, and administrators to support students.
- B.2.b. Design and deliver comprehensive school counseling programs that are integral to the school's academic mission; driven by student data; based on standards for academic, career and social/emotional development; and promote and enhance the learning process for all students.
- B.2.m. Promote cultural competence to help create a safer more inclusive school environment (American School Counselor Association, 2016).

Comprehensive School Counseling Program Component Two: Management

Assessments:

1. Suicide Prevention in Grades 7-12 Lesson Assessments – Appendix B
2. Counseling Notes – Appendix D
3. Columbia Suicide Severity Rating Scale – Appendix E
4. Suicide Resources Pre- and Post-Survey – Appendix G
5. QPR Assessment – Appendix H
6. Pre and Post Assessment – Appendix I

Tools:

1. Annual agreements

The annual agreement will outline and include the comprehensive school counseling program's mission statement, goals, a use of time agreement, a list of members of the advisory council, planning and results documents, the school counselor's caseload and responsibilities, professional collaboration and responsibilities, budget, and school counselor availability.

2. Advisory council

The advisory council will be composed of administrators, mental health professionals, community members, teachers, parents, and students. It will be led by the school counselor.

3. Data (disaggregated)

Suicide data (ideations and attempts) would need to be disaggregated by age, race, socioeconomic status, gender, academic performance levels, and attendance.

4. School Data Profile

The individual school's data profile would need to be taken into consideration including achievement, attendance, behavior, and safety.

5. Process, Perception, and Outcome Data

See individual data outcomes for each individual intervention strategy beginning on page 13.

6. Action Plans

See intervention strategies beginning on page 13.

7. Calendar

The advisory council will meet quarterly to discuss interventions, progress, and new strategies. The following intervention strategies should be completed using the suggested time frame:

- Comprehensive school counseling intervention: Beneficial at any time throughout the year. Needs to be completed annually.
- Individual counseling interventions: as needed throughout the year.
- Responsive services interventions: as needed throughout the year.

- Referral interventions: as needed throughout the year. The parent meeting should happen towards the beginning of the year.
- Consultation intervention: Completed annually at the beginning of the year.
- Collaboration intervention: Pre-assessment will be completed at the beginning of the year. Post-assessment will be completed at the end of the year.

Comprehensive School Counseling Program Component Three: Delivery

Strategy One: Comprehensive School Counseling

Intervention Topic: Guidance or Classroom Lessons to Prevent Suicide

Intended Audience: Students in Grades 7-12

Explanation/Rationale:
In an article published by the Association of American Educators, 1 in 12 teenagers attempted suicide in 2012 (Johnson, 2016). When students are taught suicide prevention in school, those numbers go down (Johnson, 2016). These lessons include tools to help students deal with their own suicidal thoughts and those of friends (Johnson, 2016). In some states, suicide prevention curriculum is required ("Classroom Curriculum on Youth Suicide Prevention," 2017). This intervention strategy is geared specifically to help students know how to respond should they experience suicidal thoughts or have friends that share their suicidal thoughts. This approach should provide clear next steps for students.

ASCA Domain and Mindset/Behavior Standards:
- PS:C1.5 Differentiate between situations requiring peer support and situations requiring adult professional help
- PS:C1.6 Identify resource people in the school and community, and know how to seek their help
- PS:C1.7 Apply effective problem-solving and decision-making skills to make safe and healthy choices
- PS:C1.11 Learn coping skills for managing life events

Materials Needed: Guidance Lesson and Supplies (Appendix B, Issues in Mental Health)

Process:
1. The counselor will prepare selected guidance lesson(s).
2. The counselor will schedule time with administrators and teachers to present the lessons to students.
3. The counselor will present the lesson in classes to students.
4. The counselor will provide support to students, as needed as a result of the teaching.

Process Data:
Process data will include the number of students who were able to receive the training. The goal will be to provide it to all students.

Perception Data:
According to the Association of American Educators, students should be able to:
- Identify risk factors associated with suicide;
- Locate resources for help;
- Increase awareness of facts and statistics about suicide; and
- Have ideas about how to help yourself or a loved one.

Outcome Data:
Results will show students responding appropriately to their own suicidal thoughts and the thoughts of their peers.

Relation to Holcomb-McCoy Text:
While the text does not address either suicide prevention or guidance lessons directly, many correlations can be made. The text encourages counselors to be aware of their own hesitancies to intervene, specifically referring to issues relating to social justice. Talking openly about issues related to suicide could also cause some discomfort. The authors make the following suggestions to overcome hesitations:

1. Take a breath.
2. Name the act.
3. Give information about why the act is offensive [or a problem].
4. Give director and model good behavior (Holcomb-McCoy, 2007, p. 98-99).

Strategy Two: Individual Counseling

Intervention Topic: Teen Suicide Prevention

Intended Audience: Students in Grades 7-12

Explanation/Rationale:
Death by suicide is arguably one of the most preventable causes of death; yet, it is the third leading cause of death among youth between the ages of 10–24 (CDC, 2015). What is perhaps most troubling about this statistic is that over 90% of individuals who died by suicide had a diagnosable, treatable mental illness and did not receive the mental health services they needed (Bertolote and Fleischmann, 2002).

ASCA Domain and Mindset/Behavior Standards:
Social/Emotional Development – Standards guiding school counseling programs to help students manage emotions and learn and apply interpersonal skills.
Category 1: Mindset Standards – Includes standards related to the psycho-social attitudes or beliefs students have about themselves in relation to academic work. These make up the students' belief system as exhibited in behaviors.

Materials Needed:
- Printed Handouts of Appendix C (Suicide Prevention Resource Center, 2018)
- School counselor to serve as facilitator
- Copies of Appendix D (Counseling Notes)

Process:
1. Counselor will review Appendix C (Suicide Prevention Resource Center, 2018) with staff members so that they can help identify those in need of individual counseling.
2. Staff members will identify participants for individual counseling.
3. Counselor will coordinate individual or small group sessions.
4. Counselor will schedule weekly sessions (duration determined by level of risk) and counsel students.
5. Counselor will establish possible outcomes with participants.
6. Counselor will maintain notes for individual and group sessions on Appendix D (Counseling Notes) sheet.
7. Counselor will provide follow-up, as needed.

Process Data:
This total would be determined by the amount of students identified as "at-risk" and in need of services or counseling.

Perception Data:
Suicide is a leading cause of death among youth. Suicide screening programs aim to identify mental health issues and prevent death by suicide (Torcasso & Hilt, 2016). Participants will work through obstacles to achieve desired results alongside the counselor and/or mental health professional.

Outcome Data:
Suicide prevention efforts in high schools are usually led by school counselors, mental health professionals, or social workers. But it is important to remember that no one—not the principal, not the counselor, and not the most passionate and involved parent—can establish effective suicide prevention strategies alone. The participation, support, and active involvement of others in the school and community are essential for success. Numbers of students expressing suicidal thoughts would decrease with the use of this intervention (Abuse, 2012, p.9).

Relation to Holcomb-McCoy Text:
One of the most important aspects of consultation is the consultant's ability to ask the right questions to get the right information from the consultee. This process of questioning is critical because if the problem is misidentified then the interventions will not get to the root of the real problem. There are three domains of questions that should be addressed during consultation from a social justice perspective. Those domains are:

- Student domain
- Consultee (e.g., teacher, parent) domain, and
- Environmental and cultural domain (Holcomb-McCoy, 2007, p. 61)

Strategy Three: Responsive Services

Intervention Topic: Response Protocol

Intended Audience: Student referred for crisis

Explanation/Rationale: The second leading cause of death for individuals 15-24 years-old in Indiana is suicide (Lange, 2017). With one in five Indiana students reporting that they have made a plan for suicide, all comments referring to suicide must be addressed. Great caution must be made in assessing any student referred because of suspected suicidal ideation. Whether referred by a student, teacher, staff or parent, the counselor is required to be prepared to address the situation, guide and document the steps followed, and follow-up with any care for a student who has expressed wishes to harm themselves. Responsive services include activities to meet students' immediate needs and concerns. One of the most critical roles that a school counselor must provide is responding appropriately and immediately to any concerns of suicidal ideation.

ASCA Domain and Mindset/Behavior Standards:
Social/Emotional Development – Standards guiding school counseling programs to help students manage emotions and learn and apply interpersonal skills.
Category 1 Mindset Behaviors. Specifically: M 1. Belief in development of whole self, including a healthy balance of mental, social/emotional and physical well-being. M 2. Self-confidence in ability to succeed. M 3. Sense of belonging in the school environment

Materials Needed:

- Columbia Suicide Severity Rating Scale (Appendix E)
- Counselor
- Mental Health Professional
- Guardian of the student in need of assistance

Process:

1. The counselor will be prepared at all times to assist a student with suicidal ideation.
2. The counselor will identify behavioral, social and emotional signs of suicide risk.
3. The counselor will administer the Columbia Suicide Screener for Schools.
4. The counselor will determine if a second opinion or further assessment is needed.
5. The counselor will communicate with guardians and any necessary third parties to develop a Transition/School Safety plan.
6. The counselor will notify all school personnel with required information and alerts.
7. The counselor will follow up with student as needed.
8. The counselor will inform administration and complete all required documentation

Process Data:
Process will include any student in need of services and use collaborative tools to envelope the student in a multi-tiered support system.

Perception Data:
An immediate acknowledgement of the student's feelings is not enough to form an intervention. A school counselor must have a protocol to handle the crisis situation.

Outcome Data:
Results would be evident in the acclimation of the student into a healthier thought pattern with appropriate supports in place to assist with ongoing emotional needs.

Relation to Holcomb-McCoy Text: This text states that when students are struggling with academics, contributing factors come from outside factors. Therefore, it is the responsibility of the social justice counselor to "provide the student and their family the support they need to improve their condition" (p. 104). This includes helping students process their behaviors and feelings, as well as collaborating with outside agencies whenever in the best interest of the student.

Strategy Four: Referrals

Intervention Topic: Referral to Appropriate Parties

Intended Audience: Parents and/or Guardians

Explanation/Rationale: Adolescents contemplating suicide often give warning signs of their distress. Parents are in a key position to pick up on these signs and provide help. Also, counselors are in a key role to help parents and/or guardians find appropriate resources to meet the needs of the child.

ASCA Domain and Mindset/Behavior Standards: N/A (students are not involved as a direct recipient of this strategy)

Materials Needed:

- PowerPoint viewing equipment and PowerPoint presentation detailing warning signs of suicide and when to get help
- Printed handouts of community mental health agencies (Appendix F, Mental Health Care Providers and Resources)
- Pre- and post- parent survey (Appendix G, Suicide Resources Pre- and Post-Survey)

Process:

1. School counselors will put together a PowerPoint presentation with information about warning signs of suicide and steps for parents on how/when to seek to support for their child.
2. School counselors will choose a date for a meeting to take place with parents to go over and discuss the PowerPoint presentation.
3. Upon arriving, parents will be given a handout with a survey on it. The survey will ask questions relating to the suicide and the referral process with mental health agencies.
4. Parents will return the survey and the counselor will begin the presentation.
5. Parents will be given a handout with a list of community mental health agencies and their contact information.
6. Parents will be given the same survey again to complete before they leave.

Process Data:
Process data would include the number of parents who attended the meeting.

Perception Data:
After the meeting, parents will know when/where to refer their child for support for suicidal behaviors.

Outcome Data:
As evidenced by the pre- and post- survey, parents will be able to understand the warning signs of suicide, when/where to refer their child for support, and the process for referring their child. An increased number of appropriate referrals will be made.

Relation to Holcomb-McCoy Text:
Communication with both the community and parents is a vital piece in ensuring student success. When working with parents, schools should use the relational narrative. In this narrative, "educators work with parents, rather than for them" (Holcomb-McCoy, 2007, p. 71). Involving parents, educating them on important issues, such as suicide, and providing resources is a great way to build relationships and best support students. Supporting students should be a collaborative effort.

Strategy Five: Consultation

Intervention Topic: QPR (Question, Persuade, Refer) Training

Intended Audience: All School Staff Members

Explanation/Rationale:
QPR training provides the opportunity to train staff members (gatekeepers) on suicide prevention. Its mission is to "reduce suicidal behaviors and save lives by providing innovative, practical, and proven suicide prevention training" (QPR Institute, n.d., para 1). The training details suicide warning signs (direct verbal clues, indirect verbal clues, behavioral clues, situational clues) and the three main components of the prevention strategy – question, persuade, refer. Questioning strategies include using direct language. Persuasion techniques offer hope, confirm worth, and are non-judgmental. Referring techniques include taking the person directly to another who can assist. This intervention is not to be a form of counseling but is intended to assist the person in gaining the appropriate help.

ASCA Domain and Mindset/Behavior Standards: N/A (students are not involved as a direct recipient of this strategy)

Materials Needed:
- QPR Certified Trainer and PowerPoint
- Copies of QPR Assessment (Appendix H)

Process:
1. The counselor will set up a date in which the staff can meet as a whole. Ideally, this would happen prior to the school year beginning.
2. The counselor will arrange for the QPR trainer to disperse the training to all attendees, highlighting facts and statistics about suicide, including diversity aspects.
3. After the discussion, attendees will have the opportunity to role-play situations.
4. The counselor will provide the post-assessment which checks for attendee's understanding.
5. The counselor will be present throughout the entire training to help answer questions regarding specific situations that could occur inside and outside the school.

Process Data:
Process data would include the number of attendees. Ideally, this would be all staff members for a particular school and/or corporation.

Perception Data:
According to the QPR institute (n.d.), attendees will be able to:
1. Increase declarative knowledge
2. Increase perceived knowledge
3. Increase self-efficacy
4. Increase diffusion of information

5. Increase in the following skills: active listening, ability to ask clarifying questions, and make appropriate referrals

Outcome Data:
Results would demonstrate increased ability to notice suicidal thoughts, act, and referral to appropriate parties.

Relation to Holcomb-McCoy Text:
Becoming a socially-justice focused counselor means creating multicultural competence for one's self and others. According to Ponterotto and Casas (as cited in Holcomb-McCoy, 2007), "multicultural competence is achieved when a counselor possesses the necessary skills to work effectively with clients from various cultural backgrounds" (p. 46). Utilizing this strategy, the counselor and QPR instructor need to make sure that attendees are aware of the data regarding differences in culture and suicide. Understanding this information will allow one's self to understand any implicit or explicit bias that may exist and counter such discrepancies with appropriate facts and actions.

Strategy Six: Collaboration

Intervention Topic: Collaboration with Other Mental Health Professionals

Intended Audience: Superintendents and Principals

Explanation/Rationale:
According to McCarthy et al., (2008), "adolescent depression is often related to suicide, the third leading cause of death for those aged 15-24" (p. 50). In 2002, 1531 youth between the ages of 15 and 19 committed suicide (according to the Centers for Disease Control and Prevention, pg. 50). Ruble et al., (2013) found that "more children and young adults die from suicide annually than from cancer, heart disease, AIDS, birth defects, stroke and chronic lung disease combined" (pg. 1025). Ruble et al., (2013) also state that "suicide currently accounts for more deaths than motor vehicle accidents" (pg. 1025). Right now, the rate of adolescent suicide is so high that McCarthy et al., (2008) argue that "it constitutes a crisis in our society" (pg. 50). Sadly, there are structural barriers, perceptions about mental health services, and a lack of resources at schools that prevent children from getting the help they need. School counselors, social workers, and psychologists play a massive role in making sure a student's academic, personal/social and career needs are met through a comprehensive school counseling program. It is vital that principals and superintendents, as leaders of a school district, enthusiastically support creating a mental health services team which consists of a variety of school and community members who collaborate together to proactively address mental health needs of all students.

ASCA Domain and Mindset/Behavior Standards: N/A (students are not involved as a direct recipient of this strategy)

Materials Needed:
- Data showing the rate of adolescent depression and suicide, especially in Indiana (see pages 2-3 for statistics or Appendix A, Suicide Rates)
- Pre-Assessment and Post-Assessment to determine mental health's strengths and areas of improvement for the following year (Appendix I, Pre and Post Assessment)
- A list of models for administrators to look at of school districts with successful mental health programs (Appendix J, Model Programs)

Process:
1. Give pre-assessment that determines school's strengths and weaknesses pertaining to mental health, which can be taken to administration.
2. Collaborate with building principals and district leaders to create a school-based mental health program that involves teachers, counselors, principals, parents and community agencies.
3. Create buy-in from all involved stakeholders using data and funding from grants and the Mental Health in Schools Act.
4. Give post-assessment for the mental health team to determine what the school-based mental health program did well and how they can improve.

Process Data:

- Administration will gain a clear idea of the need for a mental health services team
- Stakeholders involved include the number of students, parents, teachers, principals and community agencies (Dollarhide & Saginak, 2017)

Perception Data:

- Administration would be aware of mental health needs not being met. It is our duty to advocate for a mental health services team to create a program involving all major stakeholders
- Educators will receive proper training about signs to look for with children in need of help and how to follow a crisis management plan
- Relationships would be established with community agencies
- The school-based mental health program will have a clear vision in place with established roles and expectations

Outcome Data (results of the activity):

- Services will be provided to the students experiencing a type of mental disorder
- Educators and parents will be more alert and be able to recognize when a child is need of the mental health services

Relation to Holcomb-McCoy Text:

Holcomb-McCoy (2007) describe the importance of a strong community by stating:

> Identify and involve people whose support is absolutely critical, such as your school principal or chief administrator. If he or she does not actively support your initiative, it will never get off the ground. Also, involve school faculty who will be directly affected by any changes in prevention programming. According to a national study, activities that are initiated, selected, or planned by 'insiders' (i.e., persons within a school organization) tend to be more accepted by school staff; impulses to resist adoption or implementation sometimes triggered by programs imposed upon a school are less likely to be evoked. (p.73)

Comprehensive School Counseling Program Component Four: Accountability

Program results will be as follows:

- Students will understand how to identify and express feelings, identify signs and symptoms of suicide ideation, and understand support systems in place through classroom lessons.
- Students will identify and discuss feelings, make healthy decisions, and achieve desirable results through individual and small group counseling.
- Counselors respond appropriately to exhibited suicidal ideation.
- Parents and/or guardians understand the resources available in the community.
- School staff members understand the signs of suicide as a result of Question, Persuade, Refer (QPR) training.
- Administrators understand the need for a comprehensive team of mental health professionals to assist with student needs.

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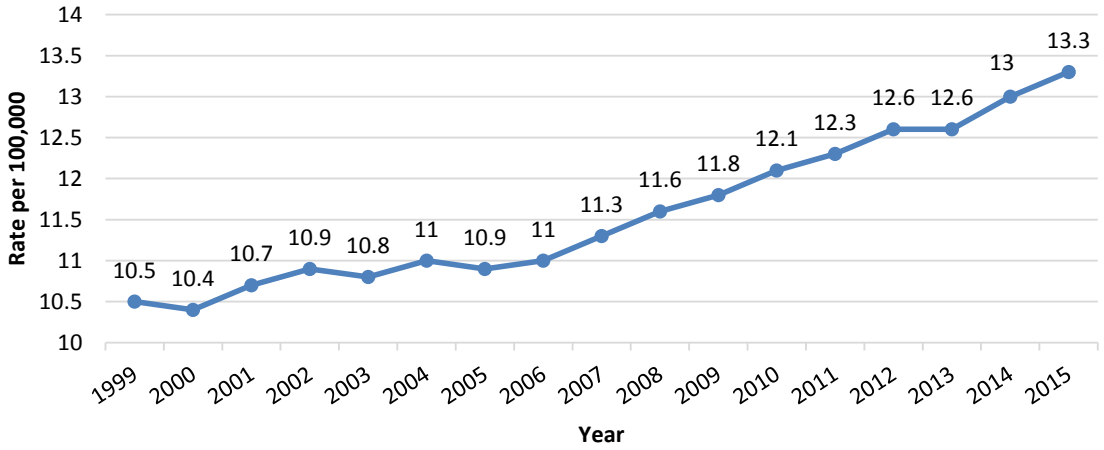
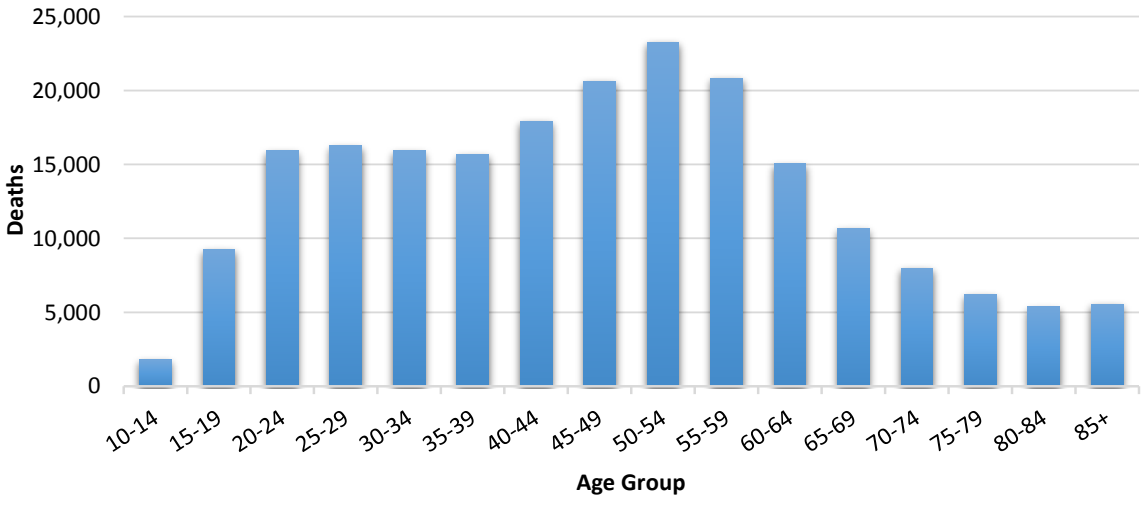
Appendix A

Figure 1. Suicide rates*, U.S., 1999–2015



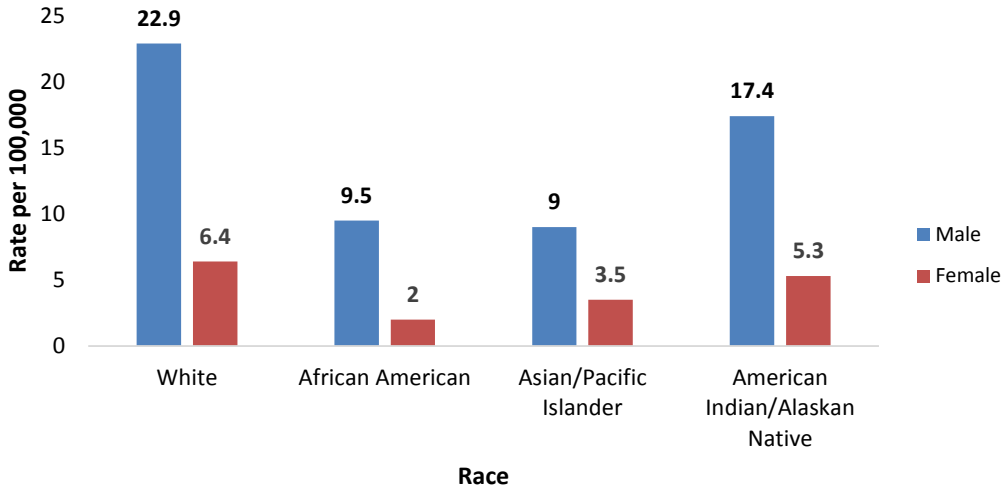
*Age-adjusted rates per 100,000 population
Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WONDER

Figure 2. Suicides by age group, U.S., 2011-2015



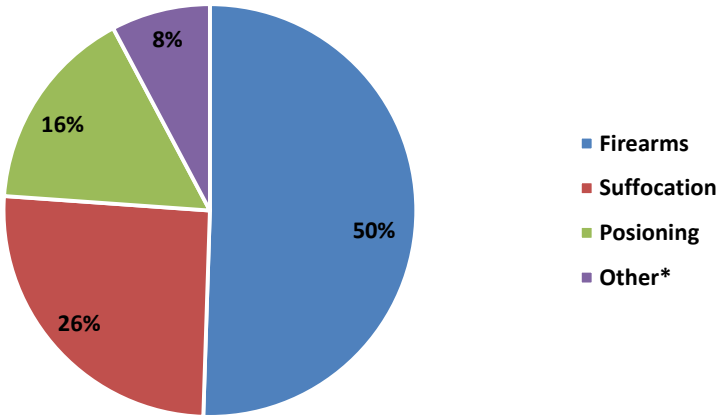
Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WONDER

Figure 3. Suicide rate* by race and sex, U.S., 2011-2015



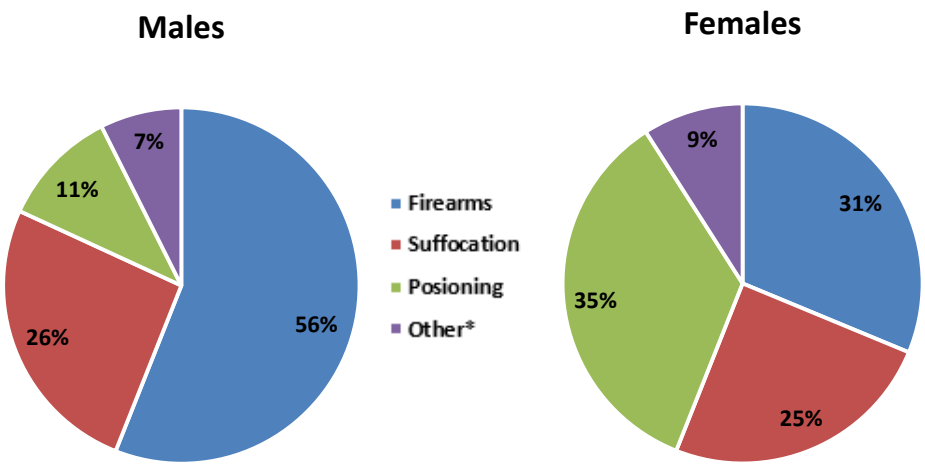
*Age-adjusted rates per 100,000 population
Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WONDER

Figure 4. Suicide by mechanism, U.S., 2011-2015



*Other mechanisms include: drowning, cutting/piercing, fall, motor-vehicle collisions, fire and unclassified/unspecified
Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WONDER

Figures 5. Suicide by mechanism and sex, U.S., 2011-2015



*Other mechanisms include: drowning, cutting/piercing, fall, motor-vehicle collisions, fire and unclassified/unspecified
Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WONDER

Suicide in Indiana

From 2011 to 2015, 21,837 Hoosiers died from injuries, averaging 12 deaths each day. During 2015 alone, 3,258 deaths from unintentional injuries occurred.[1] While 69% of the injury deaths were unintentional (accidental), 20% of the deaths resulted from suicide, 8% from homicide, and 3% were of undetermined intent (Figure 6).[1]

From 2011-2015, 4,673 suicides were reported in Indiana, of which 962 occurred in 2015.[1] Suicide was the 11th-leading cause of death among Hoosiers during this time period (Table 2).[2] The suicide rate in Indiana has increased nearly every year since 1999 with a total increase of 72% from 1999-2015.[1] Though the rate has remained relatively stable since 2012, the trend line continued to slowly increase (Figure 7). The overall suicide rate in Indiana was also higher than the U.S. and Midwest rates. When comparing age groups, Indiana suicide death rates were slightly higher than the U.S. rates in all age categories except for those over 65 years of age. The Indiana suicide rates were higher than the Midwest rate in all age categories except 10-14 years of age (Table 3).[1, 9]

From 2011-2015, suicide was the second-leading cause of death in the 15–34 age group, the third leading cause of death among those 10–14 years of age, fourth among those 35–54 years of age and eighth for the 55-64 age group (Table 2).[2] The majority of the deaths by suicide

occurred in those aged 45–54 years (996 suicides), followed by those aged 35-44 years (841 suicides) and aged 25-34 years (826 suicides) (Figure 8).[1]

National statistics indicate males die by suicide more frequently than females, and this is also true in Indiana (Figure 9).[1, 2] In 2015, the overall suicide death rate for Hoosiers was 14.4 per 100,000, 23.8 per 100,000 among males and 5.6 per 100,000 among females.[1] The suicide rate among males increased from 2011 to 2015, while the female suicide rate decreased from a high of 6.0 per 100,000 in 2011 to 5.6 per 100,000 in 2015 (Figure 10). Male suicide rates over these years have been consistently around four times greater than female suicide rates.[1] When comparing age groups, males aged 45–54 years accounted for the most deaths (766), followed by males aged 25-34 (Figure 11)

From 2011 to 2015, 93.4% of suicide deaths in Indiana occurred among White Hoosiers. Whites (15.2 per 100,000) surpassed African Americans (6.4 per 100,000) and Asian/Pacific Islanders (6.4 per 100,000) in numbers of suicides during 2011-2015 (Figure 12). More suicide deaths were reported among White males compared to all other race/gender categories (Figure 13). When comparing rates, White male Hoosiers aged 45–54 years had the highest rate of suicide, followed by White males 35-44 years and White males aged 65 and older.[1]

Of the 4,696 Indiana suicides reported from 2011 to 2015, 53% died by firearm, 25.6% by suffocation, 15.8% by poisoning, and 5.6% by other methods (Figure 14). Firearms were the leading mechanism of injury for males, while females more often died from poisoning (Figure 15).[1] White males died by suicide using firearms at a rate of 14.4 per 100,000, compared with African American males at a rate of 5.9 per 100,000. White females were more likely to die by suicide by poisoning (2.3 per 100,000) than by firearms (2.1 per 100,000) or suffocation (1.5 per 100,000) and have higher rates in all categories compared to African American females (Table 4).[1] Mechanism of injury also varies across age groups; 50% of those under 18 died of suffocation, while less than 10% of those 65 and older died from that mechanism. Firearms accounted for almost 80% of suicides from those 65 and older, 20% higher than any other age group (Figure 16).[1]

Suicide death data comes from the ISDH mortality reports and differs slightly from the nationally based National Center for Health Statistics (NCHS). In addition, accuracy of mortality data is dependent upon how thoroughly the death certificate is completed, specifically with regards to intent. Another limitation is that race/ethnicity is reported at the discretion of the person completing the death certificate and may not reflect how an individual would define his or her own race.

Appendix B

Issues in Mental Health: Suicide Prevention Grades 7-12

Building Knowledge and Skills to Prevent Suicide in Adolescents and Young Adults

Publication updated by

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Bulletin Number 01050

Introduction

This unit of instruction is designed to help teachers and pupil services personnel implement a set of lessons that build on the essential knowledge and skills related to suicide prevention. In order to implement this set of lessons you will need to use the middle school or high school DVD included in the "S.O.S: Signs of Suicide" curriculum.

There are five lessons with accompanying assessment components within this unit. Some lessons have multiple parts and can be delivered in a manner that meets your school's class schedule. The five DPI Suicide Prevention lessons are:

1. Part 1: "What is Your Depression/Suicide IQ?" This lesson presents Wisconsin norms related to depression and suicide from the 2013 Youth Risk Behavior Survey (YRBS).

   Part 2: "What is Your Depression/Suicide IQ?" This lesson is based on discussion that gives students the opportunity to reflect on the YRBS data for Wisconsin and how it connects with their own school and community.

2. "Tech Messages & Social Media: Scripts, Tweets, and Pings Related to Suicide Warning Signs." This lesson asks students to identify and use the warning signs of suicidal thoughts.

3. "S.O.S.—It's Time to A.C.T." This lesson uses the S.O.S.* DVD (appropriate for students' grade level) to present information on warning signs of suicide and develop skills to handle these warning signs.

4. "Mirror…Mirror…" This lesson has students work in small groups to discuss the concepts of loss and coping. Students will compose an individual reflection illustrating their thoughts and feelings.

5. Part 1: "Lights! Camera! Action!" This lesson has students develop suicide prevention stories using their choice of media images.

   Part 2: "Crisis Card" This lesson has students find community resources that will help them address issues surrounding depression and suicide.

Unit Learning Objectives for Issues in Mental Health: Suicide Prevention Grades 7-12

Following the completion of this unit, the student will be able to:

1. Evaluate perceptions of depression and suicide.
2. Identify warning signs, risk factors, and protective factors of depression and suicide.
3. Demonstrate problem-solving and help-seeking behaviors (ACT; acknowledge, care, tell).
4. Demonstrate the ability to find suicide prevention resources.

* The program entitled "S.O.S.: Signs of Suicide" can be ordered from:
Screening for Mental Health
One Washington Street, Suite 304
Wellesley Hills, MA 02841
Phone: 781-239-0071
www.mentalhealthscreening.org

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Health Education Teacher
Madison Metro School District

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Hamilton School District

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Table of Contents

Educator Preparation Before the Delivery of the Suicide Prevention Curriculum

This section provides information regarding *Wisconsin Statutes and Administrative Rules Related to School-Based Suicide Prevention*, issues, cautions, and resources to help you successfully deliver this unit of instruction.

Suicide is preventable: There are many evidence-based strategies that schools can utilize to prevent suicide among students. The Department of Public Instruction (DPI) offers a single-day training to help schools build a comprehensive, multi-strategy, school-based suicide prevention program. Suicide is a sensitive topic. Therefore, educators are strongly encouraged to attend one of these trainings prior to utilizing DPI's curriculum. More information about the suicide prevention training, strategies, and resources is available at http://dpi.wi.gov/sspw/mental-health/youth-suicide-prevention.

The team approach: For any topics that deal with the potential for other- or self-directed harm (i.e., mental health, suicide, child abuse, bullying, dating violence), the DPI believes it is important to have a pupil services professional partner with the classroom teacher to deliver the curriculum. The pupil services professional may serve mainly in the role of observer or present one or more lessons. Both the teacher and the pupil services professional should look for non-verbal cues, as well as verbal responses of any student that may warrant contact with the student outside of the classroom. It is important for the pupil services professional to share with students at the beginning of the unit that he/she is willing to help with any concerns students might have on suicide-related issues.

High risk students: We know from data related to suicide attempts and deaths (including data from the WI Department of Health Services, the Center for Disease Control and Prevention, and the Youth Risk Behavior Survey) that students in some groups are statistically at higher risk for suicide than other students. These groups include, but are not limited to:

- students with mental illness;
- students who have previously attempted suicide or who know someone who completed a suicide;
- victims of harassment, abuse, or victimization (including bullying);
- students who are gay, lesbian, bisexual, transgender, or questioning their sexual orientation or gender identity (especially if their families are not accepting of them);
- perfectionists;
- American Indian and white students;

- students at-risk of not graduating from high school;
- students who are highly aggressive or impulsive;
- students who self-harm; and
- students who abuse alcohol or other drugs.

You may know students in your classroom that fall into one or more of these groups, but it is likely that some are unknown to you. These students may withdraw from class discussions or make sarcastic or off-topic comments about suicide. Through prior discussion with and participation by a member of your pupil services staff, you can be prepared for a range of student responses. If a student seems upset or angry, a referral to an appropriate pupil services professional is in order.

Co-occurring suicide risk and substance abuse: Alcohol and other drug abuse may increase the risk for suicide attempts. We have not included comprehensive information on the effects of substance abuse in combination with a suicide risk in this curriculum. If you wish to address this issue in conjunction with suicide prevention, we recommend you consult with a pupil services professional in your school, a substance abuse counselor in your community, or the DPI AODA webpage: http://dpi.wi.gov/sspw/aoda.

Systematic delivery of the knowledge and skills presented in this curriculum: Suicide prevention is a critical health issue; and therefore, it is of great value to share this unit with school staff and community agencies connected to youth suicide prevention and intervention services. It is critical that everyone working in a school understand the content knowledge and skills students will be learning. Suicide prevention can be enhanced through common language, effective intervention strategies, and community commitment from all people/groups invested in the process.

Parental support can be beneficial on this issue: Suicide is a sensitive subject. It is critical to make parents aware of the unit before it is implemented. This can be done in a variety of ways to give parents information to increase their awareness of the knowledge and skills students are learning. Among ways to reach out to parents are a letter/email or a parental meeting to discuss the learning goals and objectives of the unit.

Addressing cultural competence: Suicide affects both genders and all races and ethnicities. It is important to include the contributions, images, and experiences of diverse cultural groups in this unit of instruction. For information specific to cultural competence in suicide preventions please see the resources from the Suicide Prevention Resource Center: http://www.sprc.org/library_resources/sprc/listing?tid_2=209.

Addressing active classrooms: Support the Physical Activity Guidelines for Americans physical activity recommendations to increase opportunities for students to meet the recommended 60 minutes of moderate to vigorous activity every day. Incorporate into the lesson plans more daily physical activity by incorporating classroom activity breaks. Active Classroom ideas can be found via this link: http://dpi.wi.gov/sspw/physical-education.

Addressing literacy in all subjects: In Wisconsin, disciplinary literacy is defined as the confluence of content knowledge, experiences, and skills merged with the ability to read, write, listen, speak, think critically, and perform in a way that is meaningful within the context of a given

field. Disciplinary literacy resources can be found via this link: http://dpi.wi.gov/standards/literacy-all-subjects.

Addressing Wisconsin State Standards for Health Education: This curriculum is aligned to 2011 Wisconsin Health Education Standards and emphasizes skill practice is an essential component of effective teaching and student learning. The standards can be found via this link: http://dpi.wi.gov/sspw/health-education.

Additional resources available: There are a number of high-quality resources available to support school-based suicide prevention. Some of these include:

Screening for Mental Health: www.mentalhealthscreening.org

Suicide Prevention Resource Center: www.sprc.org

Substance Abuse and Mental Health Administration: www.samhsa.gov

School Based Youth Suicide Prevention Guide: http://theguide.fmhi.usf.edu/

American Association of Suicidology: www.suicidology.org

Gay Straight Alliance for Safe Schools: www.gsaforsafeschools.org

Means Matter: www.hsph.harvard.edu/means-matter

What is Your Depression/ Suicide IQ?

1

Part 1

Teacher's Information

Suicide is not an everyday occurrence. However, Wisconsin has the 24th highest youth suicide rates; and suicide is the second leading cause of death for youth ages 5-19 in our state. (Accidental death is the leading cause.)

Learning Objectives

The student will be able to:

1. Identify the percentage and proportion of Wisconsin high school students who report experiencing depression, have suicidal thoughts, or who have engaged in suicidal behaviors.
2. Identify the prevalence of depression and possible suicidal thoughts among their peers.

Answers (From the 2013 Wisconsin Youth Risk Behavior Survey)

1. 25% Q23 (sad, hopeless) 1 in 4 students
2. 13%* Q24 (seriously considered) 1 in 8 students
3. 16%** Q24 1 in 6 females; 10% of males 1 in 10
4. 12%*** Q25 (made a suicide plan) 1 in 8 students
5. 6% Q26 (actual attempt) 1 in 16 students
6. 33% Q27 (injury resulted in 2% of the 6% who reported an actual attempt)—1 in 50 students
7. 14^{th} in the country (2013 CDC state data on youth who died by suicide)

* Significant decrease between 2001 and 2013, 20% vs. 13%.

** Females are significantly more likely to have seriously considered attempting suicide in the past twelve months than males.

*** Statistically significant difference between genders; female students higher.

Note: *Twenty-five percent of high school students felt sad/hopeless, but a lot fewer attempted suicide. Depression is common when going through a troubled time or crisis. Suicide is not a common response to depression. Suicide is a permanent solution to a temporary problem. When someone talks about suicide, take it seriously. Follow the steps presented later in this lesson and know how to respond. Adding your school/local YRBS or other data on suicide, if available, would be helpful to discuss here.*

Student Instructions

Students should make their best guess as to the percentage of Wisconsin high school students who have reported they have engaged in the following:

1. During the past twelve months, _____% of Wisconsin high school students (grades 9-12) felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities.

2. During the past twelve months, _____% of Wisconsin high school students seriously considered attempting suicide.

3. During the past twelve months, _____% of Wisconsin high school females (while _____% of males) seriously considered attempting suicide.

4. During the past twelve months, _____% of Wisconsin high school students made a plan to end their life.

5. _____% of students report actually attempting suicide.

6. Of those students who attempted suicide in the past twelve months as reported in the previous statement, _____% of the students report their attempts resulted in injury, poisoning, or overdose that was treated by a doctor or nurse.

7. Where does Wisconsin rank nationally in youth suicide rate? ____

Check your answers with those given by your teacher.

Department of Public Instruction

Wisconsin Youth Risk Behavior Survey 2013

Part 2

Teacher Information

Part 1 of this lesson explored the norms related to suicide and depression in Wisconsin and the United States for Q23 through Q27 from the 2013 Youth Risk Behavior Survey.

Emphasize that death by suicide is much higher in Wisconsin than in thirty-six other states. Tell students that studies have pointed out four hypotheses for this difference: 1) access to firearms (highly lethal means), 2) binge drinking (increases risk-taking behavior and impulsivity), 3) stigma or the negative thoughts/feelings around talking about mental illness/suicide, and 4) lack of access to appropriate mental health services.

An interesting personal reflection followed by small or large group discussion could revolve around students' perceptions of these four suggested hypotheses. Examples of reflection prompts and discussion starters:

- Ask students, "What do you think of the reasons presented?"
- Ask, "How are the four reasons connected to Wisconsin's diverse geography and communities or cultures?"
- Have students discuss the ways these represent (or not) what's happening in our school and/or community?
- Assign students to rank these four, and identify which they think is the most important for our school to address and why?
- Ask, "Do these four reasons leave out anything you feel is important? What is something you think should be included?

Tech Messages and Social Media: Scripts, Tweets, and Pings Related to Suicide Warning Signs

2

The goal of this lesson is to provide practice in recognizing suicidal warning signs.

Teacher Information

Learning Objectives

The student will be able to:

1. Identify warning signs of a possible suicide as they relate to real life situations.
2. Create scenarios that have warning signs related to suicide (FACT).
3. Demonstrate appropriate intervention skills (A.C.T.)

Curriculum Connections

Social Studies, Health, Family and Consumer Education

Overview

Students partner to develop a script where a student contacts a suicide prevention crisis line, messages a friend, or uses social media to communicate warning signs that could lead to a suicide attempt. Students will assess the level of risk using a checklist provided in this activity. (Possible scenarios include: a student messaging another student, a parent, another adult, or posting something to their social media account)

Requirements

The students will be working in pairs and will create a role-play script where 4-6 warning signs are brought out in the script.

They can use the "Warning Signs" information sheet to help guide the development of the script.

The rest of the class will use the warning sign worksheet to see how many signs are mentioned in the script.

Emphasize to your students that each warning sign is a possible message that a student may be experiencing mental health or emotional problems. Though it may not lead to a suicide plan or attempt, you need to

communicate to your students that they should consider applying A.C.T. to handling the situation.

Time

This activity will take two class periods for development, presentations, class discussion, and to learn and understand the F.A.C.T. and A.C.T. acronyms.

Materials

Checklists, writing utensil, and handouts (paper or electronic version), electronic device

Instruction

Preliminary classroom activities will include lessons on the A.C.T. process and the warning signs of suicide. Ensure that students have been provided adequate time for students to become familiar with and understand the FACT acronym. Utilize age-appropriate strategies that address individual student needs.

NOTE: When forming student pairs, teachers should be aware of the possibility of students' prior history regarding exposure or experience with suicide. Teachers need to have a plan for assisting students who appear sensitive to this activity. (i.e., refer to pupil services staff)

Assessment Criteria

Answers can be scored on the following:

1. How well the student understands health concepts as they relate to suicide warning signs.
2. How well the student incorporates A.C.T. (acknowledge, care, tell) into their script.
3. How well the student uses interpersonal communication to enhance health.

	Alignment to Wisconsin Health Education Standards
1	*Core Concepts:* Students will comprehend concepts related to health promotion and disease prevention to enhance health
8	*Advocacy*: Students will demonstrate the ability to advocate for personal, family and community health

Sample Response
Text Messages Related to Suicide Behaviors and Warnings

Role Players: This scenario is an exchange of texts between friends.

Scene Set-up: Sam is struggling in school and at home. A six-month dating relationship just ended, and Sam is going to fail four classes. Last week Sam got suspended for coming to school under the influence of alcohol. After school on Friday, Sam texts Pat:

Sam: So that week really sucked

Pat: IKR

Sam: No. I mean it REALLY sucked. Failing bio, comp, civix, & PE. Cali started dating Phil. Grounded for life from last week. I need a drink and a gun.

Pat: WTH? Don't even joke about that. Haha

Sam: Im not jokng. Last summer I ODd and nearly died, but I thought life was OK til this week. Now its worse than ever

Pat: Seriously? U never told me that. R u gonna b OK?

Sam: Ill be fine. Don't worry.

Pat: Let's go shoot hoops. You love killin it on the court.

Sam: Nah. I don't feel like it.

Pat: Where u at? Lets chat.

Sam: K. Im chillin at home cmon over

Pat: C u in 10.

Sample Answers (underlined are FACTs)
Sam: So that week really sucked

Pat: IKR

Sam: No. I mean it REALLY sucked. Failing bio, comp, civix, & PE. Cali started dating Phil. Grounded for life from last week. I need a drink and a gun.

Pat: WTH? Don't even joke about that. Haha

Sam: Im not jokng. Last summer I ODd and nearly died, but I thought life was OK til this week. Now its worse than ever

Pat: Seriously? U never told me that. R u gonna b OK?

Sam: Ill be fine. Don't worry.

Pat: Sounds like your still upset. I get it. I'd be upset to. Let's go shoot hoops and talk more.

Sam: Nah. I don't feel like it.

Pat: Where u at? Lets chat.

Sam: K. Im chillin at home cmon over

Pat: C u in 10.

Student Instructions

Many suicidal individuals talk about their suicidal feelings or plans before they attempt the suicidal act. It is important to listen to these "cries for help" by practicing the A.C.T. (acknowledge, care, tell) technique discussed in this unit.

Individuals who work at phone-based or messaging-based suicide crisis centers are given information regarding common myths about suicide. An example of a myth is that if you talk about suicide, you are more likely to attempt suicide. This is a common misconception because most people who are suicidal will show signs that friends may be able to see. Suicide crisis center workers use the Warning Signs of Suicide lists to help them determine the level of risk for attempting suicide of the person who contacts them.

Your task is to work in pairs to develop and write a script where a student contacts the suicide crisis center or another person by phone or other electronic device. The center worker or other person is trying to communicate with the student and help them address the problems presented. Once your scenario is created, your group will turn it in to the teacher.

Using copies of the warning signs "checklist," you will practice identifying suicide warning signs as you read other group's scenarios, determining what signs are present in their script, recording your findings on the checklist, and turning it in to the teacher.

Assessment Criteria

Answers may be scored on the following:

1. How well you understand suicide warning signs (identifying FACT).
2. How well you incorporate A.C.T. (acknowledge, care, tell) into your script.
3. How well you use interpersonal communication to enhance health.

Warning Signs of Suicide

Suicide is a relatively rare event. It is hard to predict who will attempt suicide. However, there are some urgent warning signs. Warning signs are observable changes, behaviors, or statements that indicate directly or indirectly that an individual is contemplating suicide.

Urgent Warning Signs

If you see or hear one of these, talk with a responsible adult right away, call 9 1 1, or seek immediate help from a mental health provider:

- Someone **threatening** to hurt or kill themselves;
- Someone **looking for ways to kill themselves**: seeking access to pills, weapons, or other means; or
- Someone **talking or writing about death**, dying, or suicide in a way that is not "typical" for them.

General Warning Signs

Warning signs can be organized around the acronym **"FACTs**." Some of these signs are not as urgent, but can still give important clues about someone's suicidal intent. Pay attention if you see, hear, or know of anyone exhibiting any one or more of these behaviors, and ACT. If you see or hear about someone exhibiting one or more of these, TELL a responsible adult, contact a mental health professional, or call 1-800-273-TALK (1-800-273-8255) for a referral. Place a mark by those that are in the script or are URGENT.

We want you to "ACT on the FACTs"

Take the following warning signs chart and make copies OR make it accessible via electronic devices.

F.A.C.T.s

Warning Signs	Mentioned in Script
FEELINGS	
• Hopeless—"Things will never get better." "There's no point in trying."	
• Helpless—"There's nothing I can do about it." "I can't do anything right."	
• Worthless—"Everyone would be better off without me." "I have no reason to live."	
• Guilt, shame, self-hatred—"What I did was unforgivable." "I'm useless."	
• Pervasive sadness.	
• Persistent anxiety or agitation.	
• Feeling trapped—like there's no way out.	
• Persistent, uncharacteristic anger, hostility, or irritability.	
• Confusion—can't think straight, make decisions.	
ACTIONS	
• Uncharacteristic aggression, rage, seeking revenge.	
• Uncharacteristic risk taking, recklessness without thinking.	
• Withdraw from friends/activities, family or society.	
• Becoming accident prone.	
• Recent losses—death, divorce, relationship, job, status, self-esteem.	
• Getting into trouble, discipline problems.	
• Increasing drug or alcohol use.	
• Themes of death or destruction in talking, texting, or social media.	
CHANGES	
• Personality—acting opposite of what's "normal" for them (i.e., more withdrawn, low energy, "don't care" attitude or more boisterous, talkative, outgoing.)	
• Can't concentrate on school, work, or routine tasks.	
• Loss of interest in hobbies or work.	
• Marked decrease in school or work performance.	
• Unable to eat/sleep, or sleeping/eating all the time.	

Warning Signs	Mentioned in Script
• Sudden improvement after being down or withdrawn.	
• Dramatic mood change.	
THREATS	
• Statements—talking about suicide directly or indirectly, written themes of death, preoccupation with death.	
• Threats—"I won't be around much longer," writing suicide note, making a direct threat.	
• Plans—giving away prized possessions, making arrangements for a funeral, studying drug effects, obtaining a weapon.	

S.O.S.—It's Time to A.C.T.

3

The goal of this lesson is to demonstrate suicide warning signs and skills youth can apply to prevent suicide.

Teacher Information

Learning Objectives

The student will be able to:

1. List warning signs related to suicide prevention.
2. Analyze the use of the skill A.C.T. in life-like scenarios.
3. Analyze the decisions portrayed in the scenarios.

Curriculum Connections

Family and Consumer Education, Social Studies, Peer Mediation

Overview

This assessment could be used as an introductory or culminating activity. The students will view the S.O.S. video and answer the questions on the worksheet. You may want to have them jot down ideas while watching a vignette. Stop the video when the vignette is complete, and then have the students write down their answers.

Requirements

The following situations from the video entitled *S.O.S.* describe potential suicide situations. The student's tasks are to answer the questions on the worksheet using the A.C.T. process and to engage in a discussion of decision-making. Students should then discuss both their answers to the worksheet questions and their perceptions of the decisions made by the students in the scenarios with a partner and/or the whole class.

*NOTE: Being able to empathize with another is a skill that can be taught here and utilized as a fundamental base for acknowledging the issue and demonstrating care.

A.C.T. Process

1. **A**cknowledge that your friend has a problem and that the symptoms are important to them and serious.
2. **C**are about your friend by letting them know that you recognize the seriousness of their situation and that you want to help them.
3. **T**ell a trusted adult about your concerns. Telling the right person can make all the difference.

Time

This activity can take one to two class periods (45 minutes per period). The DVD can take between 30 – 45 minutes; depending on the depth of discussions.

Materials

Signs of Suicide DVDs for high school and/or middle school. The program entitled *S.O.S.—Get into the A.C.T.* can be ordered from:

Screening for Mental Health
One Washington Street, Suite 304
Wellesley Hills, MA 02481
Phone: 781-239-0071
www.mentalhealthscreening.org

Student worksheet

Teacher Prompts

This activity could be used as a pre- or post-unit activity. You should discuss the warning signs and whether the person applied A.C.T. to help the person in need.

Assessment Criteria

Answers can be scored on the following:

1. How completely and correctly the students demonstrate an understanding of health concepts related to suicide prevention and the use of the A.C.T. process.

2. How well the students effectively communicate their answers.

Alignment to Wisconsin Standards for Health Education

1	*Core Concepts:* Students will comprehend concepts related to health promotion, and disease prevention to enhance health.
4	*Interpersonal Communication*: Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.
5	*Decision-Making:* Students will demonstrate the ability to use decision-making skills to enhance health.

Sample Response

The answers need to include the components of A.C.T. (acknowledge, care, tell) in each of the answers and the warning signs demonstrated in each scenario.

Student Instructions

The following situations from the *S.O.S.* video describe potential suicide situations. Answer the questions on the *S.O.S.* worksheet using the A.C.T. process, discuss your answer with a partner and be ready to discuss your answer with the class.

What is A.C.T.?

1. **A**cknowledge that your friend has a problem and that the symptoms are serious.
2. **C**are about your friend by letting them know that you care about them and that you want to help them.
3. **T**ell a trusted adult about your concerns, or take your friend to a trusted adult. Telling the right person can make all the difference.

Assessment Criteria

Answers may be scored on the following:

1. How completely and correctly you demonstrate an understanding of health concepts related to suicide prevention, and use the A.C.T. process.
2. How well you effectively communicate your answers to your partner.

S.O.S. Signs of Suicide: *Friends for Life* Video—Worksheet

Vignette 1: Friends discussing college entrance scores

What are the signs that this student is depressed and/or suicidal?

_____

_____

How did his friend use the A.C.T. process?

A _____

C _____

T_____

What factors went into the decision to tell a trusted adult or keep the situation secret?

_____

_____

What positive and negative consequences could be predicted for each decision?

_____

_____

Vignette 2: Girl struggles with the breakup with her boyfriend.

What are the signs that this student is depressed and/or suicidal?

_____

_____

How did his friend use the A.C.T. process?

A _____

C _____

T_____

What factors went into the decision to tell a trusted adult or keep the situation secret?

_____

_____

What positive and negative consequences could be predicted for each decision?

_____

_____

Vignette 3: Boy who is always being picked on.

What are the signs that this student is depressed and/or suicidal?

_____

_____

How did his friend use the A.C.T. process?

A _____

C _____

T_____

What factors went into the decision to tell a trusted adult or keep the situation secret?

_____

_____

What positive and negative consequences could be predicted for each decision?

_____

_____

Vignette 4: Boy lying on bed who has stopped interacting with friends.

What are the signs that this student is depressed and/or suicidal?

_____

_____

How did his friend use the A.C.T. process?

A _____

C _____

T_____

What factors went into the decision to tell a trusted adult or keep the situation secret?

_____

_____

What positive and negative consequences could be predicted for each decision?

_____

_____

S.O.S. Signs of Suicide: *Time to ACT* Video—Worksheet

Vignette 1: Sisters talking in the bedroom. Younger sister is depressed.

What are the signs that the younger sister is depressed and/or suicidal?

_____

_____

How did the older sister use the A.C.T. process?

A _____

C _____

T_____

What factors went into the decision to tell a trusted adult or keep the situation secret?

_____

_____

What positive and negative consequences could be predicted for each decision?

_____

_____

If you had a younger sibling you felt was depressed, what would you do?

_____

_____

Vignette 2: Two boys in the hallway at school. One is angry.

What are the signs that this student is depressed and/or suicidal?

_____

_____

How did his friend use the A.C.T. process?

A _____

C _____

T_____

What factors went into the decision to tell a trusted adult or keep the situation secret?

_____

_____

What positive and negative consequences could be predicted for each decision?

_____

_____

Have you ever felt like the angry student? What did you do?

_____

_____

Vignette 3: Two girls in the bathroom at school. One is being bullied.

What are the signs that the bullied student is depressed and/or at risk for suicide?

_____

_____

How did the friend use the A.C.T. process?

A _____

C _____

T_____

What factors went into the decision to tell a trusted adult or keep the situation secret?

_____

_____

What positive and negative consequences could be predicted for each decision?

_____

_____

Have you ever had a friend who was bullied? How did you react?

_____

_____

Mirror… Mirror…

4

The goal of this activity is for students to reflect on concepts related to loss, suicide, coping skills, and suicide prevention; making connections to people or events in their own lives.

Teacher Instructions

The teacher will lead a large group discussion on the topics of personal loss and how it can affect how people think, feel, and act. Examples of loss could be losing a favorite item, having something damaged or destroyed, a friend or family member moving away, losing a pet, or the death of someone or something. The teacher should also lead a conversation about the variety of ways people cope with loss; including the healthy and unhealthy strategies people use. During this conversation, the teacher should contrast a variety of healthy coping strategies with unhealthy activities. These might include talking to a friend, family member or other trusted person, exercise, cognitive/behavioral strategies (counting to ten, taking deep breaths, playing with a pet, etc.), helping someone else, or seeking counseling.

The teacher should also present some information about how individuals might cope with loss by suicide differently than other loss. Losing someone to suicide can produce feelings of anger, guilt, embarrassment, and/or shame that are difficult to understand; including the stigma associated to death by suicide and the variables that contribute to suicide. Family members who have experienced a death by suicide may have unresolved questions about the death and need a chance to process them.

Following the large group discussion, students should be broken into smaller groups, and the teacher will facilitate small group discussions centering on the similarities and differences between various types of loss; compared with loss by suicide. Conversation starters for the small group are:

- In what ways are the types of loss similar? (such as a friend leaving town or the death of a pet)
- How are the types of loss different?
- How are the coping skills of general loss similar to or different than what we use for losing someone to suicide?

After students have their small group discussions, the teacher will ask students to bring closure to this topic by writing a short, reflective paragraph that identifies how they feel about and cope with personal loss of any type. A stem for this reflection might be “Tell about a time that you experienced a personal loss. What did you lose? Why was it important? How did you feel about the loss? How did you cope with the loss?”

Teacher Information

Learning Objectives for Mirror...Mirror...

The student will be able to:

1. Identify their feelings of loss.
2. Identify healthy and unhealthy coping strategies.

Curriculum Connections

Family and Consumer Science, Language Arts

Lights! Camera! Action!

5

Part 1

The goal of this lesson is to provide practice in a literacy format to recognize warning signs and apply A.C.T. to save a person's life.

Teacher Information

Learning Objective

The students will be able to:

1. Apply suicide warning FACTs (feelings, actions, changes, threats) and ACT intervention (acknowledge, care, tell) through the creation media product. Examples may include but not limited to a film storyboard, public service announcement, video broadcast, podcast, etc.

Curriculum Connections

Language Arts, Social Studies, Family and Consumer Education

Overview

The students will demonstrate their knowledge of ACT and FACT using media/technology to create a presentation illustrating their understanding of the health concepts related to suicide and suicide prevention.

Requirements

Using the suggestions, resources, and materials you provide, the students will produce a short media product.

Time

This activity requires two class periods (approximately 90 minutes) for the research, creation, and sharing of the presentation.

Materials

List of possible "Lights, Camera, Action" story components.

Instruction

Classroom discussion on suicide warning signs, protective factors, and suicide prevention should be done prior to this activity.

Assessment Criteria

Answers can be scored on the following:

1. How completely and correctly the students demonstrate an understanding of health concepts related to suicide prevention.

	Alignment to Wisconsin Health Education Standards
1	*Core Concepts:* Students will comprehend concepts related to health promotion, and disease prevention to enhance health.
4	*Interpersonal Communication:* Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks

Student Instructions

Middle School

As a team of approximately five students, your task is to develop a film storyboard or produce a media product (i.e., video or PowerPoint) that is based on your understanding of the health concepts and skills related to suicide and suicide prevention. You will use available technology at the discretion and direction of the teacher to create your storyboard or video production.

Middle School Assessment Criteria

Answers may be scored on the following:

> The storyboard or media product must include at least one warning sign (FACT), the reaction represented in the acronym A.C.T., and a collaborative work effort that includes all team members.

High School

As a team of approximately three students, your task is to create a media product that demonstrates your understanding of the health concepts and skills related to suicide and suicide prevention. The media product you create will connect the warning signs of potential suicide ideation to a successful intervention; resulting in a safe resolution to the situation.

High School Assessment Criteria

Answers may be scored on the following:

> The storyboard or media product must include at least three warning signs (FACTs), the reaction represented in the acronym A.C.T., and a collaborative work effort that includes all team members.

Lights! Camera! Action! Story Components

Attention

School Counselor

Principal's Office

Alcohol

Principal

Family Myth or Fact

Sadness or Crying

Ambulance

Gun

Stress

Frustration

KILL

Drugs

Attempt

Gossiping or Rumor Spreading

Ups and Downs

Knife

Friend(s)

Secrets

Anger or Rage

Risk-taking

Family Time or Happy Family

Help

Scared

Tunnel Vision

Upset

Bully or Bully Victim

Funeral

Angry Parent

Low Interest

Confused

Moody

Depressed or Depression

Sleeping (too much or too little)

Grades Going Down

Giving Away Possessions

Problem-solving

Bad/Positive Attitude

Mad

Plan

Intervention

Respond

Caring

Friendship

Part 2

The Crisis Card

The goal for this lesson is to have students find prevention resources in their school and community.

Teacher Information

Learning Objectives

The student will be able to:

1. Access accurate information about school/community resources to prevent suicide.
2. Demonstrate the ability to find qualified suicide prevention services in the community.

Curriculum Connections

Language Arts, Social Studies, Peer Mediation, Family and Consumer Education, At-Risk Groups or Classes

Overview

The student will create a physical or electronic crisis information card. One side will present information on Warning Signs of Suicide and positive ways of handling a suicide threat. The other side will include key organizations and their contact information or website that provide suicide crisis assistance.

Requirements

This product will be done on a white card stock or electronic device. Students who create their resource on card stock should be invited to store contact information about their identified organizations on their electronic device.

Time

This activity will take one class period (45 minutes).

Materials

White card stock paper, computer or other electronic device (or pen if computers are not available); brochures, and/or electronic search engines can be used to access information about organizations, contact information, or websites.

Instruction

A discussion of key community mental health resources should be included. Key people could include the crisis counselor from the community and pupil services professionals in the school. In addition, students will do a search for accurate and reliable suicide prevention contact information and websites. Following the student searches, teachers can refer to the resources listed at the end of this section to compliment the list generated by the students. Classroom instruction should include a discussion of the warning signs of suicide (F.A.C.T.), the meaning of A.C.T. (acknowledge, care, tell), and how to determine the appropriateness of resources.

Assessment Criteria

Answers can be scored on the following:

1. How well the student demonstrates knowledge and skills on concepts as they relate to suicide prevention.

2. How well the student accesses accurate information regarding teen crises.

	Alignment to Wisconsin Health Education Standards
1	*Core Concepts*: Students will comprehend concepts related to health promotion and disease prevention to enhance health
3	*Accessing Information*: Students will demonstrate the ability to access valid health information and products and services to enhance health
4	*Interpersonal Communication:* Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks
7	*Self-Management:* Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce risks

Sample Response

Warning Signs	What To Do
Warning Signs of Suicide Verbal suicide threats Previous suicide attempts Depression Giving away possessions Change in attitude (moods)	What to do when faced with a suicide threat: 1. Acknowledge threats are real. 2. Show care for the person you are concerned about. 3. Get help by immediately telling a relative or other responsible adult about the person threatening suicide.
Name(s) of Organization(s)	Contact Information or Website
Nat'l Suicide Prev. Lifeline WI Hopeline (text-based) Emergency Services Prevent Suicide Wisconsin	1-800-273-TALK (8255) www.suicidepreventionlifeline.org text "hopeline" to 741741 911 www.preventsuicidewi.org

Student Instructions

Many young people are faced with crises every day that could be helped with the assistance of a trained, licensed professional in suicide prevention. Your task is to develop a physical or electronic crisis emergency card that is accessible 24/7.

Your crisis card will consist of specific pieces of information. The front side of the card will list the following:

Warning Signs	What To Do
_____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____

The back side of the card will include:

Name(s) of Organization(s)	Contact Information or Website
1.	

Assessment Criteria

Answers may be scored on the following:

1. Demonstration of your ability to access accurate teen crises information.

Additional Suicide Prevention Resources

National Resources

American Association of Suicidology
AAS promotes research, public awareness programs, public education, and training for mental health professionals, researchers, suicide prevention/crisis intervention centers, school districts, survivors of suicide and a variety of lay persons who have an interest in suicide prevention.

www.suicidology.org
(202) 237-2280
info@suicidology.org

American Foundation for Suicide Prevention
The only national not-for-profit organization exclusively dedicated to funding research, developing prevention initiatives, and offering educational programs and conferences for survivors, mental health professionals, physicians and the public.

www.afsp.org
(888) 333-AFSP (2377)
inquiry@afsp.org

Gay, Lesbian and Straight Education Network (GLSEN)
The mission of GLSEN is to assure that each member of every school community is valued and respected regardless of sexual orientation or gender identity/expression.

www.glsen.org

Jed Foundation
The Jed Foundation is committed to reducing the young adult suicide rate by furthering understanding of the underlying causes of suicide, by increasing awareness of the issue of college student mental health and suicide, and by creating effective prevention programs on college campuses.

www.jedfoundation.org/
(212) 647-7544
emailus@jedfoundation.org

Means Matter
The mission of the Means Matter Campaign is to increase the proportion of suicide prevention groups who promote activities that reduce a suicidal person's access to lethal means of suicide.

http://www.hsph.harvard.edu/means-matter/

National Alliance on Mental Illness (NAMI)
The nation's largest grassroots mental health organization comprised of chapters in every state and many local communities. Programs and activities including public education and information; family and consumer peer education and support; advocacy; and public events.

www.nami.org
(800) 950-NAMI (6264)

www.namiwisconsin.org
(800) 236-2988

nami@namiwisconsin.org

National Association of School Psychologists
Go to National Association for School Psychologists website, www.nasponline.org, and do a search on the term "Suicide" or "Self-Mutilation" to link to useful handouts on each of these:

Times of Tragedy: Preventing Suicide in Troubled Children and Youth, 2 Parts
Save a Friend: Tips for Teens to Prevent Suicide
Questions and Answers: Suicide Intervention in Schools
After a Suicide: Answering Questions for Students
Understanding and Responding to Students Who Self-Mutilate
Understanding Students Who Self-Mutilate: Information for Educators

National Suicide Prevention Lifeline
Crisis centers in the network are equipped to take a wide range of calls from immediate suicidal crisis to information about mental health and referrals.

www.suicidepreventionlifeline.org
1-800-273-TALK (8255)

School-based Youth Suicide Prevention Guide
The Youth Suicide Prevention School-Based Guide is designed to provide accurate, user-friendly information. The Guide is not a program but a tool that provides a framework for schools to assess their existing or proposed suicide prevention efforts (through a series of checklists) and provides resources and information that school administrators can use to enhance or add to their existing program.

http://theguide.fmhi.usf.edu/

Screening for Mental Health
Screening for Mental Health is an organization that creates resources for instruction in issues that deal with mental health, including suicide prevention. They have created videos for middle school and high school to use within their suicide prevention curriculums.

https://mentalhealthscreening.org/

Substance Abuse and Mental Health Services Administration (SAMHSA)
This U.S. Department of Health and Human Services agency is focused on building resilience and facilitating recovery for people with or at risk for mental or substance use disorders with resources including programs, policies and grants.

(877) 696-6775
http://www.samhsa.gov/

Suicide Awareness/Voices of Education (SAVE)
Committed to the education of the general public about the depressive brain diseases that, if left untreated, may result in suicide and to reduce the stigma associated with these diseases.

www.save.org
(888) 511- SAVE (7283)

Suicide Prevention Resource Center (SPRC)
"The best of science, skills and practice; prevention support, training, and informational materials" to strengthen suicide prevention networks and advance the National Strategy for Suicide Prevention. Includes a library of evidence-based practices.

www.sprc.org
(877) GET–SPRC (438-7772)

info@sprc.org

The Trevor Project
Suicide hotline for gay and questioning teens.

www.thetrevorproject.org
866-4-U-TREVOR (866) 488-7386

State Resources

Department of Public Instruction (DPI)
Student Services/Prevention and Wellness Team
Provides technical assistance, training, and resources, and facilitates school-district and community efforts to meet specific needs of students.

http://dpi.wi.gov/sspw/mental-health/youth-suicide-prevention
(608) 266-3960

GSA for Safe Schools
GSA is committed to safe middle schools and high schools for lesbian, gay, bisexual, transgender youths and all students.

www.gsaforsafeschools.org

Prevent Suicide Wisconsin
The mission of Prevent Suicide Wisconsin is to reduce the number of suicides that take place in our state each year.

www.preventsuicidewi.org

Wisconsin Crisis Network
Meets on a quarterly basis to review trends and problem-solve, and to keep updated on, and try to influence, legislation affecting crisis services. A useful resource for support in the development of your crisis plans as well as information on best practices.

Bureau of Mental Health and Substance Abuse Services
(608) 266-0907

Wisconsin Family Ties
A statewide organization run by and for families that include children and adolescents who have emotional, behavioral, and mental disorders. Programs and services include advocacy, support groups, information and referral, and education.

www.wifamilyties.org
(608) 261-8773

Appendix C

Strategies, Programs, and Practices to Consider

Handout Provided by: Suicide Prevention Resource Center, 2018

Effective suicide prevention is comprehensive: it requires a combination of efforts that work together to address different aspects of the problem.

The model above shows nine strategies that form a comprehensive approach to suicide prevention and mental health promotion. Each strategy is a broad goal that can be advanced through an array of possible activities (i.e., programs, policies, practices, and services). This model of a comprehensive approach was adapted from a model developed for campuses by SPRC and the Jed Foundation, drawing on the U.S. Air Force Suicide Prevention Program.

Identify and Assist Persons at Risk

Many people in distress don't seek help or support on their own. Identifying people at risk for suicide can help you reach those in the greatest need and connect them to care and support. Examples of activities in this strategy include gatekeeper training, suicide screening, and teaching warning signs.

Increase Help-Seeking

By teaching people to recognize when they need support—and helping them to find it—you can enable them to reduce their suicide risk. Self-help tools and outreach campaigns are examples of ways to lower an individual's barriers to obtaining help, such as not knowing what services exist or believing that help won't be effective. Other interventions might address the social and structural environment by, for example, fostering peer norms that support help-seeking or making services more convenient and culturally appropriate.

Ensure Access to Effective Mental Health and Suicide Care and Treatment

A key element of suicide prevention is ensuring that individuals with suicide risk have timely access to evidence-based treatments, suicide prevention interventions, and coordinated systems of care. Suicide prevention interventions such as safety planning and evidence-based treatments and therapies delivered by trained providers can lead to significant improvement and recovery. SPRC encourages health and behavioral health care systems to adopt the Zero Suicide framework for integrating these approaches into their systems. Reducing financial, cultural, and logistical barriers

to care is another important strategy for ensuring access to effective mental health and suicide care treatment.

Support Safe Care Transitions and Create Organizational Linkages
You can reduce patients' suicide risk by assuring them an uninterrupted transition of care and by facilitating the exchange of information among the various individuals and organizations that contribute to their care. Individuals at risk for suicide and their support networks (e.g., families) must also be part of the communication process. Tools and practices that support continuity of care include formal referral protocols, interagency agreements, cross-training, follow-up contacts, rapid referrals, and patient and family education.

Respond Effectively to Individuals in Crisis
Individuals in your school, organization, or community who are experiencing severe emotional distress may need a range of services. A full continuum of care includes not only hotlines and helplines but also mobile crisis teams, walk-in crisis clinics, hospital-based psychiatric emergency services, and peer-support programs. Crisis services directly address suicide risk by providing evaluation, stabilization, and referrals to ongoing care.

Provide for Immediate and Long-Term Postvention
A postvention plan is a set of protocols to help your organization or community respond effectively and compassionately to a suicide death. Immediate responses focus on supporting those affected by the suicide death and reducing risk to other vulnerable individuals. Postvention efforts should also include intermediate and long-term supports for people bereaved by suicide.

Reduce Access to Means of Suicide
One important way to reduce the risk of death by suicide is to prevent individuals in suicidal crisis from obtaining and using lethal methods of self-harm. Examples of actions to reduce access to lethal means include educating the families of those in crisis about safely storing medications and firearms, distributing gun safety locks, changing medication packaging, and installing barriers on bridges.

Enhance Life Skills and Resilience
By helping people build life skills, such as critical thinking, stress management, and coping, you can prepare them to safely address challenges such as economic stress, divorce, physical illness, and aging. Resilience—the ability to cope with adversity and adapt to change — is a protective factor against suicide risk. While it has some overlap with life skills, resilience also encompasses other attributes such as optimism, positive self-concept, and the ability to remain hopeful. Skills training, mobile apps, and self-help materials are examples of ways to increase life skills and build resilience.

Promote Social Connectedness and Support
Supportive relationships and community connectedness can help protect individuals against suicide despite the presence of risk factors in their lives. You can enhance connectedness through social programs for specific population groups (such as older adults or LGBT youth) and through other activities that reduce isolation, promote a sense of belonging, and foster emotionally supportive relationships.

Appendix D

Counseling Notes

Student Name: _____ Grade: _____

Reason for plan: _____

Parent Name: _____ Phone: _____

Counseling Goals: _____

_____

_____

_____

_____

_____

Date	Topic	Session Notes	Goal Worked On

Appendix E

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and <u>underlined</u>.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***<u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***<u>Have you actually had any thoughts of killing yourself?</u>***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***<u>Have you been thinking about how you might kill yourself?</u>***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u>, as opposed to "*I have the thoughts but I definitely will not do anything about them*." ***<u>Have you had these thoughts and had some intention of acting on them?</u>***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***<u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>***		
6) Suicide Behavior Question: ***<u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u>*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *<u>How long ago did you do any of these?</u>*** · Over a year ago? · Between three months and a year ago? · Within the last three months?		

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Since Last Visit**	
Ask questions that are bold and underlined	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?***		
6) Suicide Behavior ***Have you done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

Appendix F

Mental Health Care Providers and Resources
*We do not specifically endorse any of the providers or organizations on this list. This is merely a list of known resources for mental health care in and near Marion County. Rates and insurance compatibility, if applicable, will vary depending on your provider.

SUICIDE & SELF-HARM

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

Community Health Network's Zero Suicide Initiative Text Hotline
Text HELPNOW to 20121

St. Vincent Stress Center
Provides clinical intervention for depression and anxiety, alcohol and drug issues, or family concerns.
Available to address immediate crises.
www.stvincent.org/mentalhealth/
2001 West 86th St., Indianapolis, IN 46206
Toll-free: 800-872-2210 or 317-338-2273

GENERAL MENTAL & BEHAVIORAL HEALTH COUNSELING

Adult & Child
Offers counseling services for individuals and families.
www.adultandchild.org/
603 E. Washington Street, Indianapolis, IN
(317) 635-3306

ASPIRE Indiana
Broad range of services for youth and families.
www.aspireindiana.org/
24 Hr. Crisis phone: (800) 560-4038
Appointments: (877) 574-1254

Beacon of Hope Center for Women (Women Only)
www.beaconofhopeindy.org/
6920 S. East Street, Suite B, Indianapolis, IN
Crisis call line: (317) 731-6140
Main office: (317) 731-6131

BehaviorSource Mental Health Counseling
www.behaviorsource.org
9425 N. Meridian Street, Suite 204, Indianapolis, IN
(844)-452-2557 / tadkins@behaviorsource.org

Center for Family Connection
Provides services related to attachment, past trauma, grief, and loss.
www.cffamconnect.com
740 E. 52nd St. Suite 10 Indianapolis, IN
(317) 429-0725

Center Point Counseling
Offers counseling services for individuals and families.
www.centerpointcounseling.org/
7700 N. Meridian St., Indianapolis, IN
(317) 252-5518

Community Health Network Behavioral Health
www.ecommunity.com/behavioralhealth/
For **outpatient** referral, call 317-621-5719 or toll-free at
866-621-5719
For **24-hour crisis** referral, call 317-621-5700 or toll-free
at 800-662-3445

Cummins Behavioral Health Systems, Inc.
Private not-for-profit organization offering behavioral health services for all ages.
www.cumminsbhs.com/
5638 Professional Circle, Indianapolis, IN
24 Hour Emergency Phone: (317) 714-1927 x1501
Appointments: (317) 714-1927 x1500

Charis Center for Eating Disorders
www.rileychildrens.org/departments/charis-center-foreating-disorders
6640 Intech Boulevard suite 195, Indianapolis, IN
(317) 295-0608

Children's Bureau
www.childrensbureau.org/

Counseling Associates
Counseling for all ages of individuals, couples, and families.
www.counselingindy.com
931 E. 86th St., Suite 101, Indianapolis, IN
(317) 466-1516

Eskenazi Health Midtown Community Mental Health
www.eskenazihealth.edu/mental-health
(317) 941-5003

HealthNet Pediatric and Adolescent Care Center
Outpatient urgent care and primary care services.
www.indyhealthnet.org/pages/Pediatric-and-Adolescent-Care-Center/
1633 N. Capitol Ave., Suite 236, Indianapolis, IN
(317) 962-8067

The Green Room
Mental Health Counseling – Joel Bruns
www.thegrnroom.com/
1980 E. 116th St. Suite 315, Carmel, IN
(317) 292-2612 / joel@thegrnroom.com

Indiana Center for Children and Families
Provides child, adolescent and family services for abuse, trauma, special needs and life challenges.
www.indcenter.org/
1431 N. Delaware St., Indianapolis, IN / (317) 631-2002

Indiana Youth Group
Nonprofit organization for LGBT youth providing support, programs & events to build caring communities for LGBTQ youth in Indiana.
www.indianayouthgroup.org
2943 E 46th St, Indianapolis, IN / (317) 541-8726

Julian Center
Supports and serves survivors of domestic or sexual violence.
www.juliancenter.org/default.aspx
2011 N. Meridian Street, Indianapolis, IN
(317) 920-9320

Legacy House
No cost counseling and advocacy for victims of trauma, depression, family violence, and sexual abuse.
www.legacy-house.org/
2505 N. Arlington Ave, Indianapolis, IN / (317) 554-5272

Life Recovery Center
Addiction, mental health, and domestic violence support.
www.liferecoverycenterindiana.com
Toll Free: (855) HELP-LRC

Meridian Psychological Associates
www.mpaindy.com/
4401 N. Central Ave., Indianapolis, IN
(317) 923-2333

Nurse-Family Partnership (Goodwill Industries)
Support for teen parents and first-time mothers.
www.nursefamilypartnership.org/locations/Indiana/Nurse-Family-Partnership-in-Marion-County
5901 Lakeside Blvd, Indianapolis, IN
(317) 524-3999

One Sensible Solution (offers school-based appts.)
Provides mental health services for individuals and families.
www.onesensiblesolution.com/home.html
6100 N. Keystone Ave., Suite 420, Indianapolis, IN
(317) 296-4914

Options Behavioral Health System
Inpatient psychiatric services, partial hospitalization, and intensive outpatient care for all ages.
www.optionsbehavioralhealthsystem.com/
5602 Caito Drive, Indianapolis, IN / (317) 942-3102

Reach for Youth
Provides counseling for behavioral issues, depression, anxiety, substance abuse and acting out. Arrangements may be made for those who cannot afford to pay.
www.reachforyouth.org/
3505 N. Washington St., Indianapolis, IN
(317) 920-5900

GRIEF AND LOSS
Brooke's Place
Support for grieving youth and families.
www.brookesplace.org/
8935 N. Meridian Street, Suite 200, Indianapolis, IN
(317) 705-9650

Center for Family Connection
Provides services related to attachment, past trauma, grief, and loss.
www.cffamconnect.com
740 E. 52nd St. Suite 10 Indianapolis, IN
(317) 429-0725

DRUGS & ADDICTION
Fairbanks Addiction Treatment Center
Experts in alcohol and drug addiction
www.fairbankscd.org / (800) 225-4673
8102 Clearvista Parkway, Indianapolis, IN

Appendix G

Suicide Resources Pre- and Post-Survey

Please circle YES or NO for the following questions and turn this form in at the front.

1. I know of at least three mental health agencies in the community that can provide support for my child.

    a. YES NO

2. I know the warning signs of suicide.

    a. YES NO

3. I know when/how to refer my child to a community agency.

    a. YES NO

4. I understand the process schools take in referring students to outside mental health providers.

    a. YES NO

Appendix H

QPR Assessment

Name: _____

Date: _____

Instructor's Name: _____

List the three components of QPR and describe each…

1.

2.

3.

Explain why this strategy is important not only important for working with all students, but especially for those who are typically underrepresented?

What aspect of this training do you feel you need additional assistance with?

Please rate today's training on a scale of 1 to 5. (1 = poor quality, 5 = exceptional). Explain.

Appendix I

Pre and Post Assessment

Instructions: Based on the Wisconsin School Mental Health Framework ("Wisconsin School Mental Health Needs Assessment"), this survey is designed to identify the strengths and areas of improvement for your school in managing the social−emotional and mental health needs of your students.

	Not at all	Partially in place	In Place	Not Sure	Evidence
A school-wide team uses a leadership model which includes parent(s) and community providers, and integrates the work of PBIS, social-emotional learning, mental health, suicide prevention, and alcohol or other drug abuse prevention and treatment to guide comprehensive school mental health. At least one member of the team has the authority to reallocate resources, change role and function of staff, and change policy.					
Most staff support a focus on the positive social-emotional development of students.					
The school's mission, philosophy, and policies reflect an explicit focus on the social-emotional development and wellbeing of students.					
Our school discipline practices are culturally responsive.					
Families are part of regular information sharing and understand available school supports and services for student mental health needs					
Educators are versed in and use strategies that promote relationships between educators and children, educators and families, and connections between children and families to schools.					
Systems ensure there are positive school climate strategies used frequently and consistently throughout the school and there are strategies which are alternatives to exclusionary discipline.					
New initiatives are based on implementation science (purpose building, infrastructure, initial implementation, full implementation) and are integrated into existing initiatives to minimize "initiative fatigue."					
Systemic implementation includes adequate resource mapping from community, district, school, to classroom, with implementation decisions tied to data and professional development.					
School practices focuses on building strong family and school - community partnerships that support students' social - emotional and mental health needs.					
The school uses data to guide its social -emotional and mental health initiatives.					
The school collects and disaggregates data (race/ethnicity, disability, social economic status) regarding exclusionary discipline (e.g., seclusion/ restraint, suspensions, expulsions, partial days).					

The school collects data to evaluate whether implemented disciplinary practices and school policies are consistent with each other.					
Professional development for all school staff includes a focus on hope & recovery to reduce mental illness stigma.					
Professional development for all school staff includes how to identify students in need of social -emotional and mental health supports.					
Mental health, wellness and social/emotional learning opportunities are included across grade levels and curriculum					
Opportunities exist for students to learn and practice regulation of emotions and modulation of behaviors.					
School staff understand and integrate resilience-building into all activities, programs and interactions with students					
School contains predictable and safe environments (classrooms, hallways, playgrounds, and school bus) that are attentive to transitions and sensory needs.					
Conversations among staff about children and families are strength-based, solution focused, and oriented toward factors that school can impact.					
Staff members have a clear and consistent understanding about a crisis response plan for a critical incident. School staff have the knowledge and training to respond to the needs of students who are already responding normally (within a typical range) to a critical incident.					
Staff have the resources and training to effectively communicate with families about a student's social-emotional development or mental health concerns					
When there is a concern about a student's mental health, communicating with the family is a priority.					
A clear and consistent school-wide referral process is in place for students with mental health needs.					
School staff have the knowledge, training, and resources about how to refer students for selected and intensive services.					
School staff have been trained in a screening or nomination system for identifying students who need extra social/ emotional, or mental health support.					
School staff have the knowledge of the signs of a student needing more intervention following a critical incident. Staff have the knowledge of the mental health referral systems following a critical incident.					
Follow-up information is provided to staff with an educational need to know about the status or outcome of student mental health referrals.					
School mental health professionals use evidence-based interventions.					
School mental health professionals monitor students' progress in school setting and adjust interventions accordingly.					

To ensure students' progress continues across the school setting, adequate information is shared between educators, 6 school leaders, families, staff or nonteaching coach, school and community mental health professionals.					
Families are central to efforts to prevent future mental health problems through co-planning with students and families.					
Student wellness plans are used as a vehicle for improving academic and social-emotional development outcomes.					
Mental health services are culturally appropriate and linguistically relevant.					
School staff are knowledgeable about how to support a family in navigating through community services.					
School staff understands the array of services available in the community for youth and families.					
Resources or services are available for students who may be experiencing the negative consequences of specific problems, such as depression, loss or prior trauma.					
All students know where to go for resources when they, or a friend, may experience negative consequences of specific problems, such as depression, loss or prior trauma.					
When a mental health emergency arises, a professional is available to perform an assessment for students who have been referred for exigent mental health concerns. The people responsible for specific tasks or duties in a mental health emergency are clearly defined and they work as a team.					
Staff have been trained in ways to appropriately respond to students who experience urgent mental health problems					
Information about mental health emergencies is appropriately shared with staff and families.					
Follow-up services are available for students who experience mental health emergencies.					
The school has proactive plans in place for students transitioning back to school from residential or hospitalization treatment.					
To include multiple perspectives, schools solicit input from a variety of youth-serving agencies and providers					
School mental health professionals have a protocol in place for care coordination and wraparound services for students with high mental health needs.					
The school-level team guiding this work frequently communicates with students, families, any community mental health professionals and pupil services staff.					

Wisconsin School Mental Health Needs Assessment. (n.d.). Retrieved from: https://dpi.wi.gov/sites/default/files/imce/sspw/pdf/mhneedsassessmentfill.pdf

Appendix J

Model Programs, Their Results and Resources for Administrators

Academic Outcomes

- Children First Plan schools receiving attendance case management services saw improved grades in 54% of the children being served, with 71% of them being promoted to the next grade level
- New York City schools involved in the Children's Aid Society's Community Schools initiative incorporate many aspects of expanded school mental health as well as school-based health centers and enrichment activities. As a result, two schools saw math scores improve more than 30% after three years of participation in the program. One school also reported a 25% increase of children reading on grade level after three years of participation in the program (Outcomes of Expanded School Mental Health Programs, 2003)

Behavioral Outcomes

According to "Outcomes of Expanded School Mental Health Programs" (2003) also found that mental health programs have positive effects on attendance, truancy and discipline referrals.

- Dallas Public School Youth and Family Centers reported a 95% decrease in discipline referrals and a 32% decrease in absences among students who received services in their school-based clinics
- Schools involved in the Children's Aid Society's Community Schools program reported higher attendance rates than other local schools. In fact, one school involved in the program had the highest attendance rates in its district and attendance rates at the school have improved each year that it has been part of the program (Outcomes of Expanded School Mental Health Programs, 2003)

Emotional Outcomes

- In a pilot study done by the University of Maryland, significant decreases in depression and improvements in self-esteem were exhibited by high school students receiving expanded school mental health treatment during the 1992-1993 academic year when compared to a comparison group. The study also indicated that 89% of students reported doing "much better/better" since starting SMH services, and 80% of students reported that their families were doing "much better/better" since receiving SBMH services. Students also indicated improved functioning 12 months after initial treatment as reported by students completing the Youth Self Report (YSR), while clinicians reported Center for School Mental Health Assistance Outcomes Resource Packet 5 that protective factors increased significantly after six months of treatment (Outcomes of Expanded School Mental Health Programs, 2003)

School Districts as models for mental health service programs

Baltimore City Public Schools

- "A framework for the common design for school mental health programming"

Charlotte-Mecklenburg public school system partnered with Behavioral Health Centers

- 24 elementary schools received mental health services

Salt Lake City public school system partnered with Valley Mental Health (Baker, 2013)

Charlotte-Mecklenburg public school system vision for school-based mental health system

- A very thorough detailed vision to serve as a model for school districts
- Use of community stakeholders
- Desired District Outcomes
- Desired agency services
- Agency, District and School Responsibilities
- Collaborative Responsibilities
- A chart showing the school's responsibilities and the agency's
- A referral process flow-chart (Charlotte-Mecklenburg Schools Vision)

School-Based Mental Health Program Leaders

According to Anderson (2007), here are resources to use when establishing a School-Based Mental Health Plan:

- Center for School Mental Health Action and Analyses
- UCLA Center for School Mental Health
- Columbia University Teen Screen
- Center for School Mental Health Programs, Miami U, Ohio
- National Assembly on School Based Health Care (pg. 6-7).

Funding Sources

According to ASCA, Title 4 could provide additional funding for more counselors
Majority of it will come from state funding
Mental Health in Schools Act

> "This bill provides federal funding to train school staff on mental health related issues, to establish comprehensive school-based mental health services and to create links between schools and the community mental health system. NAMI calls on states to pass legislation that would… provide funding and support for training and link community mental health services to schools" ("National Alliance on Mental Illness")