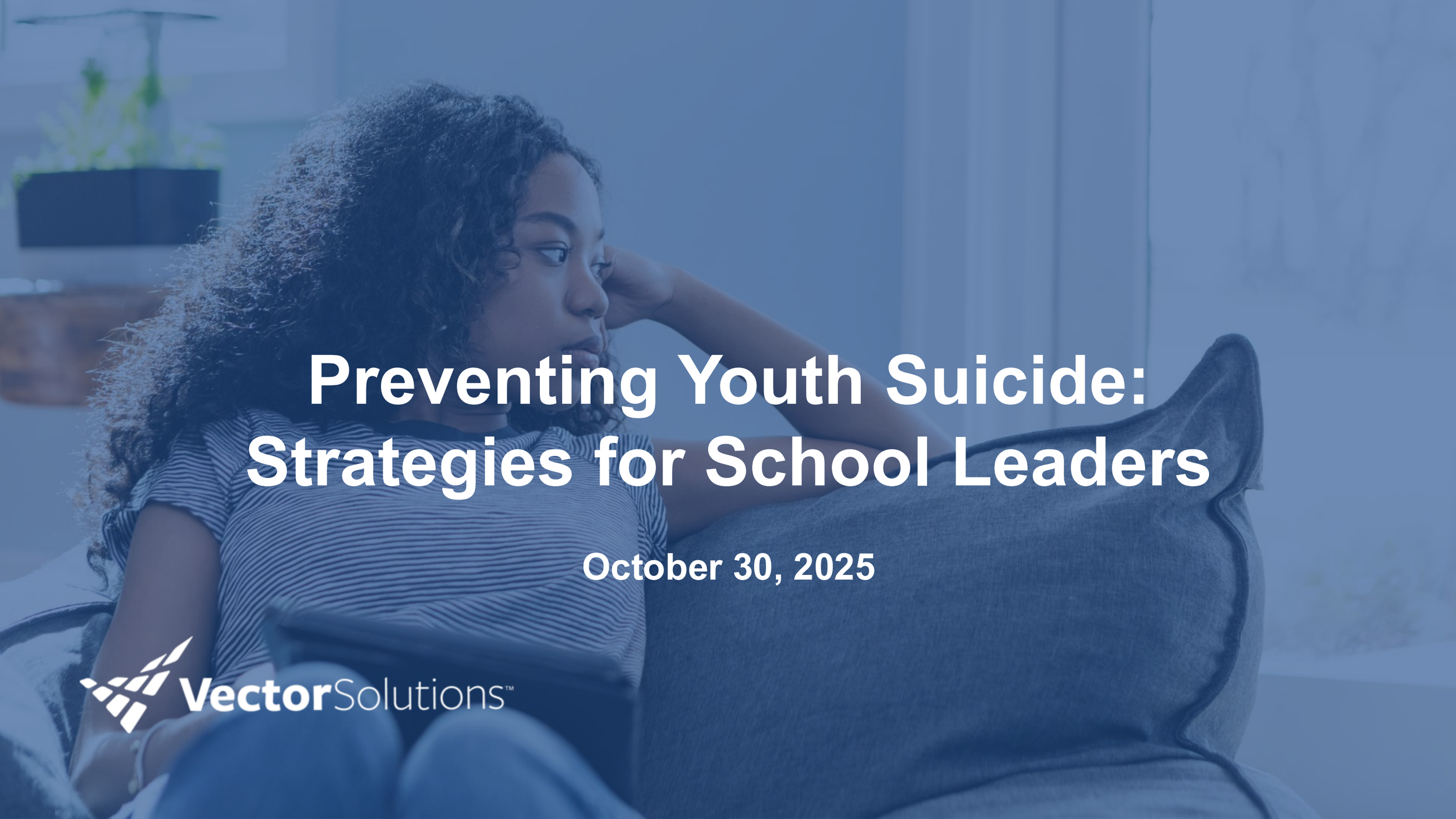
Thank you for joining us.
The webinar will begin soon.



Preventing Youth Suicide: Strategies for School Leaders

October 30, 2025

VectorSolutions™

Before We Begin

- All attendees are in listen-only mode. If you run into any audio issues during the webinar, please try another method of listening in, such as computer audio or calling in by phone.
- All registrants and attendees will receive a link to the recorded version of this webinar in a follow up email.
- If you have questions during the presentation, please let us know by typing your question into the Q&A panel. We will address these at the end of the presentation.

Content Warning

This training will address **suicide prevention and postvention**, including discussion of:

- Impacts of suicide exposure on individuals and communities.
- Data-driven findings and evidence-based strategies for prevention.
- Evidence-based intervention strategies and practical skills for supporting students at risk.

Because these topics are explored using **real data**, **research**, **and case examples**, some material may feel distressing or triggering.

This content is included because **grounding prevention in evidence leads to stronger, more effective outcomes**. We are committed to approaching the material with both **care** and **candor**.

Lisa M. Horowitz, PhD, MPH

Director of Preventing Suicide Initiative, Pediatric Mental Health Institute

Dr. Lisa Horowitz is a Pediatric Psychologist and Director of the Preventing Suicide Initiative at the University of Colorado School of Medicine / Children's Hospital Colorado. Formerly a Senior Associate Scientist at the National Institute of Mental Health at NIH for 20 years, she earned her Ph.D. in clinical psychology from George Washington University, completed a Pediatric Health Service Research Fellowship at Harvard Medical School, and obtained an MPH from the Harvard School of Public Health.

Her research focuses on suicide prevention in healthcare settings, which involves validating and implementing tools for clinicians, such as the Ask Suicide-Screening Questions (ASQ) tool. She co-authored the Blueprint for Youth Suicide Prevention (American Academy of Pediatrics, 2022) and collaborates nationally and internationally with hospitals and communities to advance youth suicide prevention initiatives.

Take Home Messages

- Youth Suicide is a major public health crisis, with significant disparities.
- Screening can help school staff start difficult conversations with the students that can help save lives.
- We can use research to make evidence-based, feasible guidelines.
- Implement universal suicide risk screening in school settings.
  - Care Pathway – 3 – tiered system:
    - Brief screen (20 seconds).
    - Further triage the screen – brief suicide safety assessment (~10 minutes).
    - Identify next steps of care for the students.

Why Suicide Prevention in Schools?

- Universal prevention:
  - Almost all children go to school.
  - All students benefit and play a role.
  - Suicidal thinking impacts academics. Staff can notice “typical behavior” for a youth and can identify major changes.
- Trusted adults can make talking about suicide less scary.
- Talking about suicide can reduce stigma.
- We can all enhance “connectedness.”

Youth Suicide in the U.S.

- **2nd Leading Cause of Death** for Youth Aged 10-24 Years-Old
- ~32,000 Youth Deaths, 6,417 (19.6%) By Suicide

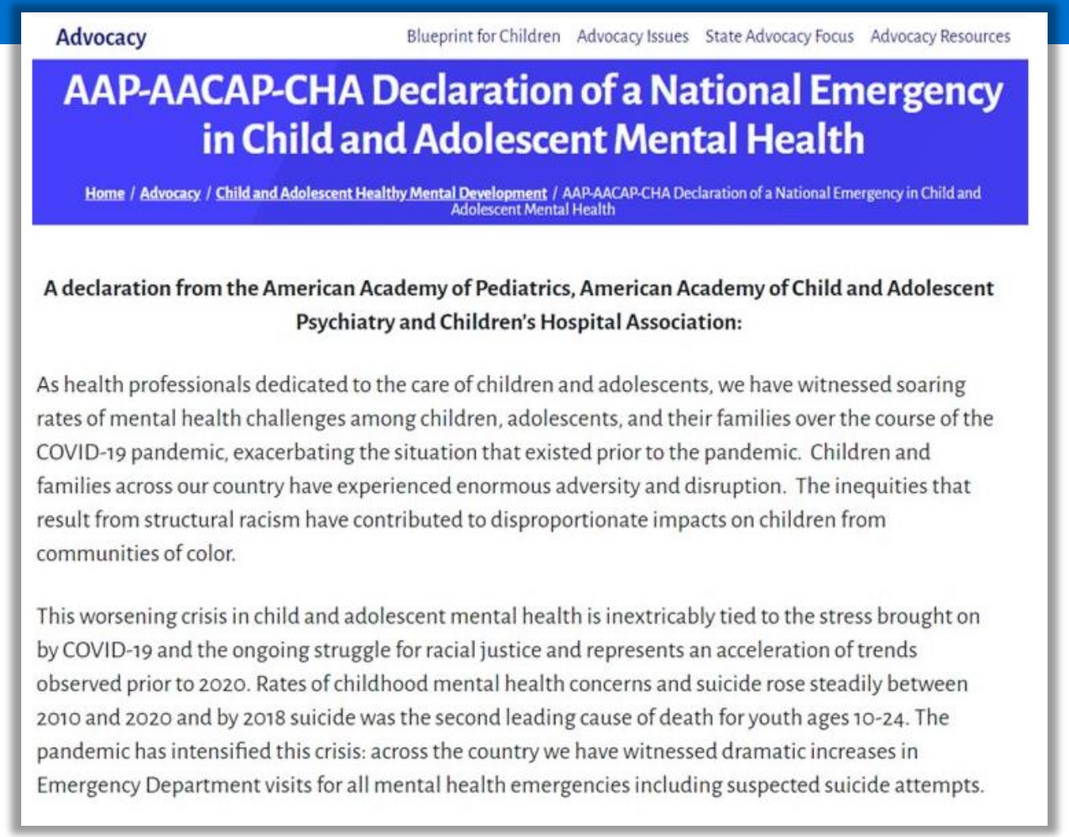
Suicidal Behavior & Ideation in the U.S.

- **Youth**
  - **Behavior**: 9.5% of high school students attempted suicide in past year.
  - **Ideation**: 20.4% of high school students reported “seriously considering” attempting suicide.

Suicide Risk Screening for Underserved Populations

- Many underserved populations at higher risk for suicide are understudied by research:
    - Black, Indigenous, and People of Color (BIPOC)
    - LGBTQ+ Individuals
    - Individuals with ASD or NDD
    - Child Welfare System
    - Juvenile Detention Centers
    - Rural Areas
- Screening can help identify underserved individuals at risk for suicide and link them to care.

Children's Mental Health is a National Emergency



Advocacy

Blueprint for Children Advocacy Issues State Advocacy Focus Advocacy Resources

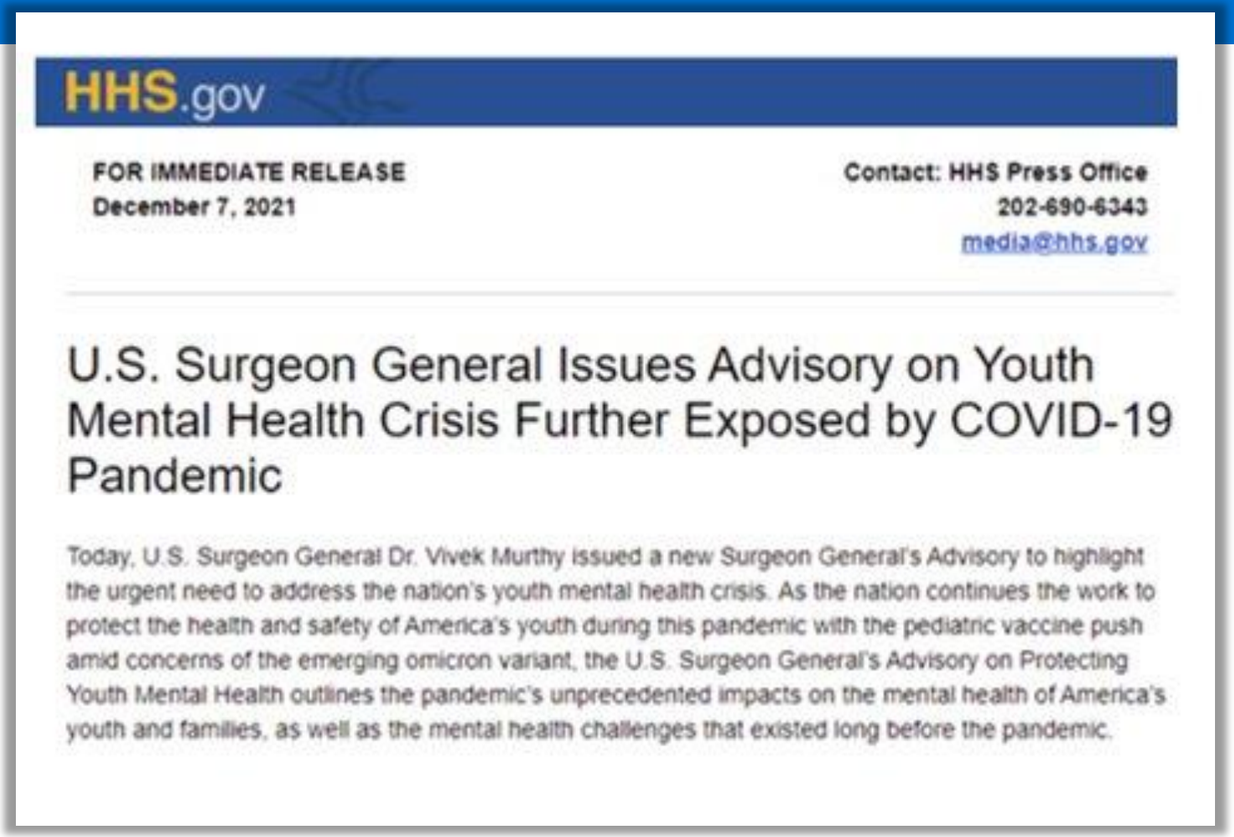
AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health

Home / Advocacy / Child and Adolescent Healthy Mental Development / AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health

A declaration from the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and Children's Hospital Association:

As health professionals dedicated to the care of children and adolescents, we have witnessed soaring rates of mental health challenges among children, adolescents, and their families over the course of the COVID-19 pandemic, exacerbating the situation that existed prior to the pandemic. Children and families across our country have experienced enormous adversity and disruption. The inequities that result from structural racism have contributed to disproportionate impacts on children from communities of color.

This worsening crisis in child and adolescent mental health is inextricably tied to the stress brought on by COVID-19 and the ongoing struggle for racial justice and represents an acceleration of trends observed prior to 2020. Rates of childhood mental health concerns and suicide rose steadily between 2010 and 2020 and by 2018 suicide was the second leading cause of death for youth ages 10-24. The pandemic has intensified this crisis: across the country we have witnessed dramatic increases in Emergency Department visits for all mental health emergencies including suspected suicide attempts.



HHS.gov

FOR IMMEDIATE RELEASE
December 7, 2021

Contact: HHS Press Office
202-690-6343
media@hhs.gov

U.S. Surgeon General Issues Advisory on Youth Mental Health Crisis Further Exposed by COVID-19 Pandemic

Today, U.S. Surgeon General Dr. Vivek Murthy issued a new Surgeon General's Advisory to highlight the urgent need to address the nation's youth mental health crisis. As the nation continues the work to protect the health and safety of America's youth during this pandemic with the pediatric vaccine push amid concerns of the emerging omicron variant, the U.S. Surgeon General's Advisory on Protecting Youth Mental Health outlines the pandemic's unprecedented impacts on the mental health of America's youth and families, as well as the mental health challenges that existed long before the pandemic.

High Risk Factors for Suicide

- **Previous Suicide Attempt**
- **Mental Illness**
- Between 15 and 24
- Being Male
- Access to Lethal Means (e.g., firearms)
- Aggressive/Impulsive/Risky behavior
- History of Sexual or Physical Abuse
- Family History Psychiatric History
- History of Bullying

- Poor Sleep
- LGBTQ+
- Medical Illness

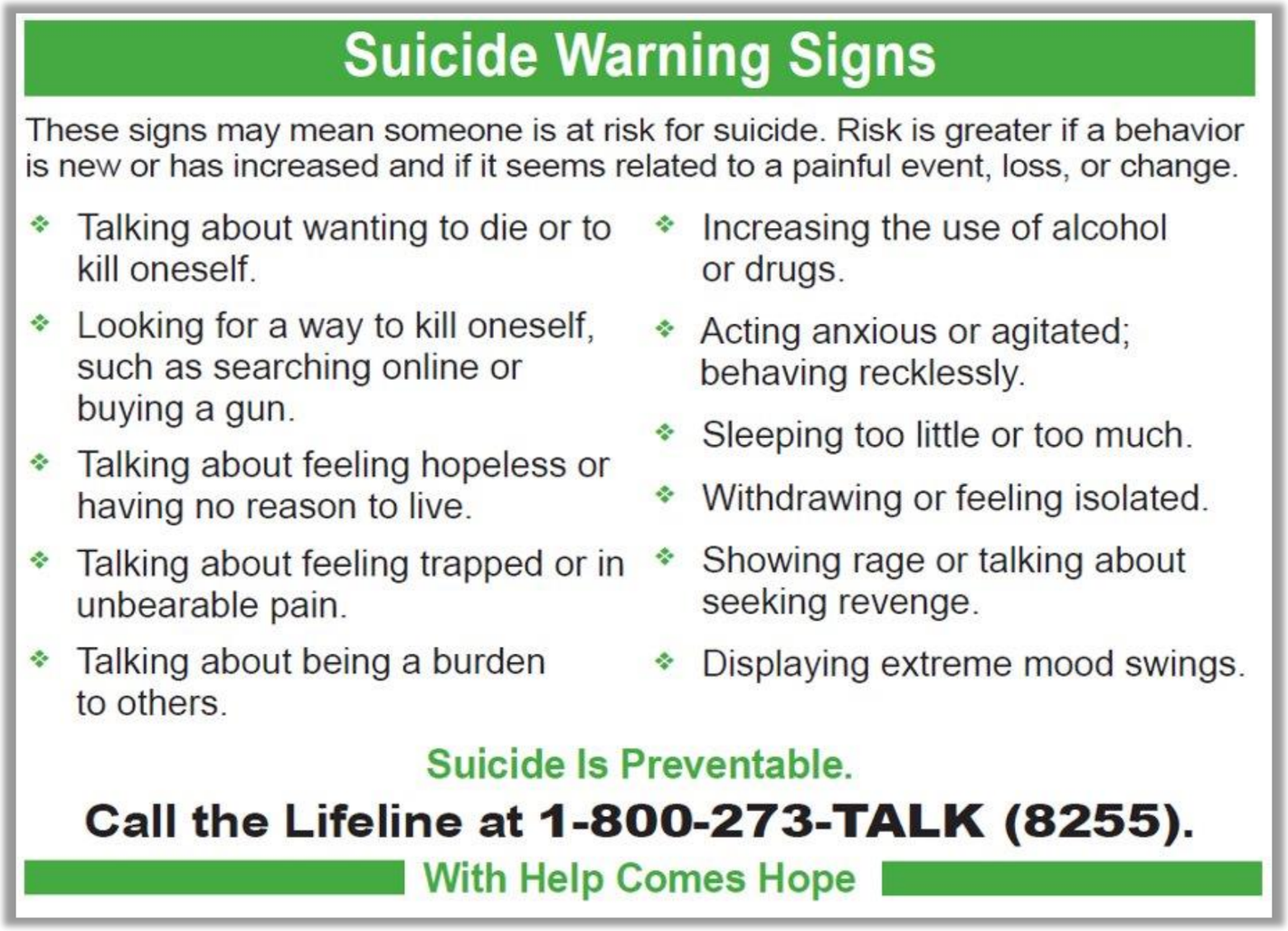
Functionality

- Not Getting Out of Bed
- Not Showing Up to School
- Not Getting Work Done
- Appearance
  - Tired, Disheveled, Hygiene, Cutting Behaviors
- Persistent Negative, Irritable Mood
- Sleep, Weight Changes
- Isolative (from Peers, Family)
- Drinking/Smoking/Partying Too Much
- Scary Talk - Death, Suicide

Triggering Events

No Single Event Causes Suicidality

- Examples:
  - Breakup
  - Bullying
  - School Problems
  - Rejection or Perceived Failure
  - Sudden Death of a Loved One
  - Suicide of a Friend or Relative



http://suicidepreventionlifeline.org/App_Files/Media/PDF/NSPL_WalletCard.pdf









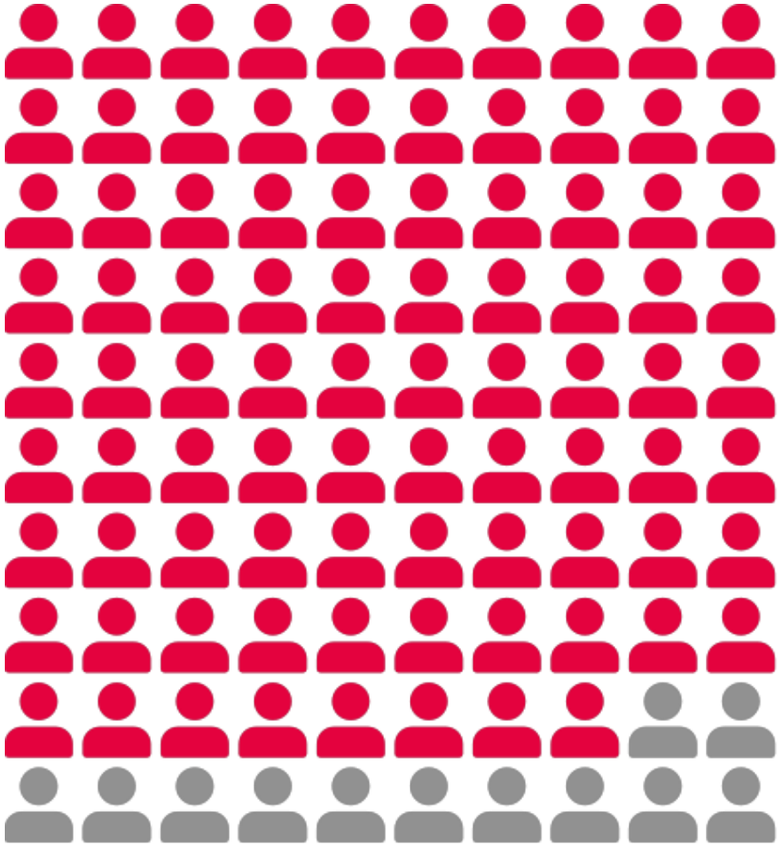

A Research Example

Can we save lives by screening for suicide risk in the medical setting?

Contact With the Healthcare System Before Death By Suicide

88%

Had a Healthcare Visit
1 Year Before Their Death

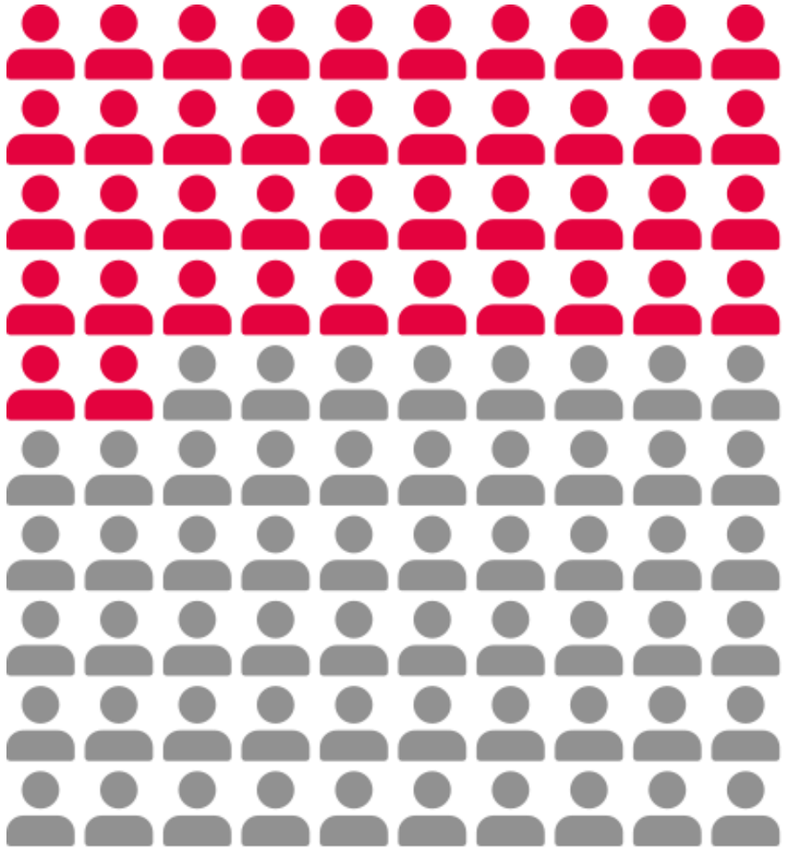


Suicide Decedents Ages 10-24 Years Old

Contact With the Healthcare System Before Death By Suicide

42%

Had a Healthcare Visit
1 Month Before Their Death



Suicide Decedents Ages 10-24 Years Old

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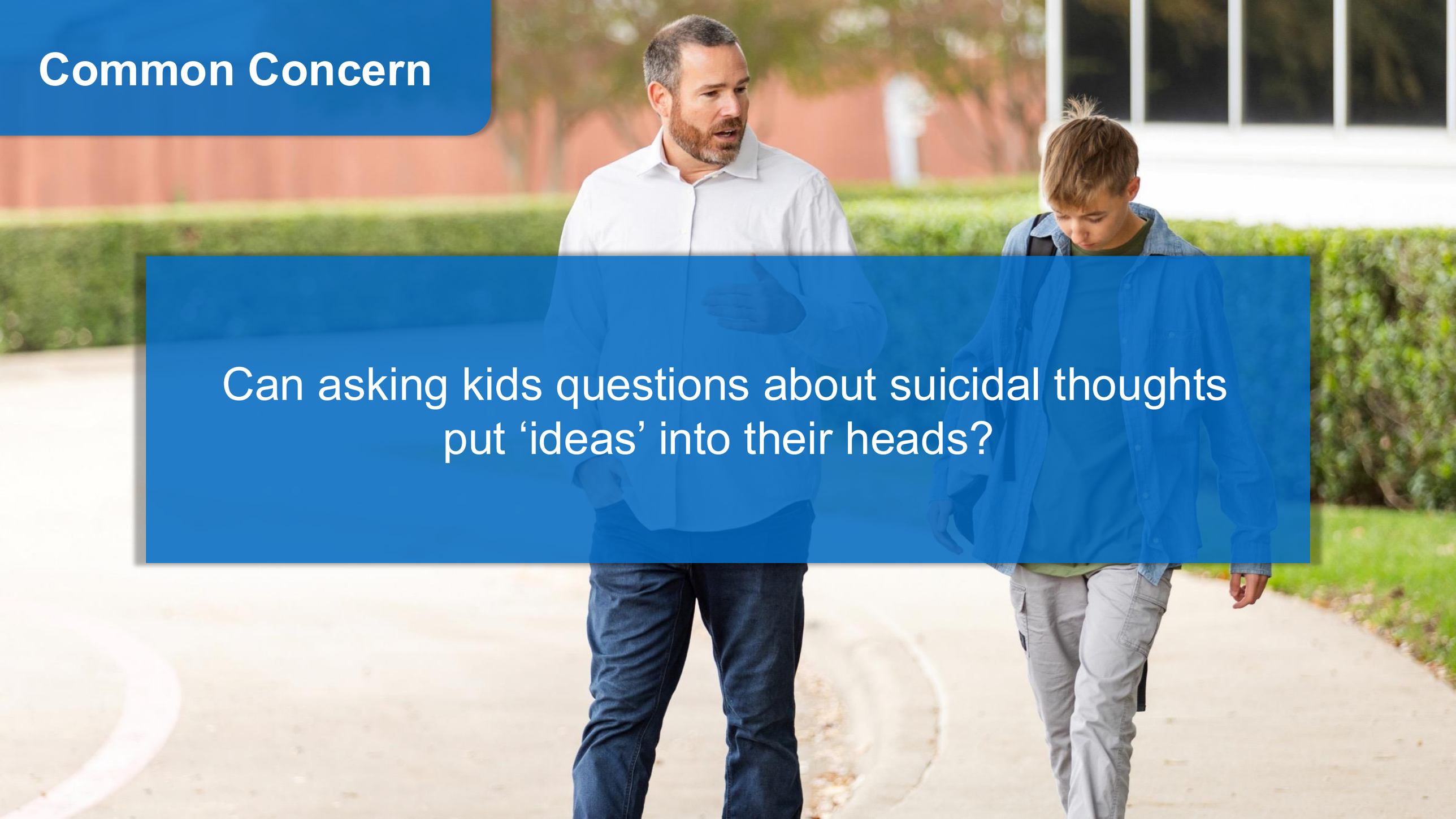
Contact with the Healthcare System Before Death by Suicide

60%

Majority of youth who die by suicide have no previously documented mental health diagnosis.

Common Concern



Can asking kids questions about suicidal thoughts put ‘ideas’ into their heads?

Iatrogenic Risk?

On the Iatrogenic Risk of Assessing Suicidality: A Meta-Analysis

Christopher R. DeCou, MS, and Matthew E. Schumann, MA

2017

Previous studies have failed to detect an iatrogenic effect of assessing suicidality. However, the perception that asking about suicide may induce suicidality persists. This meta-analysis quantitatively synthesized research concerning the iatrogenic risks of assessing suicidality. This review included studies that explicitly evaluated the iatrogenic effects of assessing suicidality via prospective research methods. Thirteen articles were identified that met inclusion criteria. Evaluation of the pooled effect of assessing suicidality with regard to negative outcomes did not demonstrate significant iatrogenic effects. Our findings support the appropriateness of universal screening for suicidality, and should allay fears that assessing suicidality is harmful.

Impact of screening for risk of suicide: randomised controlled trial

2011

Mike J. Crawford, Lavanya Thana, Caroline Methuen, Pradip Ghosh, Sian V. Stanley, Juliette Ross, Fabiana Gordon, Grant Blair and Priya Bajaj

Background
Concerns have been expressed about the impact that screening for risk of suicide may have on a person's mental health.

Aims
To examine whether screening for suicidal ideation among people who attend primary care services and have signs of depression increases the short-term incidence of feeling that life is not worth living.

Method
In a multicentre, single-blind, randomised controlled trial, 443 patients in four general practices were randomised to screening for suicidal ideation or control questions on health and lifestyle (trial registration: ISRCTN84692657). The primary outcome was thinking that life is not worth living measured 10–14 days after randomisation. Secondary outcome measures comprised other aspects of suicidal ideation and behaviour.

Results
A total of 443 participants were randomised to early (*n* = 230) or delayed screening (*n* = 213). Their mean age was 48.5 years (s.d. = 18.4, range 16–92) and 137 (30.9%) were male. The adjusted odds of experiencing thoughts that life was not worth living at follow-up among those randomised to early compared with delayed screening was 0.88 (95% CI 0.66–1.18). Differences in secondary outcomes between the two groups were not seen. Among those randomised to early screening, 37 people (22.3%) reported thinking about taking their life at baseline and 24 (14.6%) that they had this thought 2 weeks later.

Conclusions
Screening for suicidal ideation in primary care among people who have signs of depression does not appear to induce feelings that life is not worth living.

Declaration of interest
None.

What's the Harm in Asking About Suicidal Ideation?

Charles W. Mathias, PhD, R. Michael Furr, PhD, Arielle H. Sheftall, PhD, Nathalie Hill-Kapturczak, PhD, Paige Crum, BA, and Donald M. Dougherty, PhD

2012

Both researchers and oversight committees share concerns about patient safety in the study-related assessment of suicidality. However, concern about assessing suicidal thoughts can be a barrier to the development of empirical evidence that informs research on how to safely conduct these assessments. A question has been raised if asking about suicidal thoughts can result in iatrogenic increases of such thoughts, especially among at-risk samples. The current study repeatedly tested suicidal ideation at 6-month intervals for up to 2-years. Suicidal ideation was measured with the Suicidal Ideation Questionnaire Junior, and administered to adolescents who had previously received inpatient psychiatric care. Change in suicidal ideation was tested using several analytic techniques, each of which pointed to a significant decline in suicidal ideation in the context of repeated assessment. This and previous study outcomes suggest that asking an at-risk population about suicidal ideation is not associated with subsequent increases in suicidal ideation.

Evaluating Iatrogenic Risk of Youth Suicide Screening Programs
A Randomized Controlled Trial

Madelyn S. Gould, PhD, MPH
Frank A. Marrocco, PhD
Marjorie Kleinman, MS
John Graham Thomas, BS
Katherine Mostkoff, CSW
Jean Cote, CSW
Mark Davies, MPH

Context Universal screening for mental health problems and suicide risk is at the forefront of the national agenda for youth suicide prevention, yet no study has directly addressed the potential harm of suicide screening.

Objective To examine whether asking about suicidal ideation or behavior during a screening program creates distress or increases suicidal ideation among high school students generally or among high-risk students reporting depressive symptoms, substance use problems, or suicide attempts.

Design, Setting, and Participants A randomized controlled study conducted within the context of a 2-day screening strategy. Participants were 2342 students in 6 high schools in New York State in 2002-2004. Classes were randomized to an experimental group (n=1172), which received the first survey with suicide questions, or to a control group (n=1170), which did not receive suicide questions.

THE PRESIDENT'S NEW FREEdom Commission[1] and the Children's Mental Health

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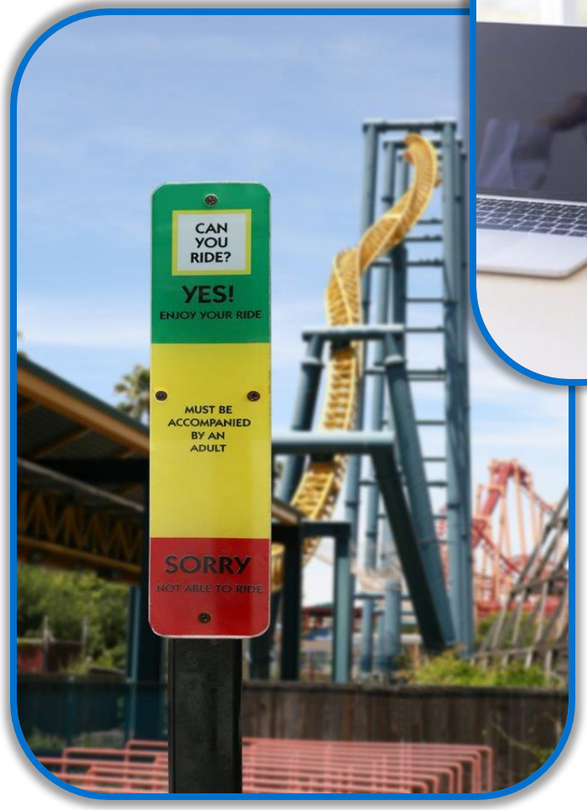
Teen Suicide Prevention – Mayo Clinic PSA (Short-Version)

https://www.youtube.com/watch?v=3BByqa7bhto&rco=1

Screening

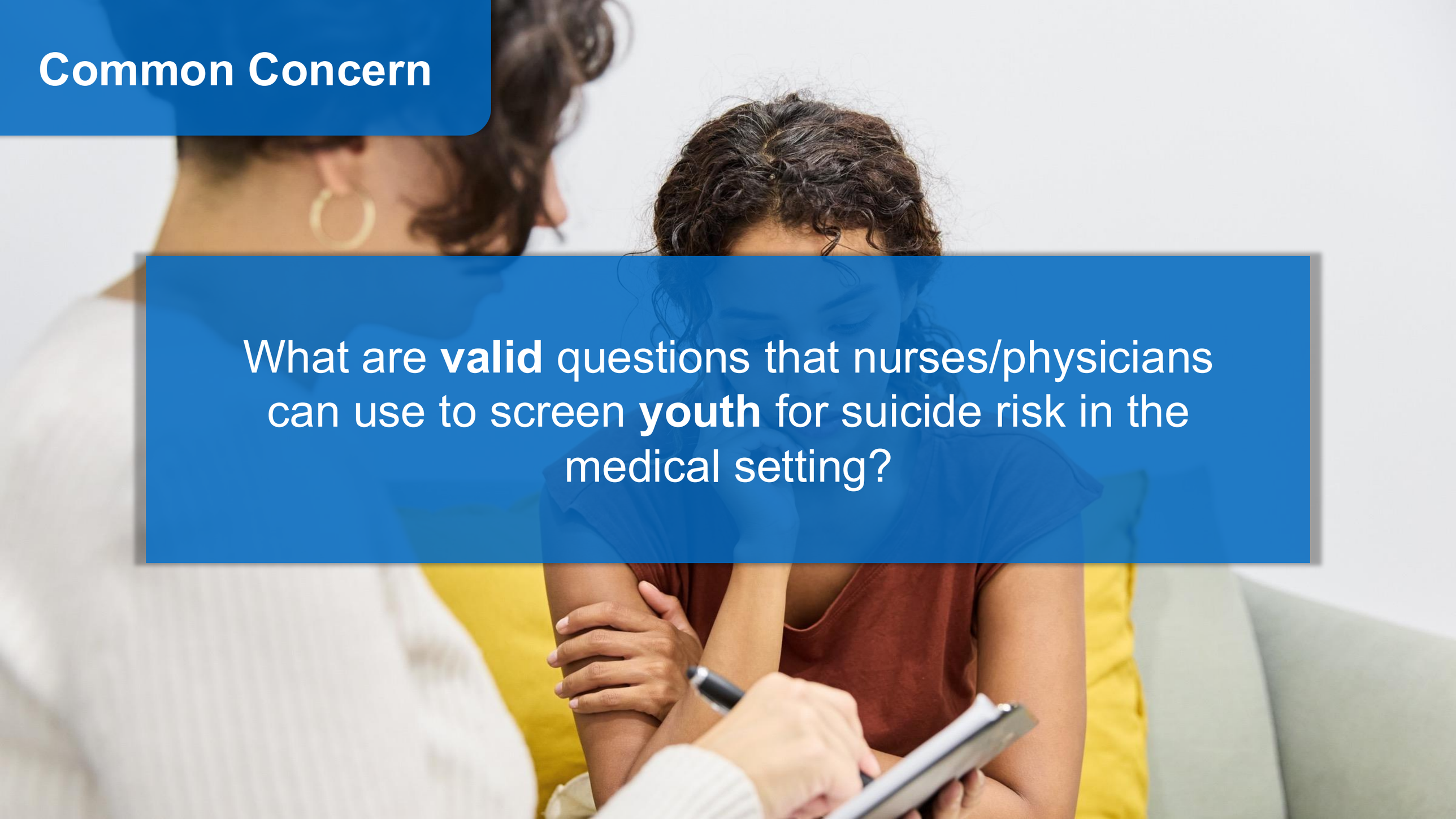


Screening vs. Assessment: What's the Difference?

- **Suicide Risk Screening**
  - Identify Individuals at Risk for Suicide
  - Oral, Paper/Pencil, Computer

- **Suicide Risk Assessment**
  - More Comprehensive Evaluation
  - Confirms Risk
  - Estimates Imminent Risk of Danger to Student
  - Guides Next Steps

Common Concern



What are **valid** questions that nurses/physicians can use to screen **youth** for suicide risk in the medical setting?

ASQ – Development & Initial Validation

Ask Suicide-Screening Questions (ASQ)

- 3 Pediatric EDs
  - Boston Children's Hospital, Boston, MA
  - Children's National Medical Center, Washington, D.C.
  - Nationwide Children's Hospital, Columbus, OH
- September 2008 to January 2011
- 524 Pediatric ED Patients
  - 344 Medical/Surgical, 180 Psychiatric
  - 57% Female, 50% White, 53% Privately Insured
  - 10 to 21 Years (Mean=15.2 Years; SD = 2.6y)

Ask Suicide-Screening Questions (ASQ)

Ask the patient:

1. In the past few weeks, have you wished you were dead?	○ Yes	☒ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?	○ Yes	☒ No
3. In the past week, have you been having thoughts about killing yourself?	○ Yes	☒ No
4. Have you ever tried to kill yourself?	○ Yes	☒ No

If yes, how? _____

_____

_____

When? _____

_____

NEGATIVE

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. Are you having thoughts of killing yourself right now?	○ Yes	○ No

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Ask Suicide-Screening Questions (ASQ)

Ask the patient:

1. **In the past few weeks, have you wished you were dead?**	☒ Yes	○ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?**	☒ Yes	○ No
3. **In the past week, have you been having thoughts about killing yourself?**	○ Yes	☒ No
4. **Have you ever tried to kill yourself?**	○ Yes	☒ No

If yes, how? _____

_____

_____

When? _____

_____

NON-ACUTE POSITIVE

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?**	○ Yes	☒ No

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Ask Suicide-Screening Questions (ASQ)

Ask the patient:

1. **In the past few weeks, have you wished you were dead?**	☒ Yes	○ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?**	☒ Yes	○ No
3. **In the past week, have you been having thoughts about killing yourself?**	○ Yes	☒ No
4. **Have you ever tried to kill yourself?**	○ Yes	☒ No

If yes, how? _____

_____

_____

When? _____

_____

ACUTE POSITIVE

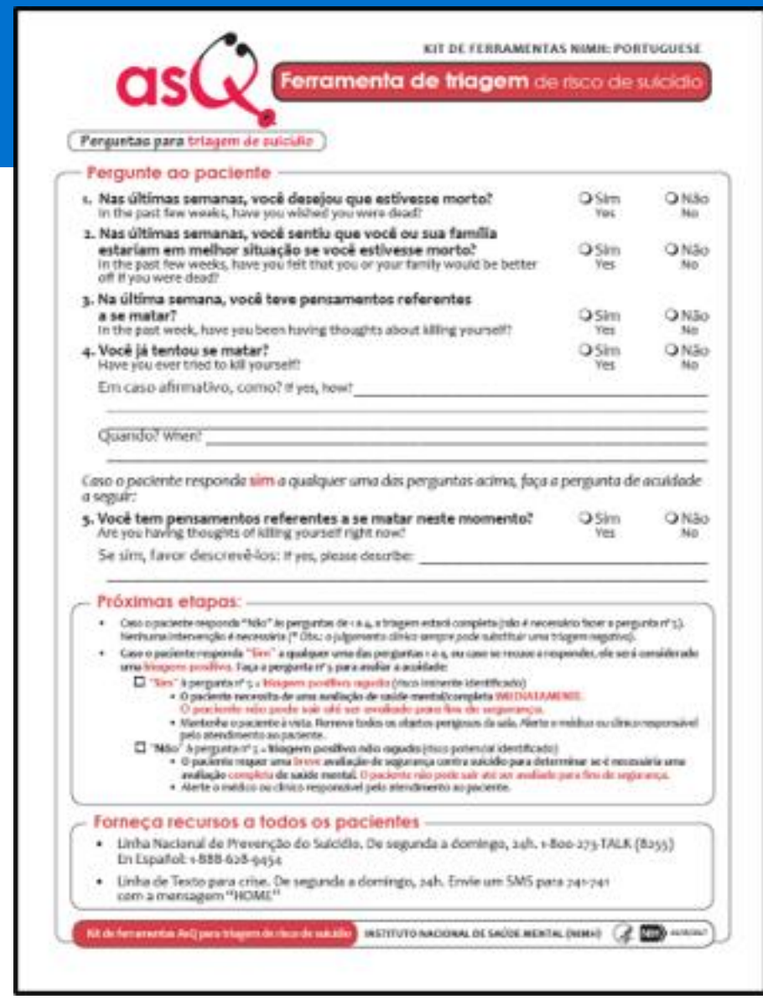
If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?**	☒ Yes	○ No

Validation and Implementation in Other Settings: Ongoing Research

- Inpatient medical/surgical unit
- Outpatient primary care/specialty clinics
- ASQ in adult medical patients
- Schools
- Child abuse clinics
- Detention Facilities
- Indian Health Service (IHS)
- ASD/NDD Population

- Foreign languages
  - Spanish
  - Italian
  - French
  - Portuguese
  - Dutch
  - Arabic
  - Somali
  - Hindi
  - Hebrew
  - Vietnamese
  - Mandarin
  - Korean
  - Japanese
  - Russian
  - Tagalog
  - Urdu


KIT DE FERRAMENTAS NIMH: PORTUGUESE

asQ Ferramenta de triagem de risco de suicídio

Perguntas para triagem de suicídio

Pergunte ao paciente

1. Nas últimas semanas, você desejou que estivesse morto? In the past few weeks, have you wished you were dead? Sim Yes / Não No
2. Nas últimas semanas, você sentiu que você ou sua família estariam em melhor situação se você estivesse morto? In the past few weeks, have you felt that you or your family would be better off if you were dead? Sim Yes / Não No
3. Na última semana, você teve pensamentos referentes a se matar? In the past week, have you been having thoughts about killing yourself? Sim Yes / Não No
4. Você já tentou se matar? Have you ever tried to kill yourself? Sim Yes / Não No

Em caso afirmativo, como? If yes, how? _____

Quando? When? _____

Caso o paciente responda sim a qualquer uma das perguntas acima, faça a pergunta de acuidade a seguir:

5. Você tem pensamentos referentes a se matar neste momento? Are you having thoughts of killing yourself right now? Sim Yes / Não No

Se sim, favor descrevê-los: If yes, please describe: _____

Próximas etapas:

- Caso o paciente responda "Não" às perguntas de 1 a 4, a triagem estará completa (não é necessário fazer a pergunta nº 5). Nenhuma intervenção é necessária (* Obs.: o julgamento clínico sempre pode substituir uma triagem negativa).
- Caso o paciente responda "Sim" a qualquer uma das perguntas 1 a 4, ou caso se recuse a responder, ele será considerado uma triagem positiva. Faça a pergunta nº 5 para avaliar a acuidade:
  - ☐ "Sim" à pergunta nº 5 = triagem positiva aguda (risco iminente identificado)
    - O paciente necessita de uma avaliação de saúde mental completa IMEDIATAMENTE. O paciente não pode sair até ser avaliado para fins de segurança.
    - Mantenha o paciente à vista. Remova todos os objetos perigosos da sala. Alerte o médico ou clínico responsável pelo atendimento ao paciente.
  - ☐ "Não" à pergunta nº 5 = triagem positiva não aguda (risco potencial identificado)
    - O paciente requer uma breve avaliação de segurança contra suicídio para determinar se é necessária uma avaliação completa de saúde mental. O paciente não pode sair até ser avaliado para fins de segurança.
    - Alerte o médico ou clínico responsável pelo atendimento ao paciente.

Forneça recursos a todos os pacientes

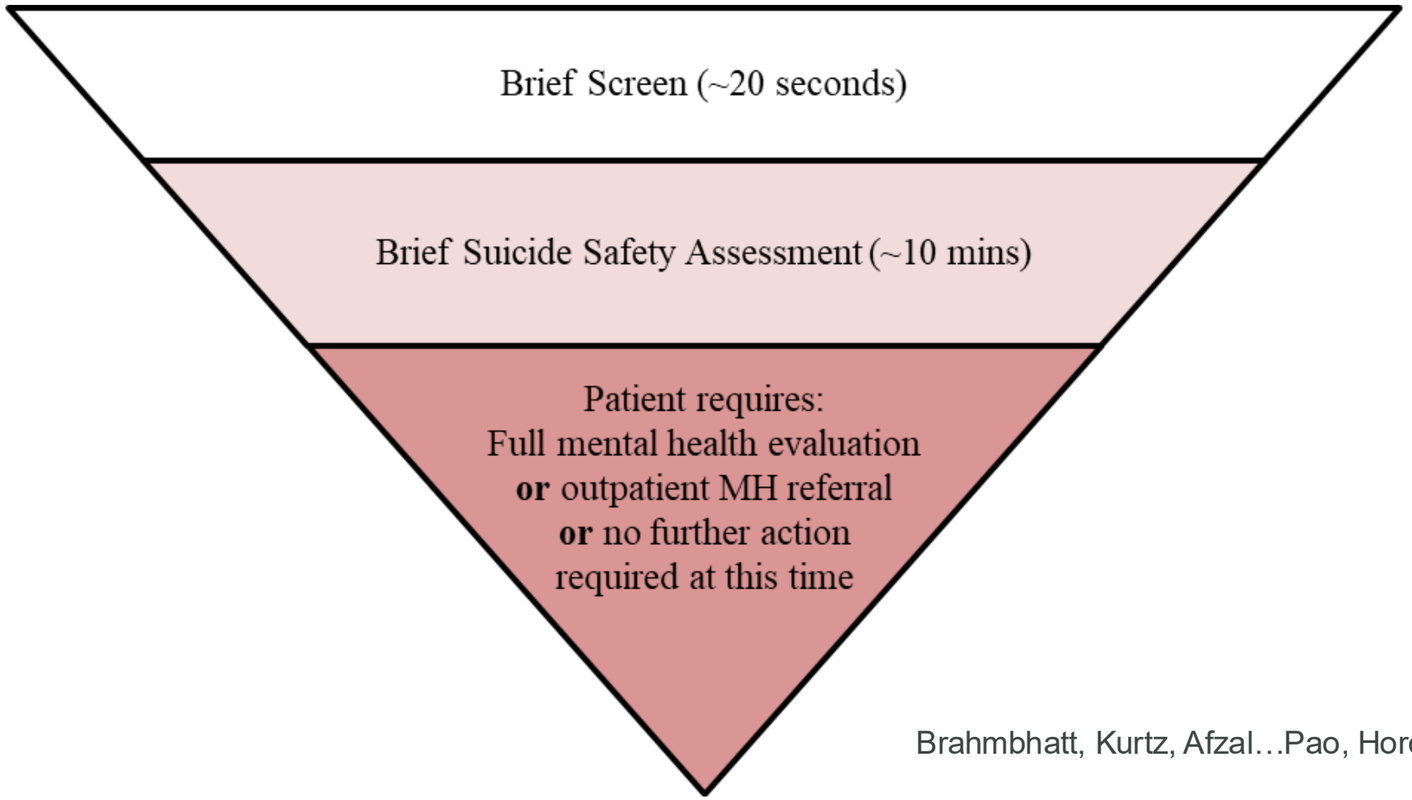
- Linha Nacional de Prevenção do Suicídio. De segunda a domingo, 24h. 1-800-273-TALK (8255) En Español: 1-888-628-9454
- Linha de Texto para crise. De segunda a domingo, 24h. Envie um SMS para 741-741 com a mensagem "HOME"

Kit de ferramentas AsQ para triagem de risco de suicídio | INSTITUTO NACIONAL DE SAÚDE MENTAL (NIMH)

ASQ Toolkit: www.nimh.nih.gov/ASQ

Universal Suicide Risk Screening Clinical Pathway

Clinical Pathway- 3-tiered system



Brahmbhatt, Kurtz, Afzal…Pao, Horowitz, et al. (2018*) Psychosomatics*

Turning Research into Practice

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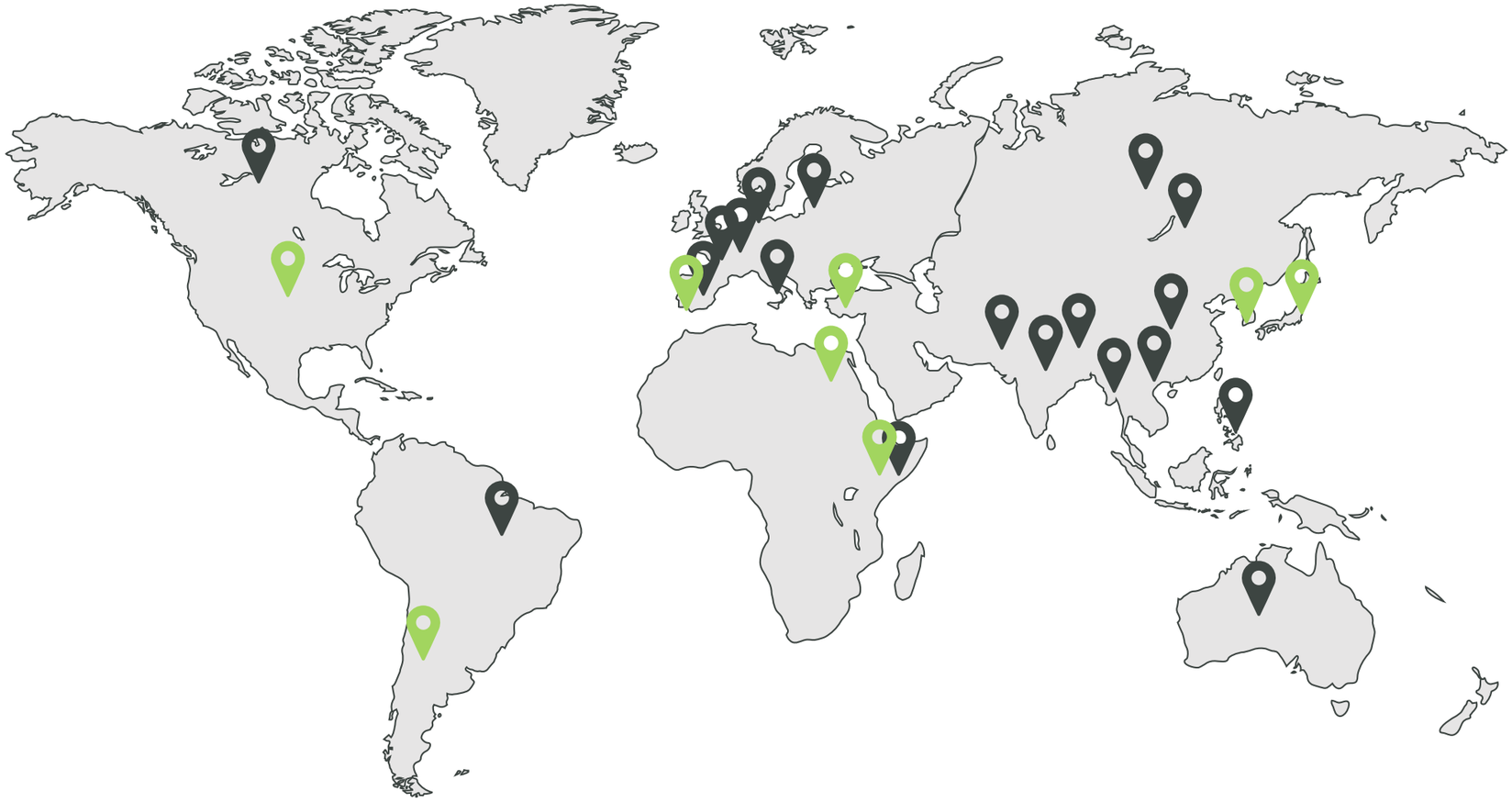
ASQ Worldwide



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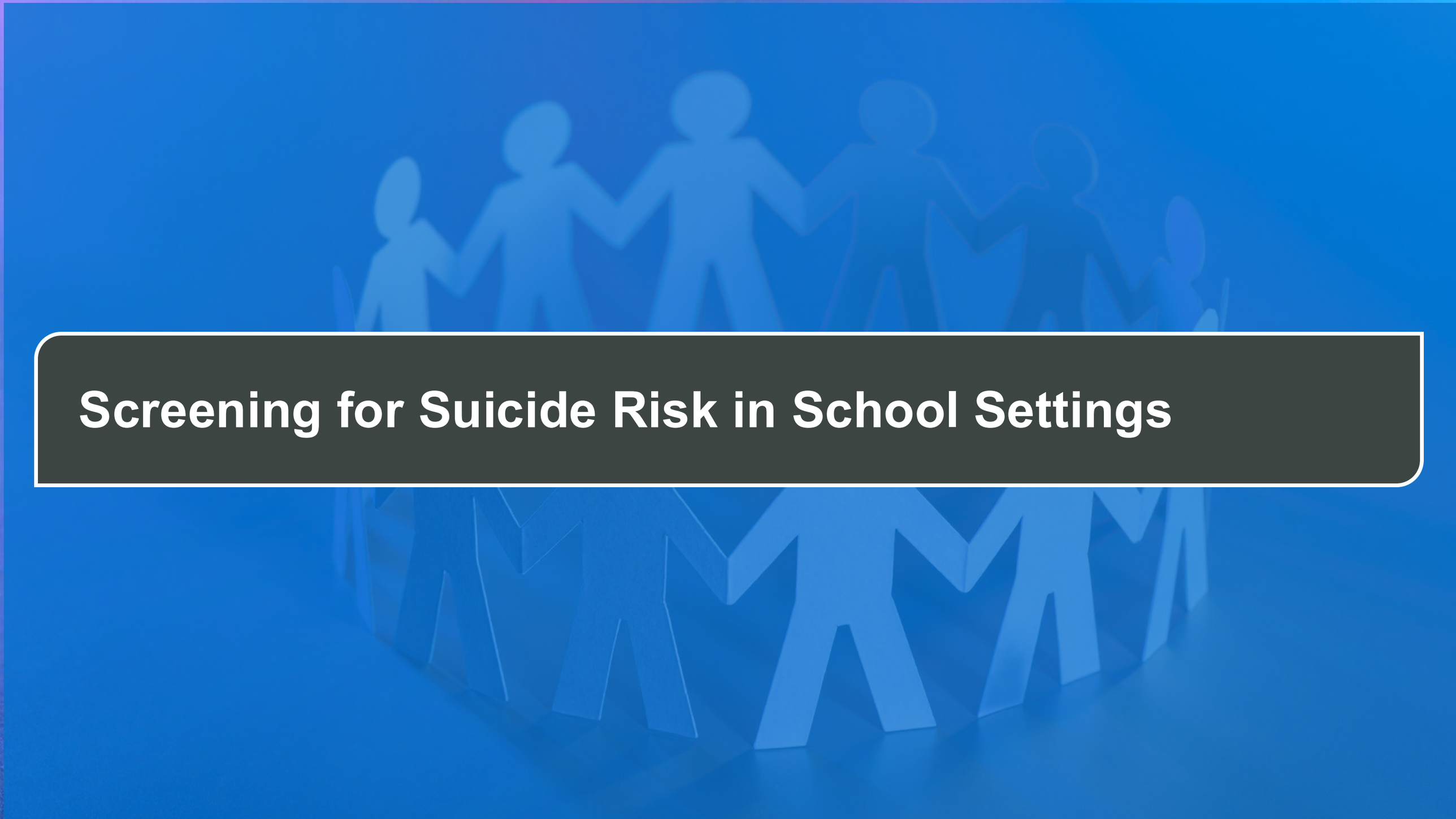
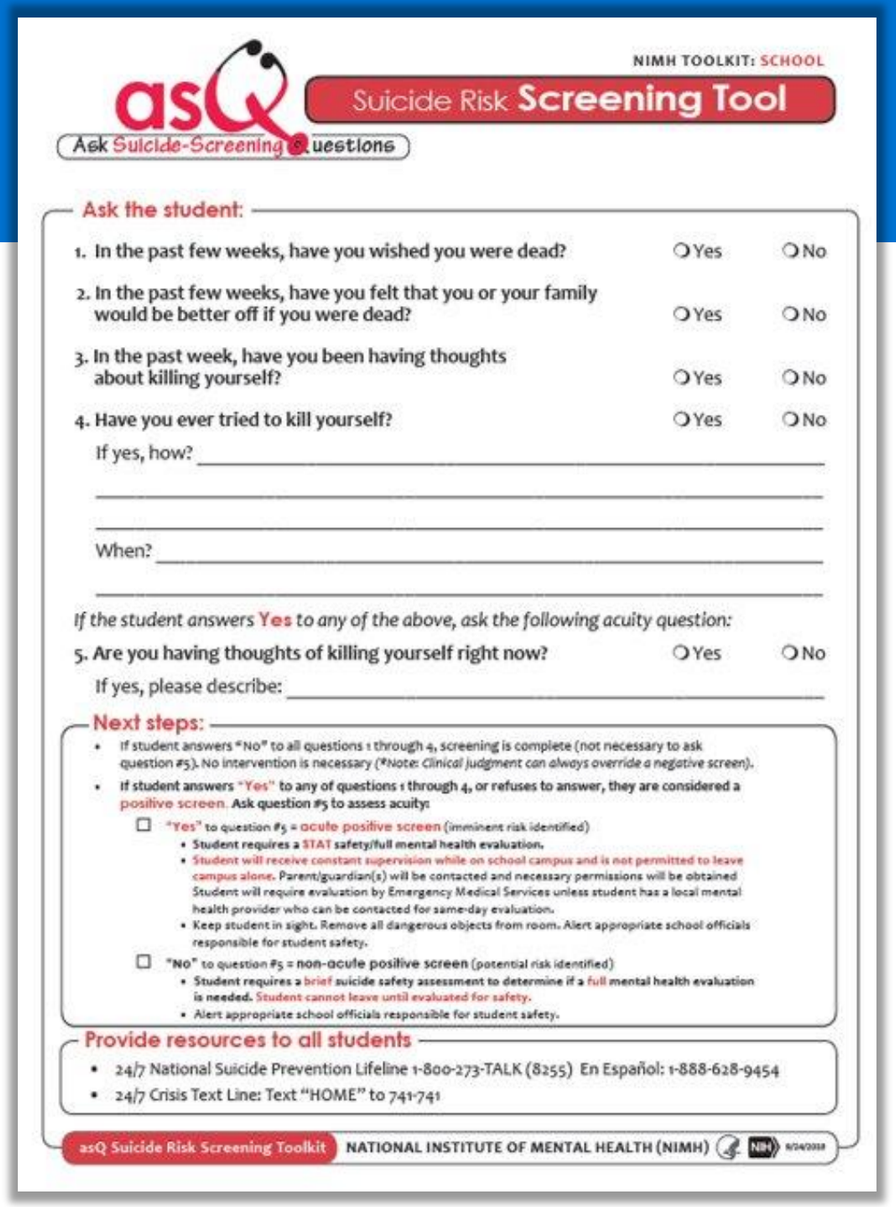
Implementation Examples



Screening for Suicide Risk in School Settings

Suicide Screening Tool



NIMH TOOLKIT: SCHOOL

asQ: Ask Suicide-Screening Questions

Suicide Risk Screening Tool

Ask the student:

1. In the past few weeks, have you wished you were dead? ❍ Yes ❍ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ❍ Yes ❍ No
3. In the past week, have you been having thoughts about killing yourself? ❍ Yes ❍ No
4. Have you ever tried to kill yourself? ❍ Yes ❍ No

   If yes, how? _____

   When? _____

If the student answers Yes to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now? ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If student answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- If student answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:
  - ☐ "Yes" to question #5 = acute positive screen (imminent risk identified)
    - Student requires a STAT safety/full mental health evaluation.
    - Student will receive constant supervision while on school campus and is not permitted to leave campus alone. Parent/guardian(s) will be contacted and necessary permissions will be obtained. Student will require evaluation by Emergency Medical Services unless student has a local mental health provider who can be contacted for same-day evaluation.
    - Keep student in sight. Remove all dangerous objects from room. Alert appropriate school officials responsible for student safety.
  - ☐ "No" to question #5 = non-acute positive screen (potential risk identified)
    - Student requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Student cannot leave until evaluated for safety.
    - Alert appropriate school officials responsible for student safety.

Provide resources to all students

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

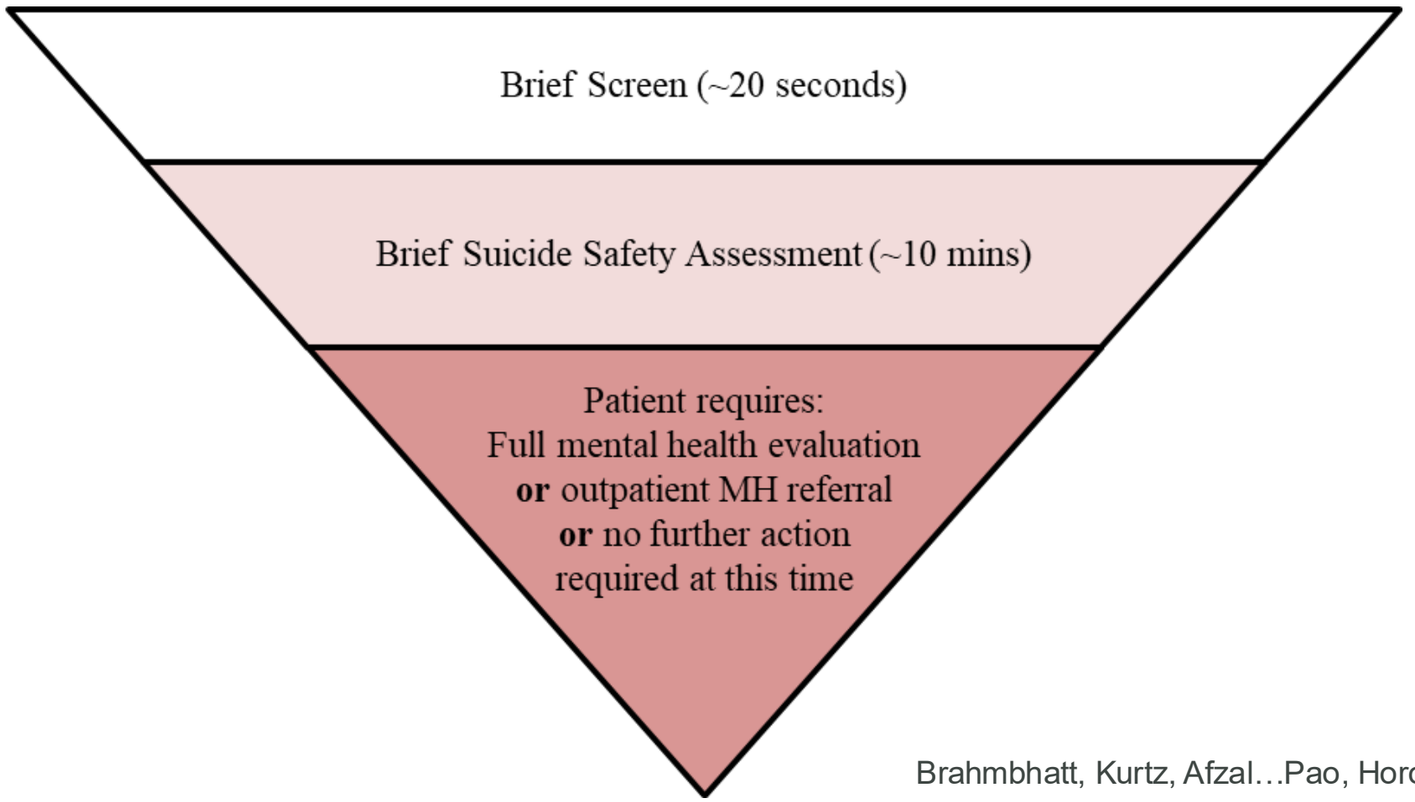
asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

School Nurses as Partners in Suicide Prevention

- Nurse champions lead the way for prevention efforts in school settings.
- Nurses serve as the first point of contact for students.
- Administer primary screeners.
- Ensure follow-up.

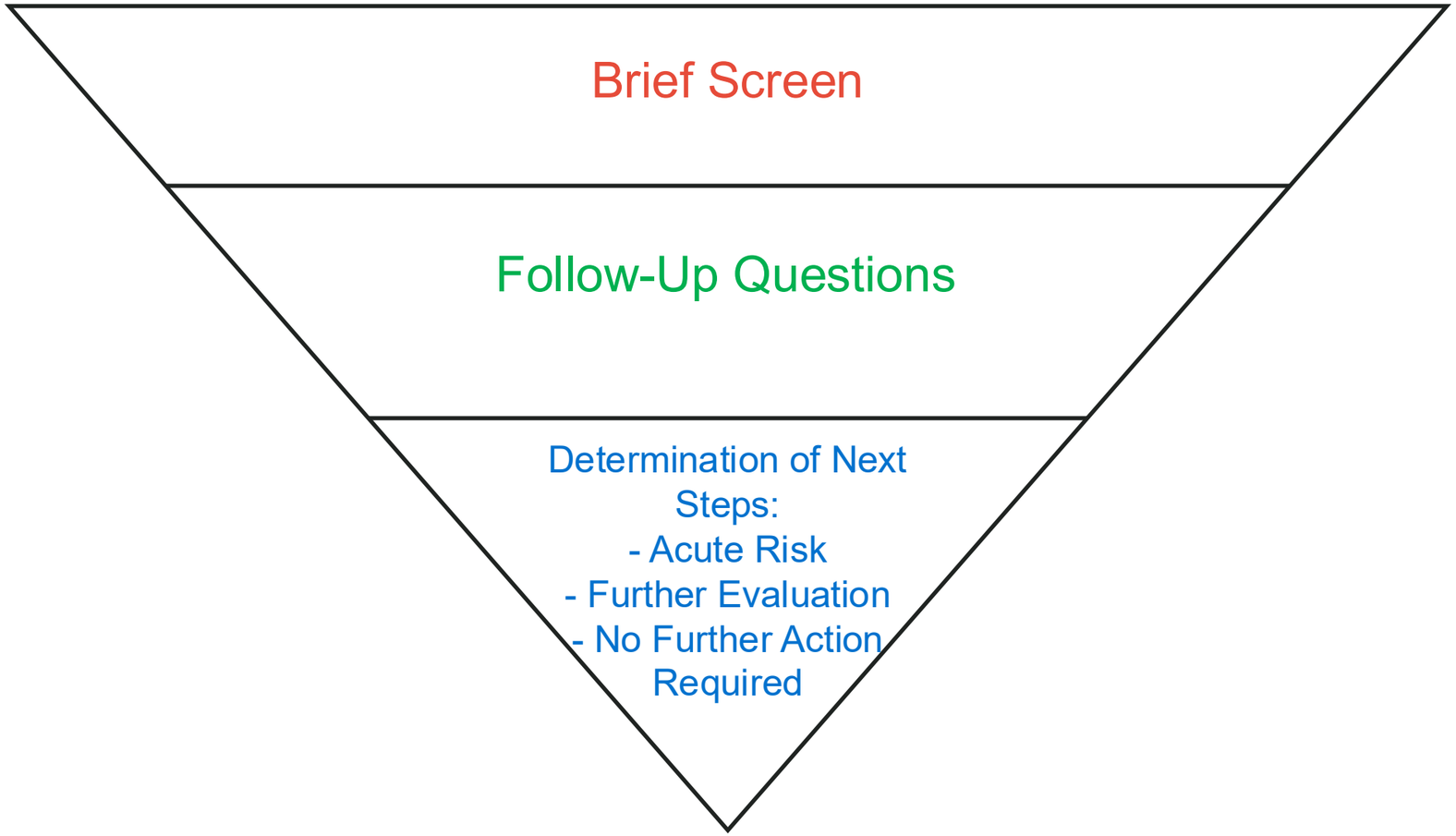
Universal Suicide Risk Screening Clinical Pathway

Clinical Pathway- 3-Tiered System



Brahmbhatt, Kurtz, Afzal…Pao, Horowitz, et al. (2018*) Psychosomatics*

Suicide Risk Pathway for Schools



Tier 1: Brief Screen

- Train!
  - Anyone Who is Trained Can Screen for Suicide Risk
- Designate Roles
- Modality
- Self Report vs Verbal
- Set Frequency
- Where Will You Screen?
- Select Eligibility Requirements
- Age and Cognitive Status

Role of the Screener

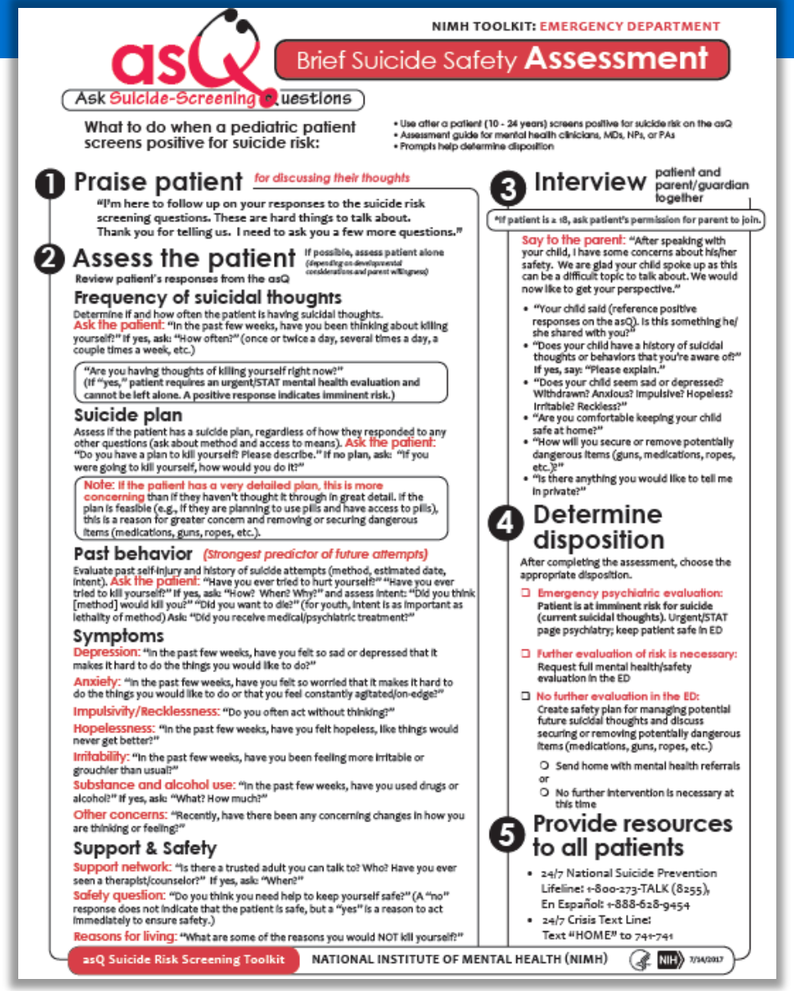
- Designate who will be screening.
  - Anyone who is trained can screen for suicide risk.
  - But, screening must be paired with a pathway.
- Tell any observer to step outside (don't ask, tell them politely).
- **Administer the ASQ verbatim (ask the questions as they are written).
- "Score" the ASQ in real time.
- Document/report screening findings.

Role of the Assessor

- What does this student need next?

Brief Suicide Safety Assessment

ASQ BSSA



NIMH TOOLKIT: EMERGENCY DEPARTMENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

What to do when a pediatric patient screens positive for suicide risk:

- Use after a patient (10 - 24 years) screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the patient If possible, assess patient alone (depending on developmental considerations and parent willingness)

Review patient's responses from the asQ

Frequency of suicidal thoughts

Determine if and how often the patient is having suicidal thoughts.

Ask the patient: "In the past few weeks, have you been thinking about killing yourself?" If yes, ask: "How often?" (once or twice a day, several times a day, a couple times a week, etc.)

"Are you having thoughts of killing yourself right now?" (If "yes," patient requires an urgent/STAT mental health evaluation and cannot be left alone. A positive response indicates imminent risk.)

Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means). Ask the patient: "Do you have a plan to kill yourself? Please describe." If no plan, ask: "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

Past behavior *(Strongest predictor of future attempts)*

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent). Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?" If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?" "Did you want to die?" (for youth, intent is as important as lethality of method) Ask: "Did you receive medical/psychiatric treatment?"

Symptoms

Depression: "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"

Anxiety: "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"

Impulsivity/Recklessness: "Do you often act without thinking?"

Hopelessness: "In the past few weeks, have you felt hopeless, like things would never get better?"

Irritability: "In the past few weeks, have you been feeling more irritable or grouchier than usual?"

Substance and alcohol use: "In the past few weeks, have you used drugs or alcohol?" If yes, ask: "What? How much?"

Other concerns: "Recently, have there been any concerning changes in how you are thinking or feeling?"

Support & Safety

Support network: "Is there a trusted adult you can talk to? Who? Have you ever seen a therapist/counselor?" If yes, ask: "When?"

Safety question: "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe, but a "yes" is a reason to act immediately to ensure safety.)

Reasons for living: "What are some of the reasons you would NOT kill yourself?"

3 Interview patient and parent/guardian together

*If patient is ≥ 18, ask patient's permission for parent to join.

Say to the parent: "After speaking with your child, I have some concerns about his/her safety. We are glad your child spoke up as this can be a difficult topic to talk about. We would now like to get your perspective."

- "Your child said (reference positive responses on the asQ). Is this something he/she shared with you?"
- "Does your child have a history of suicidal thoughts or behaviors that you're aware of?" If yes, say: "Please explain."
- "Does your child seem sad or depressed? Withdrawn? Anxious? Impulsive? Hopeless? Irritable? Reckless?"
- "Are you comfortable keeping your child safe at home?"
- "How will you secure or remove potentially dangerous items (guns, medications, ropes, etc.)?"
- "Is there anything you would like to tell me in private?"

4 Determine disposition

After completing the assessment, choose the appropriate disposition.

❑ Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts). Urgent/STAT page psychiatry; keep patient safe in ED

❑ Further evaluation of risk is necessary: Request full mental health/safety evaluation in the ED

❑ No further evaluation in the ED: Create safety plan for managing potential future suicidal thoughts and discuss securing or removing potentially dangerous items (medications, guns, ropes, etc.)

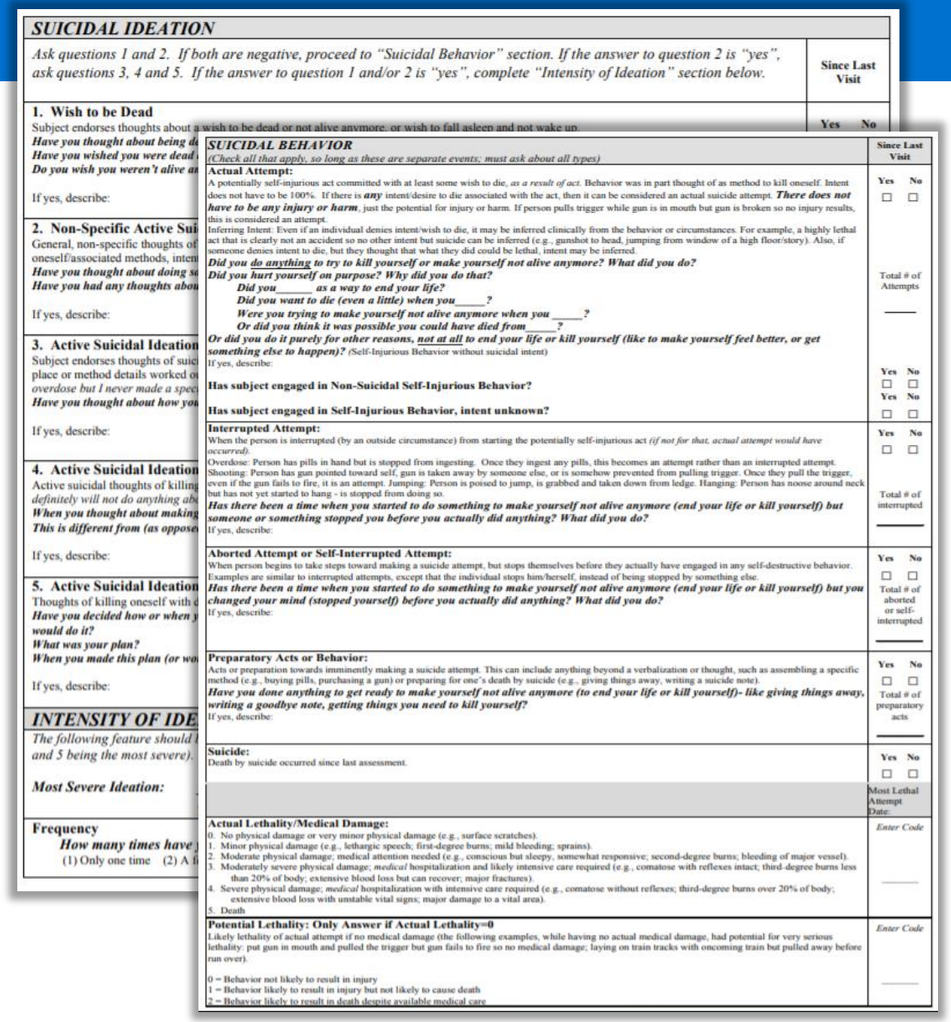
○ Send home with mental health referrals or
○ No further intervention is necessary at this time

5 Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
  En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | 7/14/2017

C-SSRS



SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

Since Last Visit

1. Wish to be Dead — Yes No
2. Non-Specific Active Sui
3. Active Suicidal Ideation
4. Active Suicidal Ideation
5. Active Suicidal Ideation

INTENSITY OF IDE

The following feature should *and 5 being the most severe).*

Most Severe Ideation:

Frequency

How many times have

(1) Only one time (2) A f

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*

Since Last Visit

Actual Attempt: Yes No

A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt.

Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.

Did you do anything to try to kill yourself or make yourself not alive anymore? What did you do?
Did you hurt yourself on purpose? Why did you do that?
Did you_____ as a way to end your life?
Did you want to die (even a little) when you_____?
Were you trying to make yourself not alive anymore when you _____?
Or did you think it was possible you could have died from_____?
Or did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, or get something else to happen)? (Self-Injurious Behavior without suicidal intent)

If yes, describe:

Total # of Attempts: ____

Has subject engaged in Non-Suicidal Self-Injurious Behavior? Yes No

Has subject engaged in Self-Injurious Behavior, intent unknown? Yes No

Interrupted Attempt: Yes No

When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).*

Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so.

Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?

If yes, describe:

Total # of interrupted: ____

Aborted Attempt or Self-Interrupted Attempt: Yes No

When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else.

Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?

If yes, describe:

Total # of aborted or self-interrupted: ____

Preparatory Acts or Behavior: Yes No

Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note).

Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?

If yes, describe:

Total # of preparatory acts: ____

Suicide: Yes No

Death by suicide occurred since last assessment.

Most Lethal Attempt Date:

Actual Lethality/Medical Damage: *Enter Code*

0. No physical damage or very minor physical damage (e.g., surface scratches).
1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains).
2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel).
3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures).
4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area).
5. Death

Potential Lethality: Only Answer if Actual Lethality=0 *Enter Code*

Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over).

0 = Behavior not likely to result in injury
1 = Behavior likely to result in injury but not likely to cause death
2 = Behavior likely to result in death despite available medical care

NIMH TOOLKIT: SCHOOL

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

What to do when a student screens positive for suicide risk:

- Use after a student (10 - 24 years) screens positive for suicide risk on the asQ
- Assessment guide for school-based mental health professionals
- Prompts help determine disposition

1 Praise student *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the student *(If possible, assess student alone depending on developmental considerations and parent willingness.)*

Review student's responses from the asQ

Frequency of suicidal thoughts

Determine if and how often the student is having suicidal thoughts.

Ask the student: "In the past few weeks, have you been thinking about killing yourself?" **If yes, ask:** "How often?" (once or twice a day, several times a day, a couple times a week, etc.) "When was the last time you had these thoughts?"

"Are you having thoughts of killing yourself right now?" **(If "yes," student requires an urgent/ STAT mental health evaluation and cannot be left alone. A positive response indicates imminent risk.)**

Suicide plan

Assess if the student has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means).

Ask the student: "Do you have a plan to kill yourself?" **If yes, ask:** "What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

Note: If the student has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

Past behavior

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).

Ask the student: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"

If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?" "Did you want to die?" (for youth, intent is as important as lethality of method) **Ask:** "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future attempts.

Symptoms *Ask the student about:*

Depression: "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"

Anxiety: "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"

Impulsivity/Recklessness: "Do you often act without thinking?"

Hopelessness: "In the past few weeks, have you felt hopeless, like things would never get better?"

Anhedonia: "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"

Isolation: "Have you been keeping to yourself more than usual?"

Irritability: "In the past few weeks, have you been feeling more irritable or grouchier than usual?"

Substance and alcohol use: "In the past few weeks, have you used drugs or alcohol?" **If yes, ask:** "What? How much?"

Sleep pattern: "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"

Appetite: "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"

Other concerns: "Recently, have there been any concerning changes in how you are thinking or feeling?"

Social Support & Stressors

(For all questions below, if student answers yes, ask them to describe.)

Support network: "Is there a trusted adult you can talk to? Who? Have you ever seen a therapist/counselor?" **If yes, ask:** "When?"

Family situation: "Are there any conflicts at home that are hard to handle?"

School functioning: "Do you ever feel so much pressure at school (academic or social) that you can't take it anymore?"

Bullying: "Are you being bullied or picked on?"

Suicide contagion: "Do you know anyone who has killed themselves or tried to kill themselves?"

Reasons for living: "What are some of the reasons you would NOT kill yourself?"

NIMH TOOLKIT: SCHOOL

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

5 Determine disposition

After completing the assessment, choose the appropriate disposition plan. *If possible, school-based mental health provider should follow-up with a check-in phone call (within 48 hours) with all students who screened positive.*

❑ **Emergency psychiatric evaluation:** The results of the ASQ tool and the BSSA suggest that the student is at **imminent risk for suicide**, meaning:

- The student has answered "yes" to ASQ Q5, has thoughts about suicide right now.
- Student is having frequent suicidal thoughts.
- The student has a detailed plan of suicide. A detailed plan is more concerning than if the plan has not been well thought out.
- The student has access to the means by which they intend to kill themselves. This is cause for great concern and parents will need specific counseling on restricting and safely storing lethal means in the home.
- If student is having current thoughts of suicide and has attempted in the past they are at greater risk and should be evaluated emergently.

❑ **Further evaluation of risk is necessary:** Create and review a safety plan with parents and the student and send the student home with a mental health referral as soon as student can get an appointment and be evaluated, ideally within 72 hours. If the parent fails to establish the outside mental health assessment within 72 hours, the school administrative staff will issue an exclusion from school until the parents have obtained a letter indicating that the student has been evaluated. Note: If an evaluation with a mental health provider cannot be accessed within 72 hours, parent (s)/guardian (s) must seek evaluation by student's treating pediatrician/physician.

- ASQ Q1-4 is positive and Q5 negative.
- The student denies immediate intent to want to kill themselves, but struggles with suicidal thoughts or other risk factors; the person conducting the BSSA determines that the suicidal thoughts do not warrant immediate attention, but will require further evaluation.
- The student does not have a detailed plan for killing themselves.
- Both parents and student confirm that the student will not have access to potentially dangerous items (guns, medications, ropes etc.). Parent will discuss their plan to secure lethal means with person conducting the BSSA.

❑ **Student may benefit from a *non-urgent* mental health follow-up:** Review safety plan and send home with a mental health referral.

- Student presents with minimal risk factors for suicide; they are not currently having suicidal thoughts or engaging in or planning suicidal behaviors.
- The BSSA reveals markers for mental health concern which may include symptoms of depression, anxiety, etc.

❑ **No Further intervention is necessary at this time.**

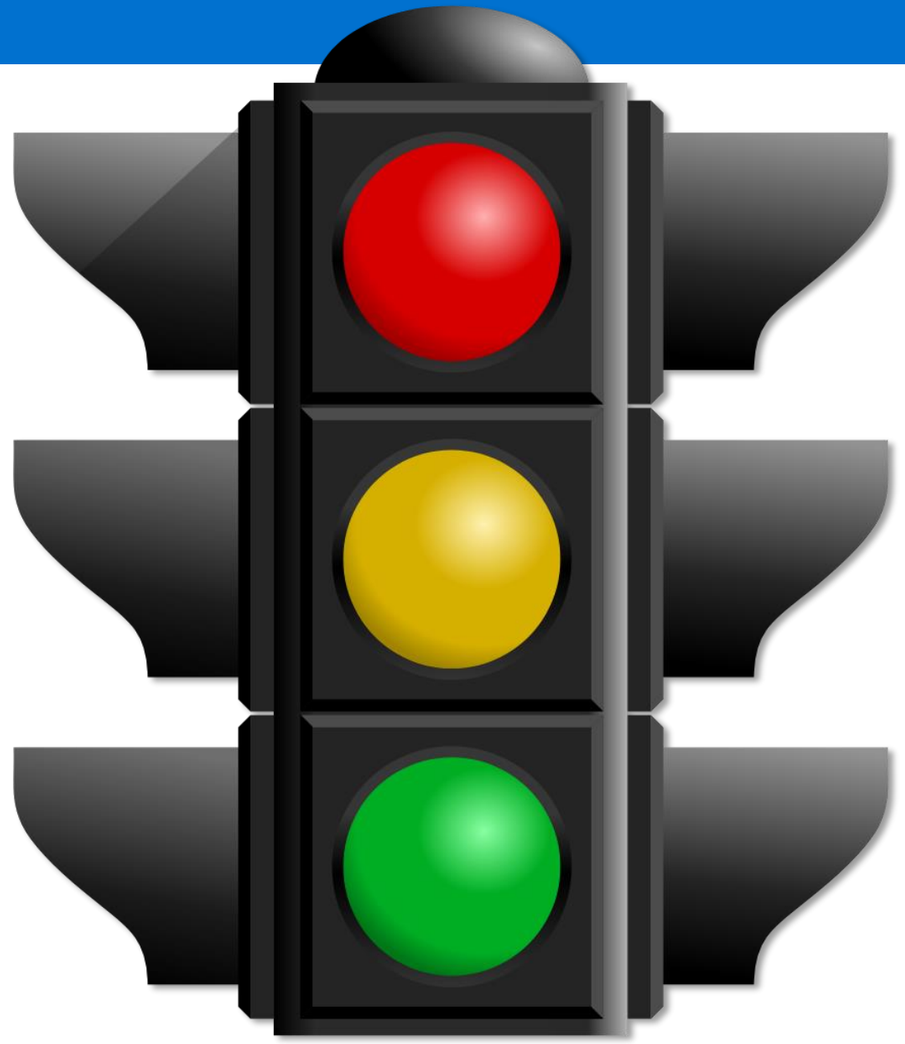
6 Provide resources to all students/parents

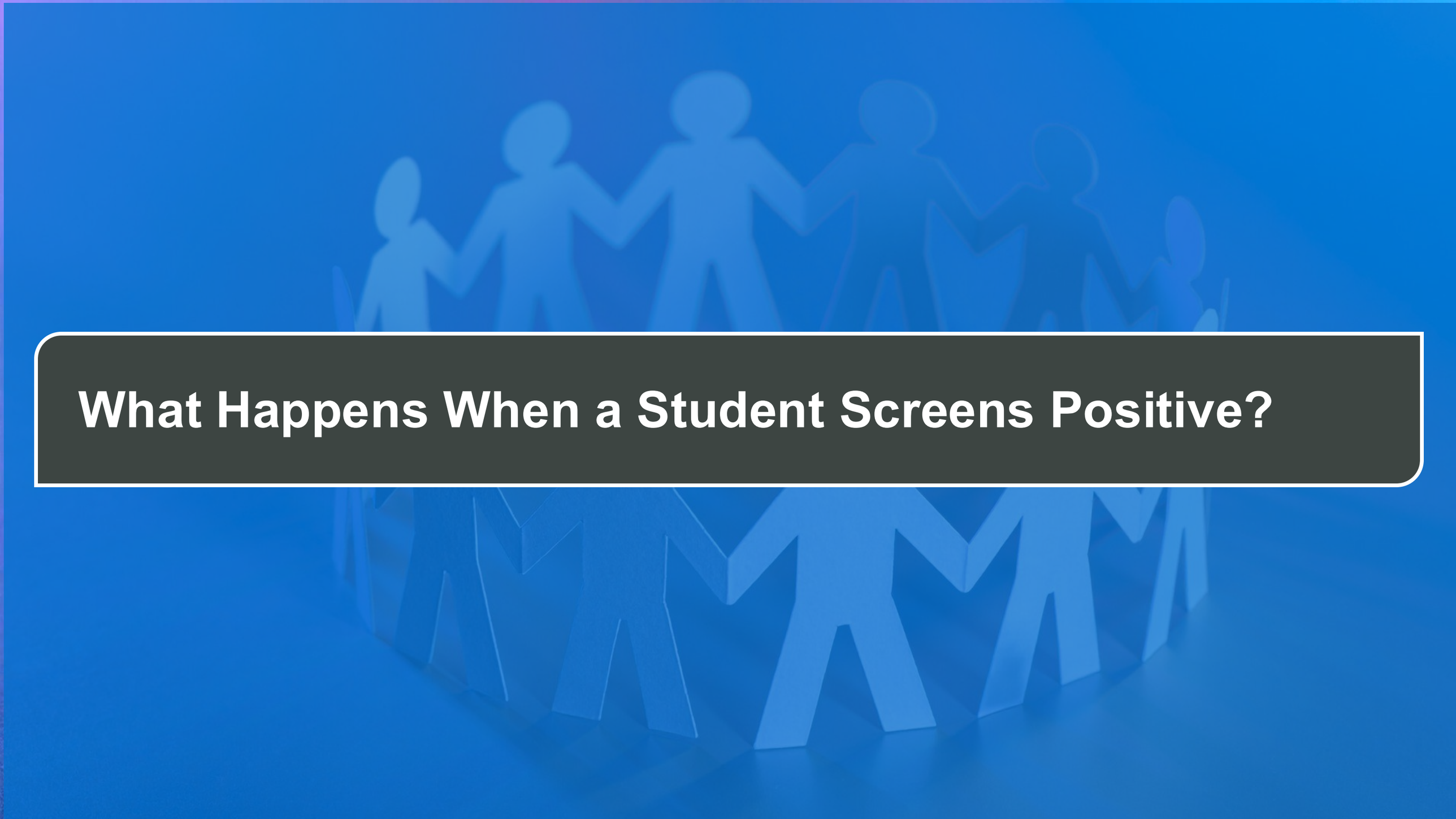
- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) 5/7/2019

What is the Purpose of the Brief Assessment?

- To help counselors identify next steps for care.
- **Imminent Risk**
  - **Student requires an emergency mental health evaluation.**
- **Further Evaluation is Needed**
  - **This is not an emergency, but student will require further mental health evaluation from a mental health professional as soon as possible.**
- **Low Risk**
  - **No further evaluation is needed at this time.**





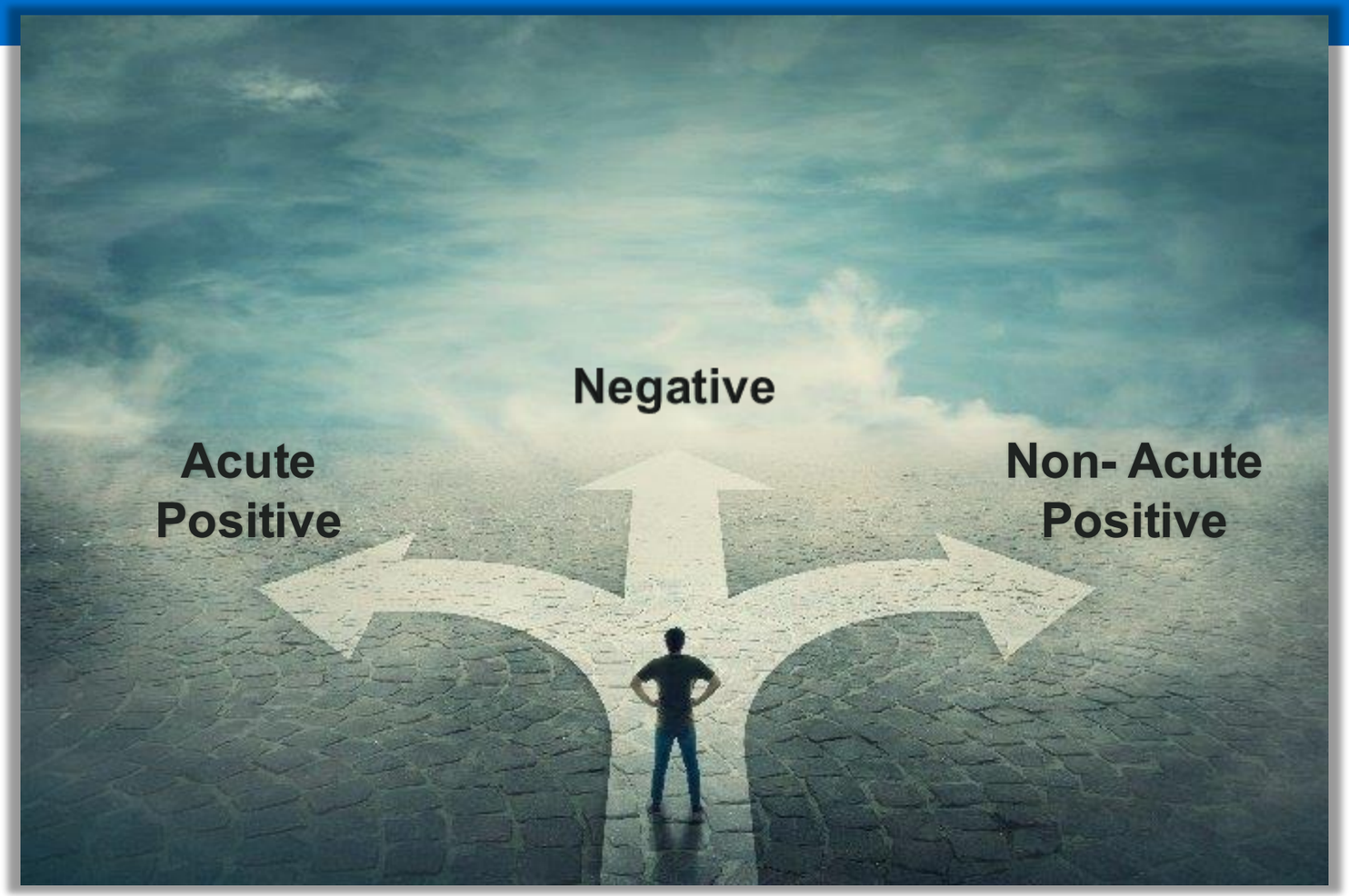
What Happens When a Student Screens Positive?

Here’s What Should NOT Happen

- Do not treat every young person who has a thought about suicide as an emergency.
- Creating pathways are a guide to avoid unnecessary interventions.

1:1 Sitter

Two Ways to Screen Positive: Acute or Non-Acute Positive?



Blueprint for Youth Suicide Prevention

- Roadmap for Future Action and Partnerships
- Health Equity is Critical
- Strategies to Identify and Support Youth Via:
  - Clinical Care Pathways
  - Community and School Partnerships
  - Advocacy and Policy Approaches

aap.org/suicideprevention

School and Community Partnerships

Engaging in Suicide Prevention Outside the Clinical Setting

Pediatric health clinicians have expertise in child and adolescent development and understand the unique ways that mental health is impacted at various stages of growth. This expertise can be extended beyond the clinic by engaging in cross-sector involvement in the community.

Team-based or collaborative care models involving medical providers, schools, and community partners are a crucial and necessary component of supporting pediatric health. Understanding the resources and care systems at play in local school districts, universities, and community organizations can help pediatric health clinicians to better support their patients in all places that they live, learn, work, and play. Cross-sectoral partnerships can form a safety net for youth at risk of suicide.

Building Community Partnerships

There are many organizations and individuals that can serve as key partners and natural champions in supporting youth mental health and addressing suicide prevention in your community:

Schools, Colleges, and Universities	Community, Faith, or Parent Organizations	Sporting, Scouts, or Youth Groups	Medical Professionals or Groups	Juvenile Justice System	Child Welfare System	Lawmakers or Policy Organizations
						

Click here to access the *Blueprint for Youth Suicide Prevention*, which provides tips and strategies for engaging with these partners.

When building new partnerships, consider these 5 steps for success:

Identify Key Partners	Understand the Landscape	Find Shared Goals	Consider Strengths	Define Success
Many partners play a role in suicide prevention. Consider: schools, clubs, scouting/sports organizations, religious institutions, mental health organizations	Before launching a new partnership, understand the scope of youth suicide risk in your community, and identify the individuals/groups already working in this space. Seek input from key stakeholders, including youth and individuals with lived experience	Identify shared priorities for suicide prevention: for example, increasing identification of youth at risk, or improving supports for mental health	Consider operational differences and individual strengths, and identify ways to leverage individual strengths to work toward shared goals	Agree upon metrics for success, and track progress toward these metrics over time

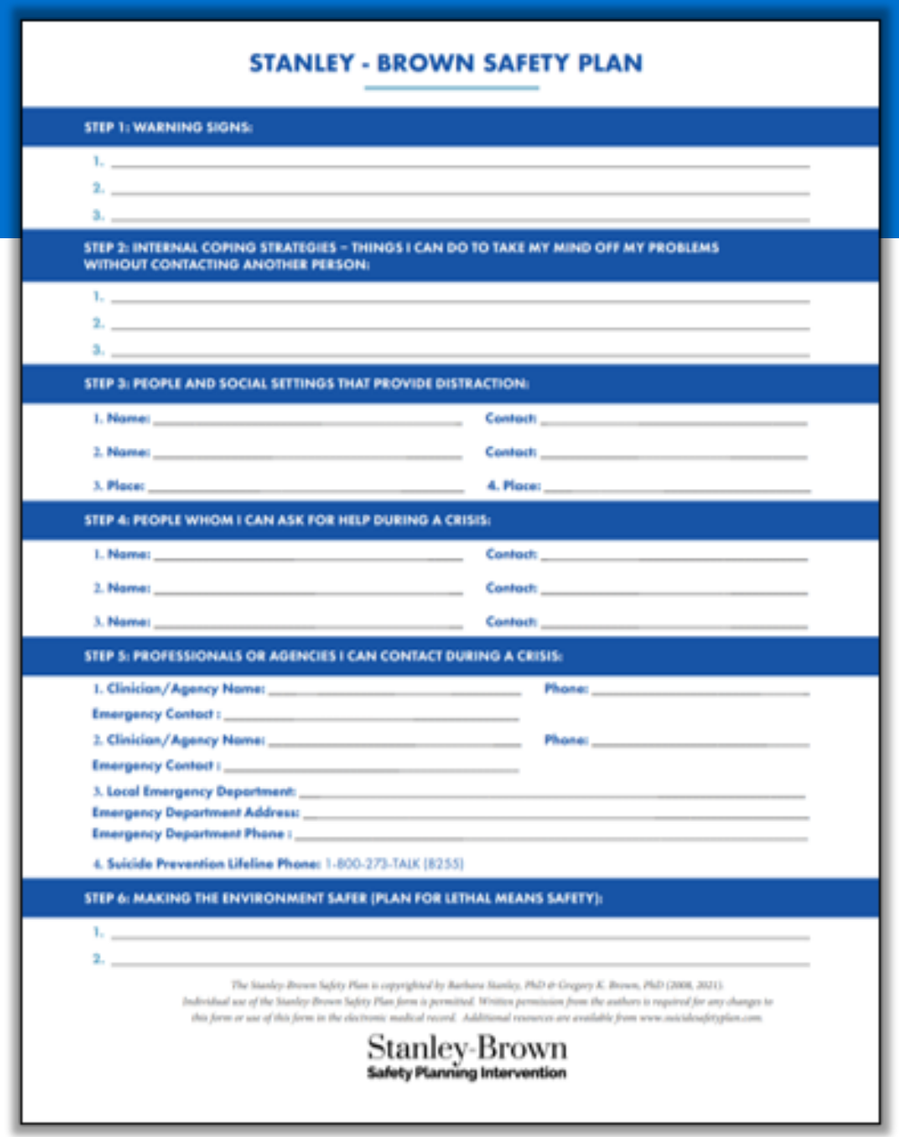
A Few Brief Interventions That Can Make a Difference

3 Brief Interventions That Can Make a Difference

1. **Safety Planning**
2. **Lethal Means Safety Counseling**
3. **Provide 988**

Safety Planning

- Warning Signs
- Coping Strategies
- Social Contacts for Support
- Emergency Contacts
- Reduce Access to Lethal Means



STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Place: _____ 4. Place: _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Name: _____ Contact: _____

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
2. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
3. Local Emergency Department: _____
Emergency Department Address: _____
Emergency Department Phone : _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

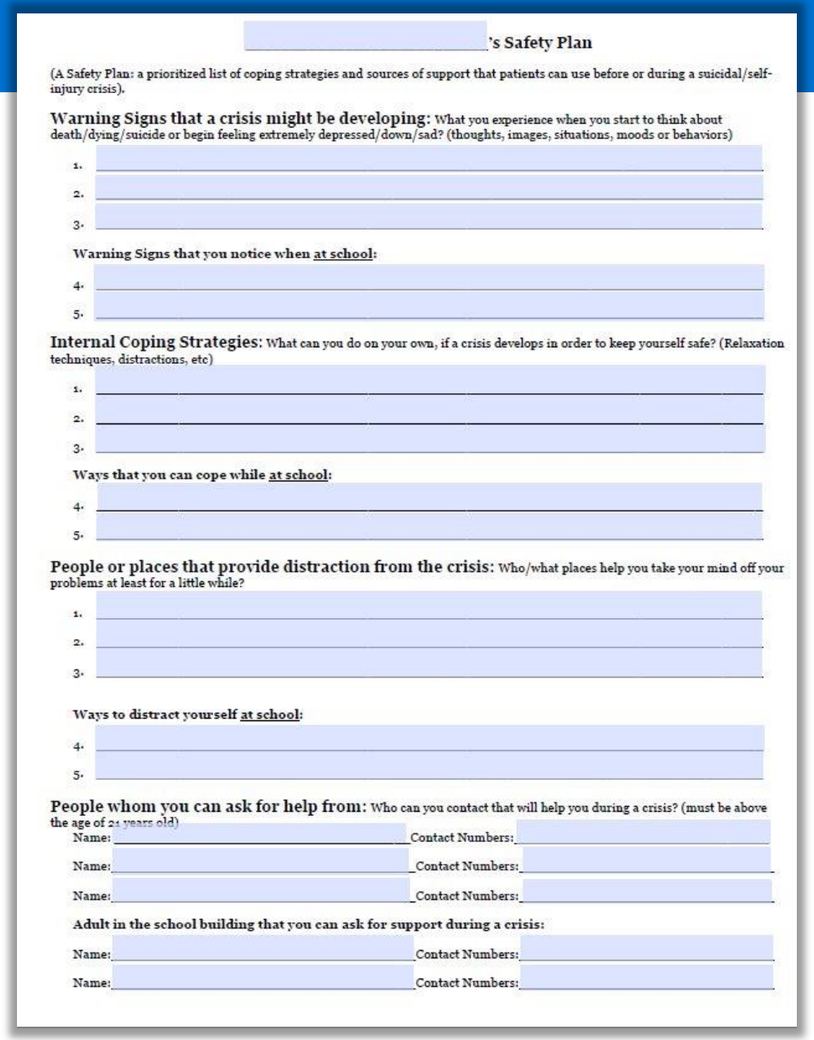
1. _____
2. _____

The Stanley-Brown Safety Plan is copyrighted by Barbara Stanley, PhD & Gregory K. Brown, PhD (2008, 2021). Individual use of the Stanley-Brown Safety Plan form is permitted. Written permission from the authors is required for any changes to this form or use of this form in the electronic medical record. Additional resources are available from www.suicidesafetyplan.com.

Stanley-Brown
Safety Planning Intervention

Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice, 19(2), 256-264.

Safety Planning - Schools



_____'s Safety Plan

(A Safety Plan: a prioritized list of coping strategies and sources of support that patients can use before or during a suicidal/self-injury crisis).

Warning Signs that a crisis might be developing: What you experience when you start to think about death/dying/suicide or begin feeling extremely depressed/down/sad? (thoughts, images, situations, moods or behaviors)

1. _____
2. _____
3. _____

Warning Signs that you notice when at school:

4. _____
5. _____

Internal Coping Strategies: What can you do on your own, if a crisis develops in order to keep yourself safe? (Relaxation techniques, distractions, etc)

1. _____
2. _____
3. _____

Ways that you can cope while at school:

4. _____
5. _____

People or places that provide distraction from the crisis: Who/what places help you take your mind off your problems at least for a little while?

1. _____
2. _____
3. _____

Ways to distract yourself at school:

4. _____
5. _____

People whom you can ask for help from: Who can you contact that will help you during a crisis? (must be above the age of 21 years old)

Name: _____ Contact Numbers: _____

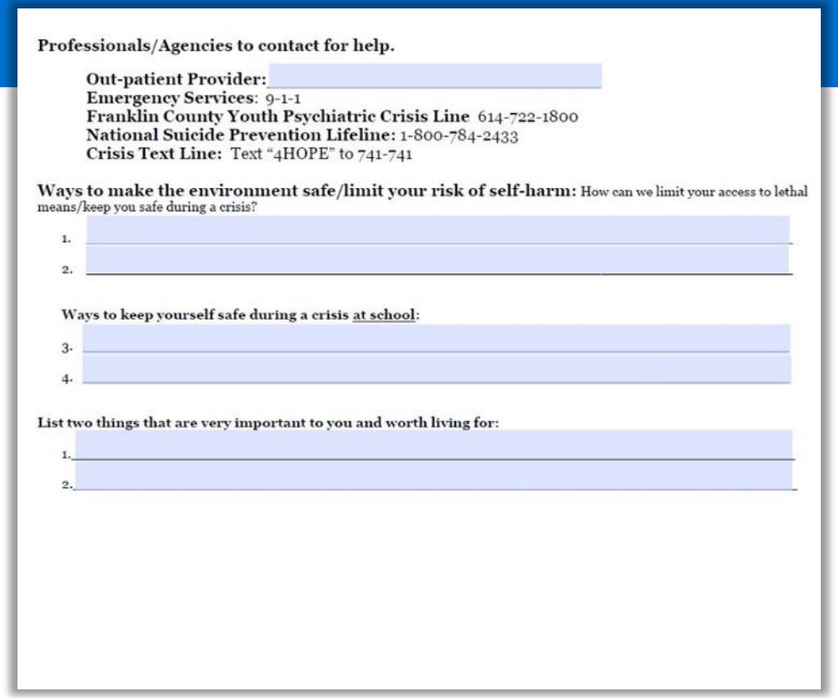
Name: _____ Contact Numbers: _____

Name: _____ Contact Numbers: _____

Adult in the school building that you can ask for support during a crisis:

Name: _____ Contact Numbers: _____

Name: _____ Contact Numbers: _____



Professionals/Agencies to contact for help.

Out-patient Provider: _____
Emergency Services: 9-1-1
Franklin County Youth Psychiatric Crisis Line 614-722-1800
National Suicide Prevention Lifeline: 1-800-784-2433
Crisis Text Line: Text "4HOPE" to 741-741

Ways to make the environment safe/limit your risk of self-harm: How can we limit your access to lethal means/keep you safe during a crisis?

1. _____
2. _____

Ways to keep yourself safe during a crisis at school:

3. _____
4. _____

List two things that are very important to you and worth living for:

1. _____
2. _____

Slide courtesy of John Ackerman, PhD

Adapted from: Stanley & Brown, 2012

Lethal Means Safety

Depression Screening

What Happens When They Tell Us They Are Thinking About Suicide?

- Do not panic.
- Be present, actively listen, express empathy.
- Provide hope and name strengths (e.g., “You have been through a lot, and I see how resilient you are”).
- Connect with a mental health professional as soon as possible.
- Make sure every child has a trusted adult.
- Safety plan, lethal means safety, 988.

How to Talk to Parents After You Detect Suicide Risk

- “After speaking with “Jason,” I have some concerns about his safety. I am glad he told me about his thoughts, because this can be a difficult topic to talk about.”

- “Jason said… Is this something he has shared with you?”

Cultural Responsivity

Ways to Engage Someone You Are Concerned About

- “I notice you have not been yourself lately. Is there something bothering you?”
- “I’m sorry you are feeling so bad”
- “I know you feel awful right now – I promise you will not always feel this way.”
- “Let’s get you some help”

Helping Parents Strengthen Connections With Their Child

- Try to Set the Stage
- Increase Opportunity (e.g., Meals, Car Rides)
- Similar to Talks About Drugs/Alcohol/Safe Sex
- Be Present and Curious
- Listen More, Talk Less!
- Guide by Example (Self-Care)
- Advocate When Appropriate
- From “Manager to Consultant”

Asking About Suicide Risk

- Ask if you believe the person is at risk for suicide.
- Acknowledge this is a difficult conversation to have.
- Asking is awkward; that is okay!
- Do not ask as though you are looking for a “no” answer (“You aren’t thinking of killing yourself, are you?”).
- Do not use language such as “committed suicide” or “successful suicide” or “failed suicide.”

School & Community Training Objectives

- Learn about youth suicide.
  - National, local statistics.
  - Risk factors and warning signs.
- Discuss effective strategies for responding to youth at risk for suicide.
  - Protective factors, coping skills, and effective support strategies.
- Discuss suicide screening, risk assessment, and safety planning with students.
- Highlight the role of stigma and media/social media in suicide contagion and suicide prevention.

Core Best Practice Elements

- Trusted Adult Trainings
  - All Staff
  - Caregiver
  - Community
- Student Education and Peer Support
- Suicide and Depression Screening

Suicide Prevention in Schools: Advantages

- Implemented by School Staff
- Engages Existing Supports Including School Staff, Parents, Peers, Community
- Incorporates Many Best Practice Elements
- Increases Dialogue Around Mental Health
- Reduces Stigma
- Sustainable

What Makes it Effective?

- **INCREASE**
  - **Help-seeking behavior** for student and how to get help for their friend.
  - **Engagement** of caregivers and school staff as partners in prevention.
- **DECREASE**
  - **Student risk** by teaching them about depression and suicide warning signs.
  - **Stigma** – Just like physical illness, mental illness requires timely treatment.

What Does Effective Staff Support Look Like?

- Scheduled check-ins with child and parents.
- Validate the student's emotional experience.
- **If a youth displays any suicide warning signs, designated staff should always notify parents.**
- Encourage meaningful activities, regular routines, support networks.

School Programs: Signs of Suicide Prevention

- Evidence-based suicide prevention program that teaches students and staff to identify and respond to suicide risk
  - Teaches action steps to students and adults when encountering suicidal behavior
  - Improved awareness and confidence of school staff
  - Increases student knowledge, awareness, and help-seeking
- Acronym (ACT)
  - Acknowledge
  - Care - show that you care
  - Tell a trusted adult

988 Suicide & Crisis Lifeline

- Call, text, or chat.
- Over 6 million contacts a year.
- On average takes 33 seconds for a call to be answered (average length 13 min), takes 4 minutes for a text to be answered (55 min conversation).
- 4% of 988 contacts result in “active rescue”, an in-person police or mobile crisis presence as a result of the call.
    - Half of these active rescues were a result of the caller asking for a visit due to an already in-progress suicide attempt or caller request for in-person presence.

988 | SUICIDE & CRISIS LIFELINE

Training in Evidence-Based Practice

- Online introduction to Collaborative Assessment and Management of Suicidality (CAMS-Dr. Dave Jobes) training for graduate students and supervisors.
  - In clinical, counseling, school psychology, social work, and advance practice nursing.
- Full CAMS training provided to clinical staff at Counseling Center and Behavioral Health.

Gatekeeper Trainings

- Designed to help everyone have conversations about people in their community.
  - UK Specific Training: UK CAN HELPS.
    - Required part of orientation class.
- QPR training: in person and online (free for Kentuckians) https://kyqpr.ukhc.org/

Fostering Resilience

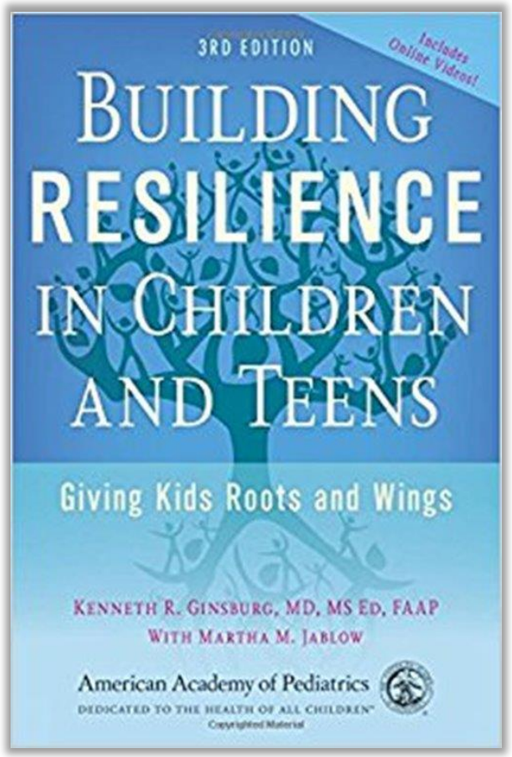
“What is good for our most vulnerable people is good for ALL people”

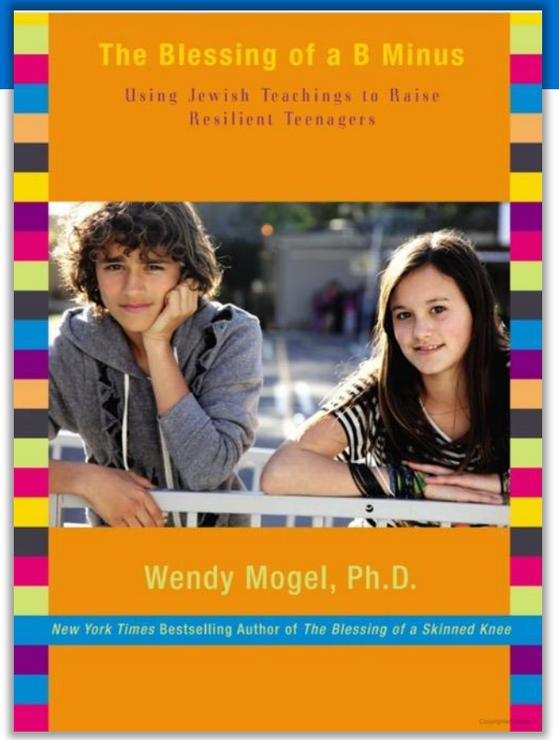
Resilience Is Not the Absence of Struggle… It's Messy.

- Does not mean immediately being okay.

What Is Resilience?

- The ability to bounce back from setbacks and thrive, grow and be effective in the face of adversity, challenges, and change.

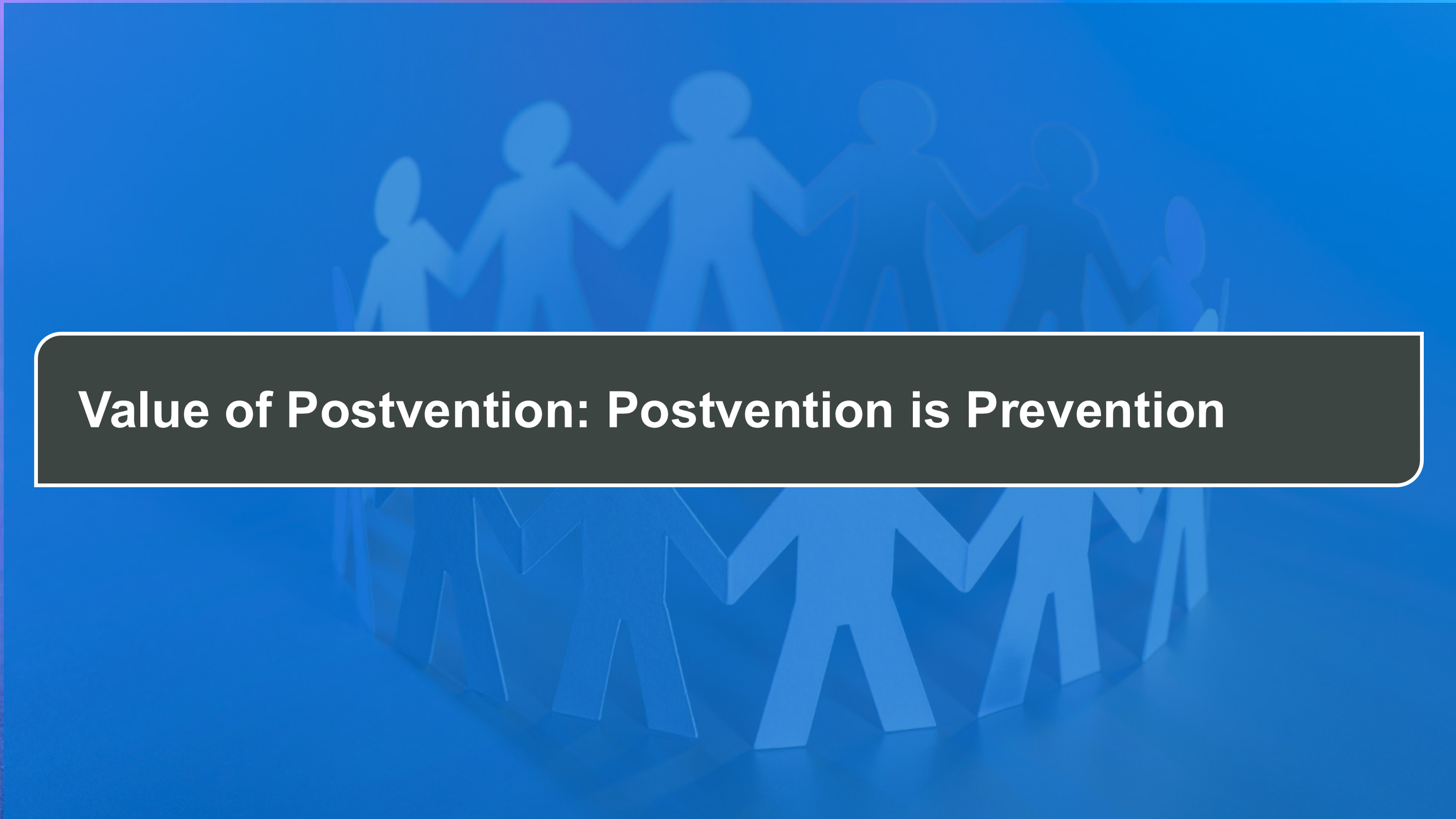




What Is Resilience?

1. Competence
2. Confidence
3. Connection
4. Character
5. Contribution
6. Coping
7. Control

Self-Care and Well-Being



Value of Postvention: Postvention is Prevention

Goals of Postvention

- Promote healthy grieving for students.
- Restore equilibrium of school and functioning of staff and students.
- Commemorate the student that died.
- Provide comfort to those who are grieving.
- Reduce the risk of contagion.
- Minimize psychiatric outcomes of distress.
    - Depression, PTSD, complicated grief, suicidal behavior.

Suicide Contagion

- Adolescents exposed to suicide are at increased risk.
- Imitative suicides account for up to 5% of teen suicides.
- Media coverage can influence suicide rates positively AND negatively.

Guiding Principles of Postvention

- Treat student deaths similarly regardless of cause.
- Students are vulnerable to risk of suicide contagion.
  - Identify and provide support to at-risk students.
  - Avoid romanticizing or glamorizing the death.
  - Focus on life of the deceased and resources for help, not the method of suicide or details that promote identification.

Guiding Principles of Postvention

- Suicide is complicated – no one cause.
- Emphasize a message that suicide is often preventable but avoid blaming.
- Encourage ongoing suicide prevention efforts.

Patient Examples

Summary

- Suicide risk screening provides an opportunity to start a difficult but critical conversation - ask directly.
- School counselors/staff are valuable partners in a public health approach to suicide prevention.
- It is crucial to further triage the screening questions and determine appropriate next steps.
  - Suicide Risk Pathway- 3-tiered system:
    - Brief screen.
    - Further triage.
    - Identify next steps.
- Three interventions that make a difference.
  - Safety Planning.
  - Lethal Means Safety Counseling.
  - 988.

You Can Do This!

Everyone can help save a life.

Helpful Resources

- **Online Resources**
  - Teen Suicide Prevention Video – Mayo Clinic
  - ASQ Screening Tool
  - Signs of Suicide (SOS) Screening Forum
  - Safety Planning Sheet
  - QPR Training
  - Suicide & Crisis Lifeline - 988

- **Referenced Books**
  - *Building Resilience in Children and Teens,* Kenneth R. Ginsburg
  - *The Blessing of a B Minus,* Dr. Wendy Mogel

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How Vector Solutions Can Help

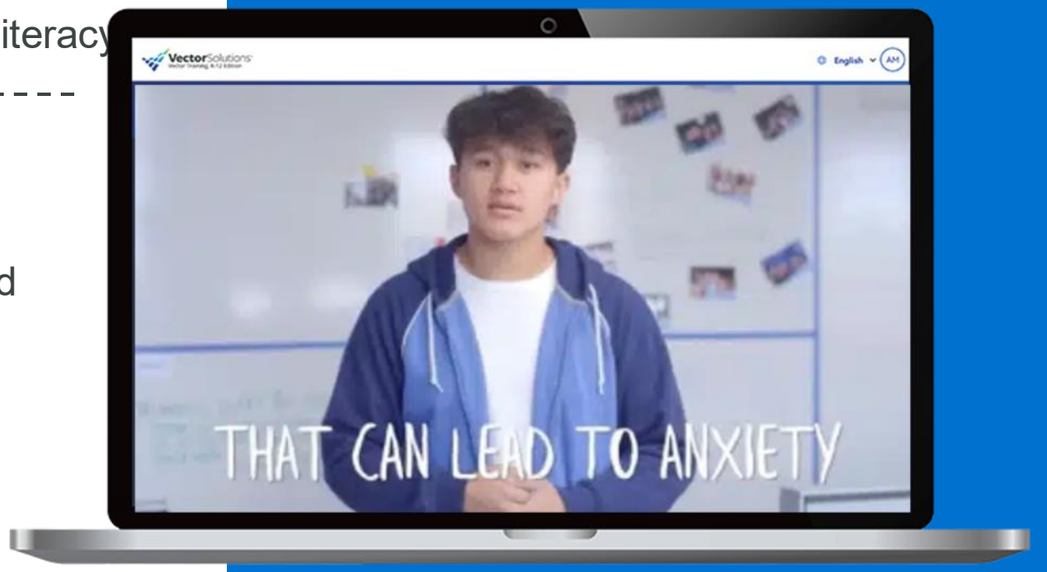
Positively Impact School Culture & Improve Student Outcomes

Student Wellness & Success Program - Grades 6-12

- **Mental Health & Well-Being:** Stress & Anxiety, Self-Harm, Suicide Risk, Substance Misuse, and More
- **Healthy Relationships:** Bullying & Cyberbullying, Resolving Disagreements, Sexual Harassment, and More
- **Personal Resilience & Safety:** Good Decision Making, Trauma Awareness, Sexual Abuse Awareness
- **Career Readiness & Life Skills:** Career Exploration, Goal Setting, Financial Literacy and More

Platform Features

- **Educator Resources:** CASEL Aligned. Facilitator's guides and lesson plans.
- **Course Customization:** Add school or district-specific policies, resources, and content.
- **Assessments:** Measure and assess learning outcomes.
- **Pre-and Post-Course Surveys and Reporting:** Measure course impact and gain insights about learner attitudes, beliefs, behaviors, and experiences.
- **Student Climate Surveys:** Gather feedback on students' perceptions and experiences regarding essential topics like:



Ensure Compliance, Strengthen Safety, and Improve Instruction with 600+ Expert-Authored, Online Courses and Powerful Course Features in ONE Place

Improve Safety, Focus on Prevention, Address Compliance, and Reduce Risk

- Safety & Compliance
- Child Sexual Abuse Prevention
- School Bus Safety Company
- Athletics Health & Safety

Protect Your Staff and the Physical and Digital Assets Across Your District

- Facilities Maintenance
- Cybersecurity Awareness

Equip Educators to Meet the Unique and Evolving Learning Needs of Today's Students

- Inclusive Instruction & Interventions
- Positive School Climate

Q&A

Note: If your question doesn't get answered during the allotted time, we will follow up by email.

Additional Questions? Visit us at VectorSolutions.com/K12

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Thank You!
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