CUERO ISD
SUICIDE PREVENTION
POLICY, PROCEDURES, AND GUIDELINES

Updated 1/8/24

CISD recognizes that suicide has become one of the top three leading causes of death among young people. It further acknowledges the schools' role in providing an environment which is sensitive to societal changes which place youth at greater risk for suicide, and one which helps to foster positive youth development. Consequently, CISD recognizes its moral and ethical responsibility to take a proactive stance in preventing the problem of youth suicide by providing programs which are conducive to the positive development of youth, and by providing appropriate intervention and referral for those potentially suicidal youth who come to the attention of school personnel. At the same time, however, CISD recognizes that suicide is a complex issue which cannot be potentially suicidal youth; it cannot provide the necessary, in-depth, clinical assessment and psychotherapy. The school system's role in dealing with youth who are at high risk for suicide is to try to identify and refer these youth to appropriate community agencies for more in- depth assessment and treatment. Therefore, any school employee who may have knowledge of a suicide possibility of suicide must take the proper steps, as specified in the following administrative procedures, to report this information to the designated school personnel, the student's family, and/ or appropriate community agencies.

ADMINISTRATIVE GUIDELINES

DEFINITION OF TERMS

1. **SUICIDE PREVENTION COORDINATOR:** Throughout this document, the term "**suicide prevention coordinator**" shall be defined as personnel who hold appropriate certification for, and who are hired for the position of School Counselor, and/ or Social Services Department worker when available, and/or District Nurse as designated by the Superintendent.

2. **RISK ASSESSMENT:** A **risk assessment** is defined as an evaluation of a student who may be at risk for suicide, and is conducted by a School Counselor, or Social Services Department. This interview is designed to elicit information regarding the student's intent to kill him/herself, previous history of suicide attempts, the presence of a suicide plan and its level of lethality and availability, the presence of support systems, level of hopelessness and helplessness, mental status, and other relevant risk factors.

3. **HIGH RISK:** A student who is defined as **high risk** for suicide is one who has made a suicide attempt, or has the intent to kill him/ herself. He/she has thought about how he/she would do this, and may have a plan. He/she has access to the method described, but may not have everything in place. In addition, he/she may exhibit feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain. Support systems are often limited. This situation would necessitate parental contact and referral, as documented in the following procedures.

4. **VERY LOW OR NO RISK:** A student who is defined as **very low or no risk** for suicide is one who has not seriously considered suicide and has no plan or method. He/ she may be experiencing feelings of pain, but is willing to work to help to change the situation.

5. **CRISIS TEAM:** At district level this will include district nurse, member of the Social Services Department, district designated counselor and superintendent or his/her designee.

At the campus level this will include an administrator, nurse, school counselor and teacher, or classroom aide.

6. **MENTAL HEALTH:** A state of mental and emotional being that can impact choices and actions that affect wellness. Mental health problems include mental and substance use disorders.

7. **POSTVENTION:** Suicide postvention is a crisis intervention strategy designed to reduce the risk of suicide and suicide contagion, provide the support needed to help survivors cope with a suicide death, address the social stigma associated with suicide, and disseminate factual information after the suicide death of a member of the school community.

8. **RISK FACTORS FOR SUICIDE:** Characteristics or conditions that increase the chance that a person may try to take his or her life. Suicide risk tends to be highest when someone has several risk factors at the same time. Risk factors may encompass biological, psychological, and or social factors in the individual, family, and environment.

9. **SELF-HARM:** Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself can be categorized as either non-suicidal or suicidal. Although self-harm often lacks suicidal intent, youth who engage in self-harm are more likely to attempt suicide.

10. **SUICIDE:** Death caused by self-directed injurious behavior with any intent to die as a result of the behavior. Note: The coroner's or medical examiner's officer must first confirm that the death was a suicide before any school official may state this as the cause of death.

11. **SUICIDE ATTEMPT:** A self-injurious behavior for which there is evidence that the person had at least some intent to kill himself or herself. A suicide attempt may result in death, injuries, or no injuries. A mixture of ambivalent feelings such as wish to die and desire to live is a common experience with most suicide attempts. Therefore, ambivalence is not a sign of a less serious or less dangerous suicide attempt.

12. **SUICIDAL BEHAVIOR:** Suicide attempts, intentional injury to self associated with at least some level of intent, developing a plan or strategy for suicide, gathering the means for a suicide plan, or any other overt action or though indicating intent to end one's life.

13. **SUICIDE CONTAGION:** The process by which suicidal behavior or a suicide influences an increase in the suicidal behaviors of others. Guilt, identification, and modeling are each thought to play a role in contagion. Although rare, suicide contagion can result in a

cluster of suicides.

14. **SUICIDAL IDEATION:** Thinking about, considering, or planning for self-injurious behavior which may result in death. A desire to be dead without a plan or intent to end one's life is still considered suicidal ideation and should be taken seriously.

15. **BARK ALERT:** An alert provided by the Bark System Software that monitors Cuero ISD's google environment.

PREVENTION OF SUICIDE

CUERO ISD will undertake the following tasks in order to promote conditions that reduce the risk of possible youth suicide:

1. Conduct, and encourage others to conduct, activities designed to raise student, parent, staff, and community awareness about the problem of youth suicide.
2. Work collaboratively with community agencies for the purpose of fostering healthy youth development within the community and also facilitating appropriate student referrals.
3. Provide developmentally-based curricula to foster positive self-esteem, and the abilities to effectively cope with loss, to identify and utilize appropriate support systems, and to recognize and respond appropriately to the warning signs of suicide.

Identification: While no one risk factor, in itself, proves suicidal intent, the presence of a combination of factors may indicate a need for further assistance. In order to promote good mental health, CISD agrees to respond to students who are experiencing stressful life conditions, and who are demonstrating an inability to cope with these stressors.

High risk students include those who have made a suicide attempt, as well as those who are exhibiting the commonly recognized warning signs of suicide as listed in this document. Staff are encouraged to be sensitive to other signs they believe may indicate a student is suicidal.

ASSESSMENT AND REFERRAL

When a student is identified by a staff person as potentially suicidal, i.e., verbalizes about suicide, presents overt risk factors such as agitation or intoxication, the act of self-harm occurs, or a student self-refers, the student will be seen by a school employed mental health professional within the same school day to assess risk and facilitate referral. If there is no mental health professional or Social Services Department worker available, a school nurse or administrator will fill this role until a mental health professional can be brought in.

For youth at risk:

1. School staff will continuously supervise the student to ensure their safety.

2. The principal and school suicide prevention coordinator will be made aware of the situation as soon as reasonably possible.

3. The school counselor will contact the student's parent or guardian, and/or mentor crisis team as described in the Parental Notification and Involvement section, and will assist the family with urgent referral. When appropriate, this may include calling emergency services or bringing the student to the local Emergency Department, but in most cases will involve setting up an outpatient mental health or primary care appointment and communicating the reason for referral to the healthcare provider.

4. If the student requires emergency medical attention or outside mental health intervention, the school counselor or other member of the district/campus crisis team will contact the parent/guardian after needed services have been arranged.

5. Staff will ask the student's parent or guardian for written permission to discuss the student's health with outside care, if appropriate.

6. In order to facilitate such identification, the CISD will provide training to all staff and students deemed necessary in recognizing the warning signs for suicide.

SUICIDE PREVENTION

STAFF PROFESSIONAL DEVELOPMENT

All staff will receive annual professional development on risk factors, warning signs, protective factors, response procedures, referrals, postvention, and resources regarding youth suicide prevention.

The professional development will include additional information regarding groups of students at elevated risk for suicide, including those living with mental and/or substance use disorders, those who engage in self-harm or have attempted suicide, those in out-of-home settings, those experiencing homelessness, American Indian/Alaska Native students, LGBTQ (lesbian, gay, bisexual, transgender, and questioning) students, students bereaved by suicide, and those with medical conditions or certain types of disabilities.

Additional professional development in risk assessment and crisis intervention will be provided to school employed mental health professionals and school nurses.

YOUTH SUICIDE PREVENTION PROGRAMMING

Developmentally-appropriate, student-centered education materials will be integrated into the curriculum of all K-12 health classes. The content of these age-appropriate materials will include: 1) the importance of safe and healthy choices and coping strategies, 2) how to recognize risk factors and warning signs of mental disorders and suicide in oneself and others, 3) help-seeking strategies for oneself or others, including how to engage school resources and refer friends for help. In addition, schools may provide supplemental small-group suicide prevention programming for students.

RISK FACTORS AND WARNING SIGNS

- Risk Factors for Suicide are characteristics or conditions that increase the chance that a person may try to take her or his life. Suicide risk tends to be highest when someone has several risk factors at the same time.
- The most frequently cited risk factors for suicide are:

- Major depression (feeling down in a way that impacts your daily life) or bipolar disorder (severe mood swings)
- Problems with alcohol or drugs
- Unusual thoughts and behavior or confusion about reality
- Personality traits that create a pattern of intense, unstable relationships or trouble with the law
- Impulsivity and aggression, especially along with a mental disorder
- Previous suicide attempt or family history of a suicide attempt or mental disorder
- Serious medical condition and/ or pain

ELECTRONIC DEVICE ALERTS

When technology receives a bark alert or another electronic device alert, the suicide prevention coordinator(s)and campus team members will be notified by email and/or phone using the information provided to the school. The following actions will be taken to ensure student safety after-hours: (After-hours is defined as 3:00 pm to 8:00 am Monday through Friday, weekends, holidays and school breaks.)

1. Inform the student's parent and/or guardian to check on the student's well-being.

2. In the event that the student's parent/guardian cannot be contacted, the police and/or emergency medical services, such as 911, may be called.

When a student is off-campus, parents/guardians are responsible for supervising internet access and usage.

OUT-OF-SCHOOL SUICIDE ATTEMPTS

If a staff member becomes aware of a suicide attempt by a student that is in progress in an out-of-school location, the staff member will take appropriate action which may include:

1. Call the police and/ or emergency medical services, such as 911.

2. Inform the student's parent or guardian.

3. Inform the school suicide prevention coordinator and administrator.

If the student contacts the staff member and expresses suicidal ideation, the staff member should maintain contact with the student (either in person, online, or on the phone). The staff member should then enlist the assistance of another person to contact the police while maintaining verbal engagement with the student.

PARENTAL NOTIFICATION AND INVOLVEMENT

In situations where a student is assessed at risk for suicide or has made a suicide attempt, the student's parent or guardian will be informed as soon as practicable by the principal, designee, or

school counselor. If the student has exhibited any kind of suicidal behavior, the counselor and student will create an initial safety plan to ensure student's safety. The parent or guardian should be counseled on "means restriction," limiting the child's access to mechanisms for carrying out a suicide attempt. A copy of the student's safety plan will be given to the student and available to the parent and/or guardian. Staff will also seek parental permission to communicate with outside mental health care providers regarding their child.

Through discussion with the student, the principal, designee, school counselor will assess whether there is further risk of harm due to parent or guardian notification. If the principal,

designee, or school counselor believes, in their professional capacity, that contacting the parent or guardian would endanger the health or well-being of the student, they may delay such contact as appropriate.

IN- SCHOOL SUICIDE ATTEMPTS

In the case of an in-school suicide attempt, the health and safety of the student is paramount. In these situations:

1. First aid will be rendered until professional medical treatment and/or transportation can be received, following district emergency medical procedures.
2. School staff will supervise the student to ensure their safety.
3. Staff will move all other students out of the immediate area as soon as possible.
4. If appropriate, staff will immediately request a mental health assessment for the youth.
5. The school employed counselor or member of crisis intervention team will contact the student's parent or guardian, as described in the Parental Notification and Involvement section.
6. Staff will immediately notify the principal or school suicide prevention coordinator regarding in-school suicide attempts.
7. Suicide Intervention Form will be completed. One copy will be filed with the student's counselor at the student's home campus. Another will be filed by the person completing the form and a final copy should be sent to the district suicide prevention coordinator. (See prevention form.)

RE-ENTRY PROCEDURE

For students returning to school after a mental health crisis (e.g., suicide attempt or psychiatric hospitalization), a school counselor or member or crisis intervention team member will meet with the student's parent or guardian, and if appropriate meet with the student to discuss re-entry and appropriate next steps to ensure the student's readiness for return to school.

1. A school counselor or other designee will be identified to coordinate with the student, their parent or guardian, and any outside mental health care providers.
2. The parent or guardian will provide documentation from a mental health care provider that the student has undergone examination and that they are no longer a danger to themselves or others.
3. The designated staff person will periodically check in with student to help the student readjust to the school community and address any ongoing concerns.

POSTVENTION

1. Development and Implementation of an Action Plan

The crisis team will develop an action plan to guide school response following a death by suicide. A meeting of the crisis team to implement the action plan should take place immediately following news of the suicide death. The action plan may include the following steps:

a) **Verify the death.** Staff will confirm the death and determine the cause of death through communication with a coroner's office, local hospital, the student's parent or guardian or police department. Even when a case is perceived as being an obvious instance of suicide, it should not be labeled as such until after a cause of death ruling has been made. If the cause of death has been confirmed as suicide but the parent or guardian will not permit the cause of death to be disclosed, the school will not share the cause of death but will use the opportunity to discuss suicide prevention with students.

b) **Assess the situation.** The crisis team will meet to prepare the postvention response, to consider how severely the death is likely to affect other students, and to determine which students are most likely to be affected. The crisis team will also consider how recently other traumatic events have occurred within the school community and the time of year of the suicide. If the death occurred during a school vacation, the need for or scale or postvention activities may be reduced.

c) **Share information.** Before the death is officially classified as a suicide by the coroner's office, the death can and should be reported to staff, students, and parents/ guardians with an acknowledgement that its cause is unknown. Inform the faculty that a sudden death has occurred, preferably in a staff meeting. Write a statement for staff members to share with students. The statement should include the basic facts of the death and known funeral arrangements (without providing details of the suicide method), recognition of the sorrow the news will cause, and information about the resources available to help students cope with their grief. Public address system announcements and school-wide assemblies should be avoided. The crisis team may prepare a letter to send home with students that includes facts about the death (with the input and permission of the concert with parents or guardians, crisis parent or guardian who is involved), information about what the school is doing to support students, the warning signs of suicidal behavior, and a list of resources available.

d) **Avoid suicide contagion.** It should be explained in the staff meeting described above that one purpose of trying to identify and give services to other high risk students is to prevent another death. The crisis team will work with teachers to identify students who are most likely to be significantly affected by the death. In the staff meeting, the crisis team will review suicide warning signs and procedures for reporting students who generate concern.

e) **Initiate support services.** Students identified as being more likely to be affected by the death will be assessed by a school employed mental health professional to determine the level of support needed. The crisis team will coordinate support services for students and staff in need of individual and small group counseling as needed. In concert with parents or guardians, crisis team members will refer to community mental healthcare providers to ensure a smooth transition from the crisis intervention phase to meeting underlying or ongoing mental health needs.

2. **External Communication** The Superintendent or Central Office administrator will be the sole media spokesperson. Staff will refer all inquiries from the media directly to the spokesperson. The spokesperson will:

    a) Keep the district suicide prevention coordinator and superintendent informed of school actions relating to the death.
    b) Prepare a statement for the media including the facts of the death, postvention plans, and available resources. The statement will not include confidential information, speculation about victim motivation, means of suicide, or personal family information.
    c) Answer all media inquiries. If a suicide is to be reported by news media, the spokesperson should encourage reporters not to make it a front-page story, not to use pictures of the suicide victim, not to use the word suicide in the caption of the story, not to describe the method of suicide and not to use the phrase "suicide epidemic"- as this may elevated the risk of suicide contagion. They should also be encouraged not to link bullying to suicide and not to speculate about the reason for suicide. Media should be asked to offer the community information on suicide risk factors, warning signs, and resources available.

PUBLICATION AND DISTRIBUTION

This policy will be distributed annually and included in all student and teacher handbooks and on the school website.

SUICIDE INTERVENTION FORM

Confidential

School_____Principal_____Date _____

Student's Name_____DOB _____Age _____ Sex

Parent's Name _____

Address_____Phone: (H)_____(W)_____

Parent's Name (non- custodial if divorced) _____

Address_____Phone:_____

Student referred by _____

Assessed by _____

Staff consulted _____

1. State reason for referral:

2. Describe level of possible suicide risk and indicators below: (i.e. risk factors, warning signs, behaviors, feelings, plan, method, etc.):

3. Describe actions taken, recommendations, and follow-up:

Action	Date/Time	Person Responsible

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *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) *Have you been thinking about how you might do this?* E.g. "*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.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		

6) *Have you ever 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. **If YES, ask: *Was this within the past three months?***	**YES**	**NO**

- Low Risk
- Moderate Risk
- High Risk

Response Protocol to C-SSRS Screening (Use Highest Level of Criteria Met)

Instructions: "YES" responses to any question on the C-SSRS should be taken seriously and family contact should be required. Choose the appropriate response protocol based on the last question answered "YES."

A "NO" response to questions 1, 2, and 6 (Lifetime) should be followed up as a Protocol 1 to ensure overall safety of the student.

A "YES" response ONLY to question 6 (Lifetime) should be followed up as a Protocol 1 to ensure overall safety of the student.

Protocol 1	Protocol 2	Protocol 3
Item 1 and/or 2 Answered "YES" only	Item 3 and/or 6(Lifetime) Answered "YES"	Item 4 and/or 5 and/or 6 (Past 3 months) Answered "YES"

Community Resources

Gulf Bend Center
6502 Nursery Drive
Victoria, TX 77904
(361) 575- 0611
24 hour hotline 1-877-723-3422

Texas Department of Protective and Regulatory Services
106 E. French
Cuero, TX 77954
(361) 275- 5737

Cuero Community Hospital
2550 N. Esplanade
Cuero, TX 77954
(361) 275-6191

The Trevor Lifeline
1-866-488-7386
www.thetrevorproject.org

National Suicide Prevention Lifeline
1-800-273-8255 (TALK)
www.suicidepreventionlifeline.org

Crisis Text Line
Text "HOME" to 741741

Grace Bound Christian Counseling
Karley Reece, MA, LPC, RPT
607 S. Esplanade St. #1
Cuero, TX 77954
(361)-243-7984
Email: karley.reece@graceboundcc.org
Website: https://karleyreece.clientsecure.me/

Kollette Tolbert, LPC
Teletherapy ages 13 and up
361-437-0462
Email: ktolbertlpc@kollettetolbertcounseling.com

Hope of South Texas
605 E. Locust
Victoria, TX 77904
(361) 572- 4300

South Texas Children's Home – Ministries
Lorraine Turner, MA-LPC
303 E. Airline St., Suite 3
Victoria, TX 77901
(361) 575-5151
8:00-5:00 pm Monday - Thursday
8:00-3:00 pm Friday
Call anytime and leave voicemail; Not for emergencies
www.stchm.org
First Baptist Church-Cuero
408 N. Gonzales St.
Cuero, TX 77954
361-575-5151

Billy T. Cattan Recovery Outreach, Inc.
Alma Saenz, Clinic Coordinator, LCDC
802 E. Crestwood
Victoria, TX 77901
(361) 576-4673 (Telehealth Services Available)
8:00-7:00 pm Monday - Thursday
www.btcro.org

New Beginnings Counseling Center
Rick Torres, LPC
Gail Spurgeon, LPC
Cheryl Green, LMSW-ACP
Ginger Corn, LPC, Med
Danna Harrison, LPC
Janie Odem, M.RD.LPC
1501 E. Mockingbird Ln., Suite 262
Victoria, TX 77904
(361) 570-8900
8:00-6:00 pm Monday – Thursday
8:00-12:00 Friday
Fax (361) 570-8903
www.newbeginningsvictoria.com

TCHATT

Texas Child Health Access Through Telemedicine

TCHATT Provides FREE Mental Health Services to Students Year-Round!

Texas Child Health Access Through Telemedicine is a partnership between UT Health San Antonio and the State of Texas.

TCHATT is a **telemedicine program** for identifying/assessing **mental health needs** and providing access to mental health services in schools.

Students will receive short-term medication management and/or therapy interventions. Referrals will be made if long-term services are needed.

Enroll your Child:

Please contact your child's school counselor or another TCHATT referral coordinator at their school.

Who is TCHATT for?

The most common type of referrals for TCHATT include:

Mood changes or anxiety: family stressors, caring less about school, friends, or activities, changes in overall mood: more sad or angry, self-esteem issues.

Thoughts of Suicide or Self-Injury: making statements about not wanting to live, not wanting to wake up, non-accidental injuries or injuries they struggle to explain, statements about being a burden to others.

Behavior problems in class: trouble focusing or paying attention, disruptive behavior, peer problems, school refusal or separation anxiety.

TCHATT does NOT provide:

Emergency Mental Health Services
Psychological Testing
Disability Evaluations
Long-term treatment/therapy

CONTACT US

Office: 210-567-5460

Fax: 210-450-2450

Email: TCHATT@uthscsa.edu

tcmhcc
Texas Child Mental Health Care Consortium

UT Health San Antonio

Teen Suicide

What is suicidal behavior?

Suicidal behavior is defined as a preoccupation or act that is focused on causing one's own death voluntarily. An intent to cause one's death is essential in the definition. Suicidal ideation refers to thoughts of suicide or wanting to take one's own life. Suicidal behavior refers to actions taken by one who is considering or preparing to cause his/her own death. Suicide attempt usually refers to an act focused on causing one's own death that is unsuccessful in causing death. Suicide refers to having intentionally caused one's own death.

What causes adolescents to attempt suicide?

Adolescence is a stressful developmental period filled with major changes-body changes, changes in thoughts, and changes in feelings. Strong feelings or stress, confusion, fear, and uncertainty, as well as pressure to succeed, and the ability to think about things in new ways influence a teenager's problem solving and decision making abilities.

For some teenagers, normal developmental changes, when compounded by other events or changes in their families such as divorce or moving to a new community, changes in friendships, difficulties in school, or other losses can be very upsetting and can become overwhelming. Problems may appear too difficult or embarrassing to overcome. For some, suicide may seem like a solution.

As many as 12 to 25 percent of older children and adolescents experience some form of thoughts about suicide (suicidal ideation) at one time or another. When feelings or thoughts become more persistent are accompanied by changes in behavior or specific plans for suicide, the risk of a suicide attempt increases.

What is known about teen suicide?

Suicide is the third leading cause of death in 15 to 24 year olds, and the third leading cause of death in 10 to 14 year olds. According to the National Institute of Mental Health (NIMH), reliable scientific research has found the following:

- There are as many as 8 to 25 attempted suicides to one completed suicide with the ratio even higher in youth.
- The strongest risk factors for attempted suicide in youth are depression, substance abuse, and aggressive or disruptive behaviors.

The Centers for Disease Control and Prevention (CDC) reports the following:

- Males are 4 times more likely to die from suicide than females.
- Females are more likely to attempt suicide than males.
- Firearms are used in over half of youth suicides.

What are the risk factors for suicide?

Suicide risk factors vary with age, gender, and cultural and social influences and may change over time. Risk factors for suicide frequently occur in combination with each other. The following are some suicide risk factors that may be present:

- One or more diagnosable mental or substance abuse disorders
- Impulsive behaviors

- Undesirable life events or recent losses (i.e., death, parental divorce)
- Family history of mental or substance abuse disorder
- Family history of suicide
- Family violence, including physical, sexual, or verbal/emotional abuse
- Prior suicide attempt
- Firearm in the home
- Incarceration
- Exposure to the suicidal behaviors of others, including family, peers, in the news, or in fiction stories

Warning Signs of Suicidal Feelings, Thoughts, or Behavior

Many of the warning signs of possible suicidal feelings are also symptoms of depression. Observation of the following behaviors by parents and caregivers may be helpful in identifying adolescents who may be at risk of attempting suicide:

- Changes in eating and sleep habits
- Loss of interest in usual activities
- Withdrawal from friends and family members
- Acting out behaviors and running away
- Alcohol and drug use
- Neglect of personal appearance
- Unnecessary risk taking
- Preoccupation with death and dying
- Increased physical complaints frequently associated with emotional distress such as stomachaches, headaches, and fatigue
- Loss of interest in school or schoolwork
- Feelings of boredom
- Difficulty concentrating
- Feelings of wanting to die
- Lack of response to praise
- Indicates plans or efforts toward plans to commit suicide, including the following:
    - Verbalizes “I want to kill myself,” or “I’m going to commit suicide.”
    - Gives verbal hints such as “I won’t be a problem much longer,” or “If anything happens to me, I want you to know …”
    - Gives away favorite possessions; throws away important belongings
    - Becomes suddenly cheerful after a period of depression
    - May express bizarre thoughts
    - Writes one or more suicide notes

Threats of suicide exhibit desperation and a cry for help. Always take statements of suicidal feelings, thoughts, behaviors, or plans very seriously. Any child or adolescent who expresses thoughts of suicide should be evaluated immediately.

The warning signs of suicidal feelings, thoughts, or behaviors may resemble other medical conditions or psychiatric problems. Always consult your child's physician for a diagnosis.

Treatment for Suicidal Feelings and Behaviors

Specific treatment for suicidal feelings and behaviors will be determined by your teen's physician based on:

- Your teen's age, overall health, and medical history
- Extent of your teen's symptoms
- Seriousness of the attempt
- Your teen's tolerance for specific medications, procedures, or therapies
- Expectations regarding future suicide risk
- Your opinion or preference

Any adolescent who has attempted suicide requires an initial physical evaluation and treatment until he/she is physically stable. Mental health treatment for suicidal feelings, thoughts, or behaviors begins with detailed evaluation of events in the adolescent's life during the two to three days preceding the suicidal behaviors. A comprehensive evaluation of the adolescent and family contributes to decisions regarding treatment needs. Treatment recommendations may include individual therapy for the adolescent, family therapy, and, when necessary, hospitalization to provide the adolescent a supervised and safe environment. Parents play a vital supportive role in any treatment process.

Prevention of Suicide

Recognition and early intervention of mental substance abuse disorders is the most effective way to prevent suicide and suicidal behavior. Studies have shown that suicide prevention programs most likely to succeed are those focused on identification and treatment of mental illness and substance abuse, coping with stress, and controlling aggressive behaviors.

According to the American Foundation for Suicide Prevention (ASFP), it is important to learn the warning signs of teenage suicide in order to prevent an attempt. Maintaining open communication with your teenager and their friends provides an opportunity for help as needed. If a teen is talking about suicide, he or she must receive an immediate evaluation.

- Warning signs for teen depression:
    - Feelings of sadness or hopelessness
    - Declining school performance
    - Loss of pleasure/interest in social and sports activities
    - Sleeping too little or too much
    - Changes in weight or appetite
    - Nervousness, agitation or irritability
    - Substance abuse
- Steps parents can take:

    - Keep medications and firearms away from children.
    - Get your child help (medical or mental health professional).
    - Support your child (listen, avoid undue criticism, remain connected).
    - Become informed (library, local support group, Internet)
- Steps teens can take:
    - Take your friend's behavior and discussion of suicide seriously.
    - Encourage your friend to seek professional help, accompany if necessary.
    - Talk to an adult you trust. Don't be alone in helping your friend.

Myths about Suicide

Many myths have developed about suicide and those who engage in suicidal behaviors. The following are the most common myths and are NOT TRUE:

1. People who talk about suicide usually don't go through with it.
   FALSE. Many people who die by suicide have given definite warnings to family and friends of their intentions. Always take any comment about suicide seriously.

2. Suicidal people are fully intent on dying.
   FALSE. Most suicidal people are undecided about living or dying. This is called "suicidal ambivalence." While a part of them wants to live, death seems like the only way out of their pain and suffering. They sometimes "gamble with death," leaving it up to others to save them.

3. Sometimes a bad event can push a person to complete suicide.
   FALSE. Suicide results from serious psychiatric disorders rather than from any single event.

4. Thinking about suicide is rare.
   FALSE. According to a recent study, one in five high school students considered ending his or her life in the past year.

5. Everyone who dies by suicide is depressed.
   FALSE. Although depression is often associated with suicidal feelings, not all individuals who kill themselves are depressed. Many want to escape their situation seeing no other options. Adolescents, in particular, are very impulsive, and fail to think through alternative solutions to their life's problems.

6. You have to be "crazy" to die by suicide.
   FALSE. The majority of individuals who commit suicide do not have a diagnosable mental illness. They are people just like you and me who at a particular time are feeling isolated, desperately unhappy and alone. Suicidal thoughts and actions may be the result of not being able to cope with life's stresses and losses.

7. You can't stop someone who really wants to die by suicide.

FALSE. Know the warning signs. If you see these signs, be willing to talk about suicide with the person in danger. Ask questions in a non-threatening way. Let the person know you hear what they are saying, and make it clear that you intend to be there for them. Try to stall them. Say if they've made up their mind, they can always do it later. Get help. Love and instinct may not be enough.

8. Most people who attempt suicide have gotten it out of their systems and won't try it again.
   FALSE. If a person attempts suicide once, it is likely that they will try again. Any attempt is regarded as an indicator of further attempts. It is likely that the level of danger will increase with each attempt. If their situation does not change, the pain is still there and they will most likely try again.

9. Talking to someone about suicide will put the idea into his/ her head.
   FALSE. If a person is not suicidal, they will reject the idea. If a person has been thinking about suicide and you ask, most welcome the chance to talk about their feelings. Talking to teens about suicide will NOT put the idea in their head. For too many students, suicide is already something they've considered. Bringing up the subject and discussing it openly is one of the most important things you can do.

If you are concerned that you or someone you know may be at risk for suicide, we strongly encourage you to do one or more of the following:

- Contact a mental health provider on your campus or in your community
- Call 1-800-273-8255(TALK), the National Suicide Prevention Hotline, for a referral
- Call your school or school district emergency number
- Call 911