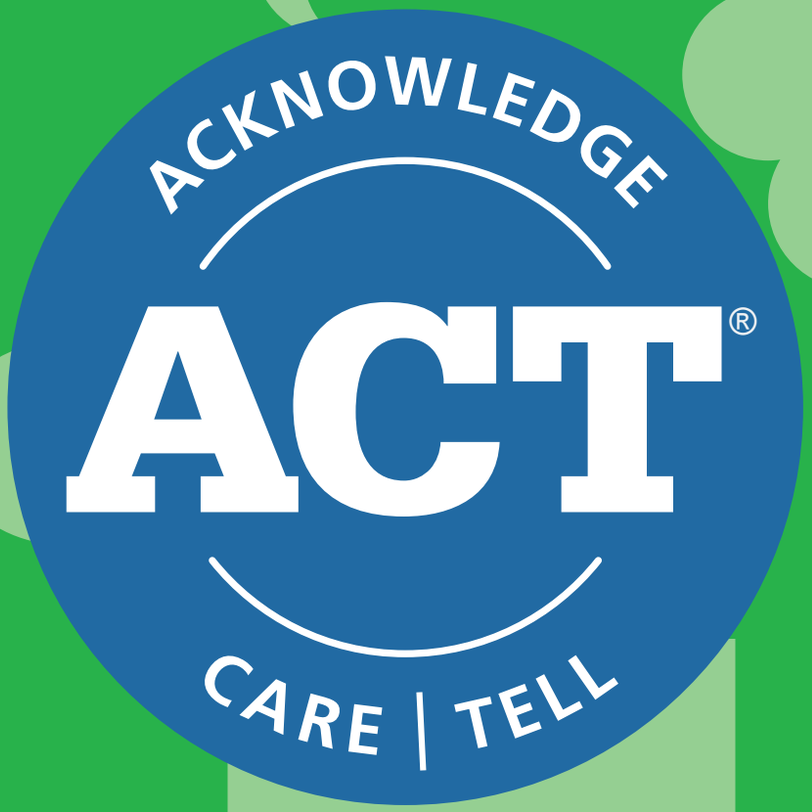
SOS Signs of Suicide® Prevention Program

Middle School Program Implementation Guide and Resources



Acknowledge:
Listen to your friend, don't ignore threats

Care:
Let your friend know you care

Tell:
Tell a trusted adult that you are worried about your friend

A Program of Screening for Mental Health, Inc.

SMH Screening for Mental Health®

SOS Signs of Suicide® Suicide Prevention Program

MS 8-16M

SOS Signs of Suicide®
MIDDLE SCHOOL PREVENTION PROGRAM

Implementation Guide and Resources

Douglas Jacobs, MD
Founder and Medical Director

SMH Screening for Mental Health®

— A special thanks to the SOS PROGRAM SUPPORTERS —

American Academy of Child and Adolescent Psychiatry
American Academy of Nurse Practitioners
American Counseling Association
American School Counselor Association
American School Health Association
Center for Clinical Social Workers
National Association of School Nurses
National Association of School Psychologists
National Association of Secondary School Principals
National Association of Social Workers
National Association of Student Councils
National Student Assistance Association
School Social Work Association of America
United Educators Insurance

Acknowledgements: Original Planning Committee

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William Beardslee, M.D.
Children's Hospital
Boston, MA

Cynthia Bucken
Nipmuc Regional Middle/High School
Upton, MA

Ellen Courshene
Wellesley Middle School
Wellesley, MA

Laurie Curley, PhD
JFK Middle School
Hudson, MA

Kathy Farnsworth
Robert E. Melican Middle School
Northborough, MA

Deborah Hardy, Ed.D, Ed.M., M.S.
Irvington Middle School
Irvington, NY

Jon Hisgen, MS, CHES
Wisconsin Department of Public Instruction
Madison, WI

Kay Hurley
Sarah W. Gibbons Middle School
Westborough, MA

Karen Ingerman
Remington Middle School
Franklin, MA

Joann Kenney
Dover Sherborn
Regional Middle School
Dover, MA

Cheryl King, PhD
University of Michigan Depression Center
Child and Adolescent Depression Program
Ann Arbor, MI

Richard Lieberman, NCSP
Los Angeles Unified School District
Los Angeles, CA

Tara Manke, PhD
Stacy Middle School and Middle School
East Milford, MA

Elaine Mitsocke
Robert H. Adams Middle School
Holliston, MA

Julie Phipps
Robert E. Melican Middle School
Northborough, MA

Scott Poland, NCSP
NOVA Southeastern University
Fort Lauderdale, FL

Jefferson Prince, M.D.
Massachusetts General Hospital
and North Shore Medical Center
Boston, MA

Barent Walsh, PhD
The Bridge of Central MA
Worcester, MA

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Larry Berkowitz
Joanna Hooper
Jim McCauley
Riverside Trauma Center
Needham, MA

Tricia Buonacore
Littleton Middle School
Littleton, MA

Rebecca Davis
Douglas Jacobs
Candice Porter
Screening for Mental Health
Wellesley, MA

Julie Gagnon
Cathy Keene
Katherine Mariani
Overlook Middle School
Ashburnham, MA

Christopher P. Lucas
New York University
New York, NY

Marian McCord
CHADS Coalition
St. Louis, MO

Joanne Meyers
Elyssa's Mission
Northbrook, IL

Luis Morales
CHEC Middle School
Washington, DC

Kari Patterson
Concord Middle School
Concord, MA

Scott Poland
NOVA Southeastern University
Ft. Lauderdale, FL

Jan Ulrich
State of Kentucky
Frankfort, KY

Barent Walsh
The Bridge of Central MA
Worcester, MA

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Section 1: Overview

Introduction

Welcome and congratulations for championing the youth suicide prevention effort in your school and community by participating in the SOS Signs of Suicide® Middle School Program (SOS Program). The program helps adults and students demystify the confusion around what constitutes normal development and what may be a potentially serious mental health issue.

The program highlights the relationship between depression and suicide, teaching that suicide is, most often, a fatal response to a treatable disorder—depression. Through the SOS Program, school staff, students, and their parents will learn about depression, suicide, self-injury, and the associated risks of alcohol use. SOS teaches the action steps individuals should take should they encounter the signs of depression or suicide within themselves or on behalf of a friend: **ACT**: **A**cknowledge that your friend has a problem, tell the person you **C**are, and **T**ell a trusted adult.

We hope that you will see the success of the program through healthier and better-educated students, parents, and staff who are more prepared to address mental health issues including the symptoms of depression, suicidality, and self-injury. Through your participation, you have taken an important step towards protecting youth by identifying those who may be at-risk for mental health problems, and encouraging help-seeking and appropriate treatment.

We wish you great success in your prevention efforts. Please don't hesitate to contact our office if we can assist you.

Program Rationale and Goals

The strongest risk factors for suicide in youth are depression, substance use, and a history of previous attempts. According to the Centers for Disease Control and Prevention, suicide is the 2nd leading cause of death of children and adolescents ages 11-18 in the United States (CDC, 2013). In 2010, 8 percent of youth (about 1.9 million people) age 12-17 in the U.S. had experienced a major depressive episode during the past year (SAMHSA, 2012). In children and adolescents, an untreated depressive episode may last 7 to 9 months, an entire academic year (U.S. Department of Health and Human Services, 1999). Depression has been linked to suicide, poor school performance, substance use, running away, and feelings of worthlessness and hopelessness.

The SOS Middle School Program was created to assist you in addressing the problems of youth depression and suicide simultaneously and age appropriately. The program uses a universal approach to assist in identifying at-risk youth. The goals of the program are to:

- Decrease suicide and suicide attempts by increasing knowledge and adaptive attitudes about depression among students
- Encourage individual help-seeking and help-seeking on behalf of a friend
- Link suicide to mental illness that, like physical illnesses, requires treatment
- Address the key risk factors associated with self-injury and suicide
- Engage parents and school staff as partners in prevention by educating them to identify signs of depression, self-injury, and suicidality in youth, and provide referral resources
- Reduce stigma associated with mental health problems as they become topics for discussion that are integrated in the health curriculum, and conditions that are responsive to treatment
- Increase self-efficacy and access to mental health services for at-risk youth and their families
- Encourage schools to develop community-based partnerships to address issues associated with student mental health

Research indicates that youth are more likely to turn to peers than adults when facing a suicidal crisis. The SOS Program incorporates peer-to-peer intervention as the model of its implementation strategy. By training students to recognize the signs of depression and suicidality, and empowering them to intervene when confronted with a friend who is exhibiting these symptoms, the SOS Program capitalizes on an important social/emotional aspect of this developmental period. For students, the program goals are to:

- Help youth understand that depression is a treatable illness
- Educate youth that suicide is not a normal response to stress, but rather a preventable tragedy that often occurs as a result of untreated depression
- Inform youth of the risks associated with alcohol use to cope with feelings
- Increase help-seeking by providing students with specific action steps to take if they are concerned about themselves or others and identifying the resources available to them
- Encourage students and their parents to engage in a discussion about these issues
- Encourage peer-to-peer communication about the ACT help-seeking message

One of the most important factors determining if a prevention program is maintained is support from three groups: administrators, teachers, and parents. Persons who are informed about youth suicide are more apt to have a positive impact on students than those who are not educated. The ability to recognize warning signs and to interpret them as indicators that a child may need assistance reduces the risk that parents, educators, and community members will misinterpret student behavior or react inappropriately. For this reason, materials are provided to help gain the support of parents and school staff and educate them about the warning signs of depression, self-injury, and suicide and the action steps they should take if they encounter a youth who may be at-risk.

Program Materials

SOS DVD and Discussion Guide
The SOS *Time to ACT* video is the main teaching tool of the SOS Program. The aim of the video is to create a supportive and responsive atmosphere for those youth who may be at risk for depression, suicide, or self-injury by empowering them to recognize the warning signs and seek help. The video is approximately 19 minutes in length and is accompanied by a Discussion Guide that includes topics for classroom discussion led by a school health professional or counselor.

The main help-seeking message of the video is **ACT: A**cknowledge, **C**are, **T**ell.

- **A**cknowledge that you are seeing signs of depression, suicide, or self-injury in a friend and that it is serious
- **C**are—Let your friend know that you care about him or her, and that you are concerned that he or she needs help that you cannot provide
- **T**ell a trusted adult, either with your friend or on his or her behalf

There are 3 sections of the video:

- **Vignettes:** Dramatizations that show adolescents who are showing signs of depression and the words and actions others might use to help. Each vignette includes a friend or family member who is trying to help— first the wrong way (i.e. getting angry, not taking the person seriously, or blaming them, etc.), and then the correct way (i.e. telling them that they are concerned and that they need to speak with a trusted adult).
- **Group Discussion:** Middle school students discuss the topics of depression, suicide, bullying, self-injury and getting help.
- **Student Interview with a School-based Counselor:** The video's host models speaking with a trusted adult.

The SOS Screening Form: Brief Screen for Adolescent Depression (BSAD)
A brief, validated, seven-question screening tool for adolescent depression is completed and scored.

NOTE: Results from the BSAD are not diagnostic, but indicate the presence, or absence, of symptoms that are consistent or inconsistent with depression or suicide. Negative responses to the questionnaire do not rule out depression/suicidality and positive responses do not conclusively establish depression/suicidality. A thorough diagnostic evaluation by a healthcare professional is always necessary to determine whether or not there is the presence/absence of depression/suicidality. Parents should be contacted immediately by phone if a student is deemed at-risk for suicide.

Your program includes the following:

- The SOS Student Screening Form (BSAD) with Scoring Instructions
- Spanish-language templates of both screenings are included in this manual (please see Materials for Reproduction—Spanish Language Templates)
- Parent Screening Form (BSAD) with Scoring Instructions in Section 6. This tool is also available:
    - o In hard copy: contact our office to order
    - o In PDF form, along with other program materials, in our free downloadable resources

ONLINE: The Parent BSAD Online Screening Tool allows schools to provide parents with the opportunity to consider their child's moods and behaviors from the privacy of their home or mobile device at any time. The screening is often hosted through the school's parent portal or website where schools customize a message to parents on the screening homepage, upload their school logo, create custom demographic questions and choose from a selection of color schemes to make the site their own. Most importantly, schools customize the school and community resources provided at the end of the screening. School administrators can gain insight into student mental health through the BSAD's comprehensive reporting feature, which anonymously tracks screening data. Contact Screening for Mental Health at 781-239-0071 for more information.

Training Trusted Adults DVD
This DVD for staff, parents and community members explains the elements of the SOS Program. It's an educational tool that details the issue of depression and suicide among youth and emphasizes the important role parents and school personnel can play in helping at-risk students.

Plan, Prepare, Prevent: The SOS Online Training Module
The online module offers school professionals a 90-minute interactive course for planning and implementing the SOS Program. Continuing Education credits may be available for free for school social workers, school nurses, guidance counselors, and school psychologists. Visit www.mentalhealthscreening.org/gatekeeper

Life Teammates® Packet for Coaches
Tools to help coaches reinforce the ACT messaging with student athletes and help build "Life Teammates."

Student Newsletter
Using short articles, the Student Newsletter provides reinforcement for the ACT message, information about the warning signs of depression and suicide, the risks associated with using alcohol and drugs, strategies for dealing with cyber-bullying, and ways to enhance resilience when facing stress.

Parent Newsletter
The Parent Newsletter is designed to increase skills and confidence among parents in recognizing and responding to signs of depression, bullying, self-injury, and suicidality among their children. The newsletter also serves to encourage parents to initiate a discussion about these concerns with their children and instill confidence for seeking treatment for their children, if needed.

Interactive Classroom Games
Classroom games serve to increase student knowledge and skills about a topic. Games that have learning complexity and are successfully infused into the curriculum are a highly effective strategy in getting students to move the knowledge and skills they received into long-term memory. Four games have been provided to reinforce the teaching points of the SOS *Time to ACT* video and the information provided in the Student Newsletter.

Student Response Cards and Template
These cards provide students with an opportunity to request follow-up with an adult (See Materials for Reproduction-Students to make additional copies). To customize with expected response time, reproduce, cut into individual cards and provide to students to enable them to request follow-up.

Posters
Reinforce the ACT message.

ACT Stickers
Distribute to participating students. The stickers are designed to promote peer-to-peer communication by making the ACT message popular, personal and powerful, as participating students build awareness around the ACT help-seeking message among their peers.

Follow-Up Form Template
(See Materials for Reproduction, Section 6) To reproduce for staff to track those students seeking follow-up as a result of participating in the program.

Wallet cards
For students that can be customized to include local hotline numbers and other information about where to seek help.

Self-Injury Packet for Staff
(See Additional Resources, Section 7)

Self-injury is a maladaptive coping skill for youth experiencing intense emotions and is generally not an attempt to die by suicide. Between 150,000 and 360,000 adolescents in the U.S. self-injure. Many are unaware that while self-injury may appear to be an attempt at suicide, it is most often not. However, self-injury is a risk factor for suicide because death can occur as a result of self-injury, even if that was not the intention, and those who self-injure may become suicidal in the future.

The packet helps raise awareness about the signs of self-injury and to establish action steps for teachers, parents and school-based clinicians when dealing with an individual who is self-injuring. Reproduce and distribute the materials designated for teachers, parents of students who self-injure, and school-based clinicians as part of your prevention efforts.

Valuable Resources Flyer
To supplement your SOS Program. This one page flyer provides links for more information on postvention in the aftermath of a suicide (http://www.sprc.org/sites/sprc.org/files/library/AfteraSuicideToolkitforSchools.pdf) and school connectedness (http://www.cdc. gov/healthyyouth/protective/pdf/connectedness.pdf).

Section 2: Planning

SOS Signs of Suicide Prevention Program Readiness Checklist

Before implementing a universal peer-to-peer suicide prevention program with students, schools should review this Readiness Checklist and consider areas that need to be addressed. If your school has never implemented a suicide prevention program, you may answer "No" to a number of questions. Please refer to the materials provided in your SOS Program or contact Screening for Mental Health Youth Programs at youth@mentalhealthscreening.org to discuss ways to prepare your school leadership, faculty, staff and community for universal suicide prevention programming and depression screening.

READINESS CHECKLIST

- ☐ Does your school currently have a suicide prevention plan in place?
- ☐ Are teacher and staff education and/or training one component of your school's suicide prevention program?
- ☐ Does your school provide training sessions to all staff, including coaches, bus drivers, maintenance/janitorial staff, and cafeteria workers about adolescent suicide warning signs and risk factors, and what to do if approached by a student who may be at-risk for suicide?
- ☐ Has your school decided on the most effective strategy(ies) to disseminate suicide prevention information about adolescent suicide warning signs and risk factors?
- ☐ Has your school decided on the most effective strategy(ies) to disseminate suicide prevention information about faculty/staff response if approached by a student who may be at-risk for suicide?
- ☐ If your school does provide training sessions, is there a designated trained individual or individuals who provide these training sessions and is there a targeted audience?
- ☐ Does your school staff know the warning signs and risk factors for suicide?
- ☐ Does your school staff know the myths surrounding adolescent suicide?
- ☐ Does your school staff know the facts about youth suicide?
- ☐ Are there procedures in place that provide information to parents about adolescent suicide, such as at parent-teacher meetings or parent-teacher association meetings?
- ☐ Are written procedures currently in place that help guide faculty, staff, and students about how to respond to a suicidal threat or crisis?
- ☐ Does your school leadership review and maintain the school's emergency procedures and are written policies in place for responding to at-risk youth?
- ☐ Do emergency procedures include protocol for notifying parents and providing emergency health care services?
- ☐ Does your school staff know what to do and who to contact (at your school) if they come in contact with a student who expresses suicidal thoughts or expresses suicidal threats?
- ☐ Does your school have a list of community agencies and resources that could provide help and assistance to a student at-risk for suicide?
- ☐ Is there a person within your school, such as a guidance counselor, social worker or school psychologist, who is assigned the responsibility of maintaining and reviewing the list of referral sources for students at-risk for suicide?
- ☐ Is there a person within your school, such as a guidance counselor, social worker or school psychologist, who is assigned the responsibility of coordinating student referrals to outside mental health providers in crisis and non-crisis situations?
- ☐ Is there a person within your school, such as a guidance counselor, social worker or school psychologist, who is assigned the responsibility of maintaining and reviewing suicide prevention efforts at the school?
- ☐ Is there a person within your school, such as a guidance counselor, social worker or school psychologist, who is assigned the responsibility of notifying the nearest emergency room and/or mental health facility about universal depression screening to ensure that staff at these facilities will be available to evaluate emergency patients on the day of the program?
- ☐ Does your school have a licensed mental health professional (school nurse, school counselor, psychologist, social worker, licensed mental health counselor, psychiatrist, or physician) available not only to assist with program implementation, but also to handle clinical emergencies that may arise?

Planning Your Program: Planning Checklist

- ☐ Identify a project coordinator and team members who will implement the program and follow up with students identified as at-risk.
- ☐ Meet with all program team members to cover what participation in the SOS Program entails. Project coordinator and team members can each take the 90-minute online training module for further education on suicide prevention and the SOS Signs of Suicide Prevention Program.
  Visit www.mentalhealthscreening.org/gatekeeper
- ☐ Have all participating staff familiarize themselves with the kit materials.
- ☐ Assign roles and areas of responsibility within your team (logistics within the school, obtaining parental permission, planning for pre-program parent education program and staff in-service, determining staffing and administrative needs, preparing and distributing referral resource information, providing follow-up, storing records, etc.).
- ☐ Know your school or district procedure for dealing with potentially suicidal students and review the protocol with all staff.
- ☐ As a student in distress may disclose to any adult, ensure that all staff and school personnel are aware of the program and know how to recognize warning signs of youth suicide and respond to those who may approach them seeking help. Consider conducting a staff in-service training (see Educating Staff and Parents, Section 3). Utilize the *Training Trusted Adults* DVD and discussion guide.
- ☐ Designate date(s) and times during which the program will take place. Work with school administration to plan for and accommodate the program.
- ☐ Contact local mental health facilities and related organizations that help youth. Let them know you plan to implement the SOS Program. Alert them to the dates and times of your program and verify referral procedures, wait lists, sliding scale fees and information for the uninsured.
- ☐ Create a referral list to distribute to parents so that they are aware of the mental health services available within the school and community. Visit the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Services Locator (www.findtreatment.samhsa.gov) or call SAMHSA's Toll-Free Referral Helpline at 1-800-662-HELP (1-800-662-4357) to identify other mental health resources in your community.
- ☐ Review your school or district's requirements for parental permission and take appropriate steps to implement them. Consider hosting a parent night to help streamline safe messaging to parents. Utilize the *Training Trusted Adults* DVD and discussion guide.
- ☐ Prepare information to send to parents about the program. Consider hosting a parent night event (see Educating Staff and Parents, Section 3). Sample passive and active consent forms are included in this guide. To access customizable/downloadable forms, contact our office.
- ☐ Have a structured plan or use the Student Follow-Up Form (see Materials for Reproduction, Section 6) to follow students who have been referred for further evaluation and/or treatment. Be sure to indicate if parents were contacted and who is responsible for making follow-up appointments with clinicians.
- ☐ Place posters in a wide variety of areas to reinforce the program's help-seeking message.
- ☐ Identify an alternative setting for those students not participating in the program.
- ☐ Preview the *Time to Act* and *Training Trusted Adults* DVDs to ensure that they are working before your program begins.

Planning Your Program

Who Implements The Program?

THE PLANNING TEAM

Whenever feasible, the best approach to school-based suicide prevention activities is teamwork that includes teachers, administrators, school nurses, and school mental health professionals working in close cooperation with community-based agencies. The first step in planning your program is identifying a project coordinator to oversee program planning and implementation. This person will champion the effort to gain support for the program where it is needed. He or she will oversee all aspects of program planning and implementation to ensure that all components of the program are addressed and/or delegated to others.

Once the project coordinator is identified, recruit a team of individuals from within your school, organization and/or local community to plan and implement a smooth, successful and clinically sound program. Your program team may be comprised of social workers, nurses, counselors, psychologists, health teachers, student assistance professionals, parent liaisons, community mental health or health practitioners who can volunteer their services to help implement the program and/or serve as referral resources. Some schools incorporate planning for the SOS Program into another regularly held meeting, oftentimes one that addresses other safe school activities. Having clearly defined and agreed upon responsibilities and holding individuals accountable for following through will increase the success of your program.

You may also choose to involve parents, students or peer helpers as part of your program team to help plan your program. Please note that while parents, students and peer helpers may assist in the planning stages of your program, they should not be directly involved in the program's implementation. Parents, students and peer helpers can provide testimonials for your program and help get more broad based support for your prevention efforts.

SECURITY ISSUES AND HANDLING EMERGENCIES

Members of the program team are responsible for reviewing the school's emergency procedures and ensuring there are written policies in place for responding to at-risk youth before the program is implemented. Plan to have a licensed mental health professional at your school throughout your program, not only to assist with program implementation, but also to handle clinical emergencies that may arise. This person may be a school nurse, school counselor, psychologist, social worker, licensed mental health counselor, psychiatrist, or physician.

Be aware of, and follow, your school's procedures for notifying parents and providing emergency health care services. Notify the nearest emergency room and/or mental health facility about the program ahead of time. Staff at these facilities should be available to evaluate emergency patients. Be sure they will be able to handle any emergencies that arise on the day(s) of your program.

Building Bridges with Community Providers

You may want to partner with local mental health providers in your community and invite them to help with your program planning, implementation and to assist with referrals. Partnering with local providers is useful for several reasons:

- Some schools may not have adequate staff to conduct the program if it is being implemented on a large-scale basis.
- Students may feel more comfortable speaking about their personal issues with an "outsider" rather than an individual with whom they interact on a daily basis.
- As an introduction to community-based mental health resources for those who pursue treatment outside of the school.
- To gain broader support in the community for your suicide prevention efforts.
- To enhance the school's referral network for follow-up with at-risk students identified through the program.

Such partnerships can be beneficial to all parties, with schools having additional resources for its prevention efforts and agencies having a consistent source of referrals. Consider contacting local and state professional and advocacy organizations (See Additional Resources, Section 7). They may be natural allies in your suicide prevention efforts.

CASE EXAMPLE

A school district in Omaha, NE prioritized partnering with community-based providers following a cluster of student suicides. They refer to this initiative as "Building Bridges With the Community." Each year, on Martin Luther King Day, the school district invites community-based professionals to a workshop dedicated to a theme of interest to both school staff and the mental health community.

In addition, the school district updates referral information about local providers at the beginning of each school year. These updated lists are then distributed to school staff. The school district also sends the contact name and information of all school counselors, social workers and psychologists at the beginning of the school year to each of these agencies.

As a result of these proactive efforts, this school district now has dedicated local providers who prioritize the schools' requests for evaluation and treatment for youth in the schools. The long wait lists and wasted time previously spent relying on outdated referral lists with little known providers no longer exists.

TIPS FOR PARTNERING:

- When asking for assistance, offer something in return. Simply increasing visibility in the community may be an adequate benefit.
- Be passionate about your efforts to reduce youth suicide. Balance urgency with success stories.
- Remind potential partners of the importance of their contribution.
- Make sure they know how the proposed partnership benefits them.
- Be specific about what you are asking them to contribute.
- Maintain regular communication and modify the relationships as needs change.
- Look for creative ways to convey your gratitude to partners and thank them publicly. For example, write a story about your community partnership for your local paper, school publication or town and school websites.

Suggestions for Program Implementation

Logistics

SETTING
In a classroom setting (recommended), students may view and discuss the SOS *Time to ACT* DVD and then complete the SOS Student Screening Forms as well as the Student Response Card in that same class.

In an assembly/classroom combined option, students can view and discuss the SOS *Time to ACT* DVD during an assembly period in the auditorium and complete the SOS Student Screening Forms and Student Response Card at a later time in a classroom setting.

These are suggestions only; all options may be conducted over several days, school-wide or class-by-class. Please feel free to design a program appropriate to your needs and resources.

WHICH STUDENTS TO SCREEN?
If your school does not have the staff and/or outside resources to offer the program to the entire student body, you may select a portion of the school population, i.e. certain grades or students in certain classes, such as health class or advisory. Alternate supervised settings must be provided for those youth who do not want to participate in the SOS Program or whose parents do not want them to participate.

THE BSAD AND ALCOHOL
Your SOS Program includes hard copies of the Brief Screen for Adolescent Depression (BSAD). This validated, seven-question survey is part of the larger Columbia DISC screening. The purpose of this tool is not to tell whether students are depressed, but rather inform them about whether they, or their friends, may have symptoms that need further evaluation.

Given the strong correlation between adolescent alcohol use and suicide attempts (Schilling et al., 2009), you may also wish to ask the following two questions relevant to alcohol when screening students (responses for both questions are yes/no):

1. In the past year, has there been a time when you had five or more alcoholic drinks in a row? (By “drinks” we mean any kind of beer, wine, or liquor.)
2. In the past year, have you used alcohol because you were feeling down?

A sample BSAD including alcohol questions is located in Section 6 Materials for Reproduction - Students. For a reproducible version of the BSAD including these two questions, please contact our office.

ONGOING SCREENING
Schools may also choose to use the screening forms and educational materials in their nursing or counseling office throughout the school year. Students can be screened before an appointment as part of the intake process when they are seeking help in that office.

ANONYMITY
The Screening Form can be administered in any setting and may either be anonymous or non-anonymous. Pros and cons for each option are listed on the following page. Your program team and school regulations should determine which option is best for your school.

Anonymous screenings may be strictly anonymous and utilize a self-scoring method, in which students complete a Screening Form and score it themselves, using the Student Scoring Instructions. The program leader discusses what different scores mean and what action steps should be considered depending on the scores.

Scoring The BSAD scoring instructions are on the back of the form. Some schools have students self-score before collecting the forms; at other schools, staff and/or mental health professionals from the community score the tool. In addition to screening in students who score high on the screening or who answer ‘yes’ to questions 4 or 5, you may consider following up with students who are unable to identify a trusted adult.

The anonymous with voluntary identification method uses the same format as described previously but adds an additional step of having each student complete the Student Response Card (see Materials for Reproduction-Students section 6). This card allows students to voluntarily identify themselves if they wish to be contacted for follow-up. In addition, the card asks if students want to talk with someone at the school about themselves or a friend, and the students must answer yes or no, sign it, and then hand in the card.

If conducting a **non-anonymous screening**, ask students to write their names or student ID numbers on the Student Screening Forms. You may also assign students designated numbers chosen at random by your program team.

NOTE: Depression and suicide may be extremely sensitive issues for some teens. If any student(s) feels overwhelmed and needs to leave the room, excuse them and make sure they have someplace safe to go where they may talk with a professional about their feelings.

STUDENT RESPONSE CARD

All students should complete a Student Response Card regardless of the screening option used. This tool provides an efficient and effective way for students to indicate if they would like to speak with an adult following the program. Students who seek to talk to a trusted adult about themselves or a friend identify themselves through the Student Response Card.

SCREENING IMPLEMENTATION OPTIONS: PROS AND CONS

	Pros	Cons
Anonymous	• Students may be more likely to answer screening questions honestly if they know their anonymIty is protected	• Program team cannot identify students needing referrals for further evaluation • Students must refer themselves unless all students are required to speak with a counselor or other clinical staff
Anonymous with voluntary identification using Response Card	• Gives students the opportunity to ask to be contacted for a follow-up meeting yet doesn't specify if it is for themselves or a friend • No one is singled out. All students must fill out form and indicate either yes or no. Students can't identify which of their classmates are asking for help	• Students may hesitate to seek follow-up appointments on their own • Adds more work for staff because it requires review of every Response Card so that those who request a meeting are not overlooked
Non-anonymous	• Program team can identify students needing referrals for further evaluation	• Students may be afraid to answer screening questions honestly if they know school personnel can identify them • More work for staff because it requires that they review every screening form the day of the program to ensure that students with high scores receive help
Non-anonymous with number ID	• Program team can identify students needing referrals for further evaluation, yet students' identities are still protected to some degree	• Same as above

Ensuring Follow-up

A critical component of your planning is ensuring follow-up for youth who come forward for help as a result of the program. Procedures for each school or district will differ based on the organizational structure, state laws, and availability of support services. However, all school staff should be familiar with the protocol for responding to youth who approach them for help to ensure a consistent and effective response (see Materials for Reproduction — Staff).

The Program Team must have the capacity to respond to requests for follow-up in a timely, coordinated and effective manner. While it is recommended that follow-up be provided the day of your program, if this is not feasible, set realistic expectations for when follow-up can be expected by students seeking help. Any student needing immediate assistance the day of your program can be instructed to approach the designated school staff immediately. You can include this information on the bottom of the Student Response Card distributed to students for them to complete at the end of your program (see details below).

THE STUDENT RESPONSE CARD

Have all students complete a Student Response Card after watching the SOS *Time to Act* DVD and participating in the discussion. By having all students complete the card, you are not singling out only the students who have concerns about themselves or a friend. That way, students who wish to speak to a counselor about symptoms in themselves or a friend will be identified and follow-up will be arranged.

NOTE: To protect anonymity, do not ask students to pass forward completed Student Response Cards. You may want to customize the cards to set expectations for when students requesting follow-up can expect to be approached by staff. Emphasize that those needing immediate assistance should approach staff the day the program is implemented.

INDIVIDUAL MEETINGS WITH YOUTH SEEKING FOLLOW-UP

How schools follow up with at-risk youth will vary. Some schools provide evaluative and treatment services for students within the school, while others may do an initial assessment and then refer at-risk youth to a community-based provider. You may use the Brief Screen for Adolescent Depression (BSAD) included in the manual and/or a standardized tool in follow-up meetings with youth identified through the program to help determine whether the individual needs further evaluation.

After the screening, those who score positive should be referred to a healthcare professional who can conduct a thorough diagnostic evaluation to determine whether or not there is the presence/absence of depression/suicidality. If you are referring youth who need follow-up to someone else in the school or to a community-based provider, you may send a copy of the completed screening tools as part of your referral. Remember, results from the screening tool are not diagnostic, but merely indicate the presence, or absence, of symptoms that are consistent, or inconsistent, with depression or suicide. Negative responses to the questionnaires do not rule out depression/suicidality and positive responses do not conclusively establish depression/suicidality. You may wish to also follow up with students who are unable to identify trusted adults in order to promote this protective factor in youth.

ADDING ANONYMITY TO STUDENT FOLLOW-UP

Many schools find it useful to announce that a handful of students will be randomly selected to provide general program feedback. Calling a few students down for a brief interview helps create anonymity for those students who need further mental health evaluation.

TALKING TO YOUR STUDENTS ABOUT DRUGS AND ALCOHOL

As alcohol use is strongly associated with suicide in adolescents, it is recommended that you inquire about drug and alcohol use with students as you conduct your follow-up. Youth engaging in substance use while feeling down have demonstrated a threefold increase in self-reported suicide attempts (Schilling et al., 2009). Screening for alcohol use provides another avenue for early identification.

TRACKING STUDENTS WHO NEED FOLLOW-UP

Families are central to children's educational success and their social and emotional adjustment. Family involvement at each step, from program referral through the implementation of individualized interventions, requires that they feel valued and supported. Be sure to provide a referral list for parents/guardians (see Materials for Reproduction — Parents). Modify the Student Follow-Up Form (see Materials for Reproduction — Staff) based on your school's procedures to help track students who require follow-up after participating in the program. It is important to document whether a student received appropriate services in a timely manner or if school staff need to take additional steps.

PROVIDE REFERRAL INFORMATION

Provide information regarding school and community mental health resources for parents. Include community hotline numbers in your resource list (see Materials for Reproduction — Parents). Some schools have printing capabilities and create business-size cards with information regarding school and community mental health resources for parents.

IDENTIFY ADDITIONAL REFERRAL RESOURCES

Visit SAMHSA's Center for Mental Health Services Locator: www.FindTreatment.samhsa.gov
This locator provides comprehensive information about mental health services and resources and is useful for professionals, consumers, families and the public.

Section 3: Educating Staff and Parents

Before You Start: Important Vocabulary

Below are four important terms to know in suicide prevention training. Emphasize to all staff, parents, and other community members that no one event creates suicidality: it takes a combination of stressors across different areas in one's life to reach a point where someone feels hopeless enough to attempt suicide. Much of this information is taken from Preventing Suicide: A Toolkit for High Schools, produced by the Substance Abuse and Mental Health Services Administration (http://store.samhsa.gov/ product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669).

RISK FACTOR

A risk factor is an attribute that is associated with increased risk of suicidal behavior.

- Risk Factors are NOT causes
  Examples:
  - **Behavioral Health** (depressive disorders, non-suicidal self-injury (NSSI), substance use)
  - **Personal Features** (hopelessness, low self-esteem, social isolation, poor problem-solving)
  - **Adverse Life Circumstances** (interpersonal difficulties, bullying, history of abuse, exposure to peer suicide)
  - **Family Characteristics** (history of family suicide, parental divorce, history of family mental health disorders)
  - **Environment** (exposure to mental health stigma, access to lethal means, limited access to mental health care, exposure to suicide)

WARNING SIGN

A warning sign is a verbal or behavioral clue that an individual may be experiencing depression or thoughts of suicide.

- Most individuals give warning signs or signals of their intentions.
- Seek immediate help if:
  - Someone is threatening to to kill themselves
  - Actively seeking means
  - Talking, posting and/or writing about death.
    Examples:
    - "Life isn't worth living"
    - "My family would be better off without me"
    - "I won't be in your way much longer"
- Other warning signs to take seriously
  - Risky behavior, recklessness
  - Increased substance use
  - Decreased interest in usual activities
  - Extreme withdrawal

PROTECTIVE FACTOR

A protective factor is a personal trait or environmental quality that can reduce the risk of suicidal behavior.

- Protective factors don't imply that anyone is immune to suicidality but help reduce risk.
  Examples:
  - **Individual Characteristics** (adaptive temperament, coping skills, self-esteem, spiritual faith, resiliency)
  - **Family/Other Support** (connectedness, social support)
  - **School** (positive experience, connectedness, sense of respect)
  - **Mental Health and Healthcare** (access to care, support through medical and mental health relationships)
  - **Restricted Access to Means** (i.e. firearms/medications/alcohol, safety barriers for bridges)

PRECIPITATING EVENT

A precipitating event is a recent life event that serves as a trigger, moving an individual from thinking about suicide to attempting to take his or her own life.

- Precipitating events are often confused with causing suicide.
- No single event causes suicidality; other risk factors are typically present.
  Examples:
  - A breakup
  - A bullying incident
  - The sudden death of a loved one or getting into trouble at school
  - Family turmoil or legal trouble
  - Severe disappointment/failure

Sample Lecture for Staff In-Service and Parents Night Presentation

1. Present Your Plan to Implement the SOS Program
Sample Introduction: "In an effort to reduce depression and suicide among our students, we plan to implement the SOS Signs of Suicide Prevention Program [specify school-wide, in health classes, grade level, etc.] on (specify date).

Our goal is to help students recognize the symptoms of depression or warning signs of suicide in themselves or their friends and teach them the appropriate action steps they should take to get help. The purpose of this program is not to tell whether students are depressed, but rather inform them about whether they, or their friends, may have symptoms that need further evaluation.

Through the SOS Program, school staff, students, and parents will learn about depression, suicide, and the associated risks of alcohol use. They will also learn steps for getting help through the simple acronym ACT: Acknowledge that your friend has a problem, express that you Care, Tell a trusted adult."

2. Explain Why Implementing SOS is Important

- While child suicide is uncommon, mortality from suicide increases steadily through the teens. Suicide is the second-leading cause of death for those ages 11-18 (CDC, 2013).
- Over 90% of children and adolescents who die by suicide have a diagnosable mental health disorder at the time of their death (Gould et al., 2003), yet 80% of youth with mental illness are not identified or receiving services (Merikangas et al., 2011). Adolescents who suffer from depression are at much greater risk of suicide than children without depression (U.S. Department of Health & Human Services, 1999). Overall, approximately 20% of youth will have one or more episodes of major depression by the time they become adults (NAMI, 2003).
- Childhood is an important time to promote healthy development, as many adult mental health disorders have related antecedent problems in childhood. Since a previous suicide attempt is the leading risk factor for adult suicide, introducing prevention early may help promote prevention throughout the lifecycle.

3. Review Suicide Risk Factors, Warning Signs, Precipitating Events and Protective Factors
Refer to the previous page for detailed descriptions of vocabulary. You may want to stress to parents the importance of safe storage of firearms in the home.

Note on firearms in the home:

- A 2004 study published in the *Journal of Epidemiology and Community Health* found that those who stored their firearm locked, unloaded, or both were less likely to commit suicide with it compared to those who had direct access (unlocked, loaded, or both). (Shenassa et al., 2004)
- The four practices of keeping a gun locked, unloaded, storing ammunition locked, and in a separate location are each associated with a protective effect and suggest a feasible strategy to reduce risk of suicide by firearms in homes with children and teenagers where guns are stored (Grossman et al., 2005). However, whether these measures prevent firearm suicide or unintentional injury in children and adolescents is not clear.

Sample Summary:
"The goal of the SOS Program for school staff, students, and our parents is to learn about depression, suicide, and the associated risks of alcohol use, and increase confidence to seek help for those who need it. Through your participation, we are taking an important step toward protecting our students and your children by identifying mental health problems and encouraging them to seek help from trusted adults. We hope that the program will help instill confidence in you, our staff, and our students about identifying the signs of depression and suicide and how to access help if someone needs it."

NOTE: Identify a school contact for attendees to address questions or concerns that may arise after the training.

Preparing School Personnel Through Training and Involvement

Training faculty and staff is universally advocated and supported by research as an essential component to an effective suicide prevention program. When dealing with the sensitive issues of depression and suicide, there are guidelines that all schools participating in the program need to cover with school personnel before the program. First, what are school procedures for dealing with students who disclose suicidal intent? Know your school or district procedure for dealing with potentially suicidal students and distribute this information to all staff.

A student may disclose the need for help to any adult at your school. Therefore, it is important that all school personnel, both professionals and staff, be aware that the SOS Program is being presented and why. They should know the warning signs for depression and suicidality and how to effectively respond to students who may approach them for help. Research indicates that training faculty and staff to develop the knowledge, attitudes, and skills to identify students who may be at risk for suicide and make referrals can produce positive effects on an educator's knowledge, attitudes, and referral practices. In-service training can help to educate school staff and support your prevention efforts. The following pages include suggestions for conducting your staff training.

Show the *Training Trusted Adults* DVD to help familiarize staff with suicide prevention and the SOS Program. A discussion guide for this DVD is included later in this section and in the DVD case. Taking time for this conversation can help educators share their concerns about youth depression, self-injury, and suicide, establish a sense of cohesion, and increase staff confidence in addressing these problems.

Schools lacking resources to conduct staff training can distribute a letter for all staff about the plan and rationale for implementing the program, dates of implementation, depression and suicide warning signs, protocol for responding to youth requesting help, and school staff available to contact if they have concerns about a student.

PLAN, PREPARE, PREVENT: THE SOS ONLINE TRAINING MODULE
Available at www.mentalhealthscreening.org/gatekeeper. This 90-minute, interactive online course provides your SOS implementation team with an in-depth understanding of suicide prevention and a step-by-step guide through the implementation process. Continuing education credits/contact hours are provided for several disciplines and a certificate of completion is offered to anyone who finishes the module. There may be staff in your building who are not on your implementation team but who express an interest in this continued learning; we invite you to share the online course with them as well.

Planning Your Staff Meeting Checklist: Key Steps for a Successful Training

- ☐ Preview the *Training Trusted Adults* DVD. Make sure the disc is in working order, familiarize yourself with its content and think about your own reactions to this video.
- ☐ Read the DVD Discussion Guide (provided at the end of this section). Consider key questions and talking points.
- ☐ Review risk factors and warning signs of depression and suicidality as well as protective factors. Print copies of corresponding handouts to distribute during the training. Be prepared to answer questions and clarify information for staff.
- ☐ Understand myths and corresponding facts about depression and suicide. Print related handouts.
- ☐ Review protocol for how staff should respond when approached for help by a student. This process may mean referring the student to you or another point person in the school. Have printed guidelines ready.
- ☐ Review your school's policy for following up with at-risk students. Be prepared to give detailed information.
- ☐ If applicable, inform staff of date, time and setting of program implementation.

Parents as Partners in Safeguarding Youth

Sometimes parents may find it difficult to navigate the emotional journeys their children are experiencing, or are not sure what behavior is typical development or normal "growing pains" and what is problematic. Research has found that parents often do not know how to identify suicidal signs in their children, with one study showing that as many as 86% of parents were unaware of their children's suicidal behavior and another study finding that parents were unaware of their children's depressive symptoms, as well as their alcohol use, both risk factors for youth suicidal behavior (Doan, 2012). These studies highlight the difficult reality that parents are sometimes ill equipped to recognize and respond appropriately to their children's mental health crises. However, research also indicates that with education, parents' knowledge of suicidal signs and attitude about the importance of youth suicide prevention improves. For this reason, parent materials are an integral part of the SOS Program. The goal is to actively engage parents in your prevention efforts, to gain their support, and to encourage discussion among parents and their children about the issues of depression and suicide.

Inform parents about your plans to implement the SOS Program. Consider taking the following steps to increase cooperation in your prevention efforts and to broaden community support:

- Distribute educational materials to all parents, regarless of whether their child has been identified as at-risk.
- Throughout the year, include articles about depression, suicide, and resilience in your school newsletter, town paper, or town or school website.
- Reach out to faith-based communities to offer education programs.
- Conduct annual parent forums to proactively address promoting youth safety.
- Include information about your youth suicide prevention efforts at health fairs.
- Involve parents and the PTO/PTA early in your prevention planning and ask advocates for your efforts to encourage the support of other parents.

PARENTAL CONSENT

If your school or district guidelines require you to obtain parental consent before implementing a suicide prevention program, we recommend that you send out a letter introducing the program with a permission slip to parents. Be sure to include a copy of the Parent Screening Form and information about who to contact at the school if they have questions or concerns.

There are two different methods of acquiring parental consent: active and passive. We advise using whichever option your school district requires. **Active consent** allows for a student's participation only if the parent or guardian has explicitly granted either verbal or written permission. **Passive consent** requires either verbal or written communication to the school only if the parent or guardian does not wish to have his or her child participate. A lack of a response from the parent or guardian indicates consent for his or her child to participate. Sample parental consent letters and permission slips for both active and passive consent are included. TIP: Incorporate written consent with other paperwork required for parents to sign (See Materials for Reproduction - Staff Section 6 for information about maximizing parent consent returns and sample forms).

BRIEF SCREEN FOR ADOLESCENT DEPRESSION – PARENT VERSION

The SOS Program includes a parent version of the screening form in the reproducible materials section of this guide. It is used to help parents look for warning signs of depression and suicidality in their children. There are several additional ways to access this tool:

- You may order hard copies at https://shop.mentalhealthscreening.org
- PDF copies of this and other program materials are available online. Contact our office for assistance. With this option, you may print as many copies as you need.
- **AVAILABLE ONLINE:** The Parent BSAD Online Screening Tool allows schools to provide parents with the opportunity to consider their child's moods and behaviors from the privacy of their home or mobile device at any time. The screening is often hosted through the school's parent portal or website where schools customize a message to parents on the screening homepage, upload their school logo, create custom demographic questions and choose from a selection of color schemes to make the site their own. Most importantly, schools customize the school and community resources provided at the end of the screening. School administrators can gain insight into student mental health through the BSAD's comprehensive reporting feature, which anonymously tracks screening data.

Suggestions for a Parent Night

Consider hosting a parent night to help streamline safe messaging to parents. A parent night event can be very similar in content to the staff training. The goals of the event should be to gain support for your prevention efforts and provide parents with information about the signs and symptoms they should watch out for in their children, and the mental health resources available in the school and the community.

The following are suggestions for conducting a parent night event:

- Plan an educational presentation for parents on ensuring the safety of youth. Invite a guest speaker with expertise in this area. Ask the PTA/PTO to sponsor the program.
- Title the parent night event in a general way, such as "Keeping Your Teen Safe" or "Safeguarding Youth."
- Serve food.
- Combine the event with another well-attended or mandatory event, such as orientation, parent/teacher conferences, registration for courses, special events or sports.
- Show the *Training Trusted Adults* DVD and facilitate a discussion (guide provided at the end of this section and in the DVD case). Show the video during open house night for parents in the fall and at any health fair events you host during the year.
- Answer questions; dispel myths by reviewing Common Myths (see Section 3).
- Review the symptoms of depression, risk factors, protective factors and signs of suicide.
- Encourage parents to restrict access to lethal means, especially access to firearms and educate them about how limiting access to lethal means is an effective way to prevent youth suicide.

Prevention themes to stress with parents include:

- Do not be afraid to talk to your kids about suicide.
- Know the risk factors and warning signs of youth suicide.
- Respond immediately if your child is showing warning signs.
- Reach out to the school for resources.
- Make all firearms in the house inaccessible to kids.

Planning Your Parent Meeting Checklist: Key Steps for a Successful Training

- ☐ Preview the *Training Trusted Adults* DVD. Make sure the disc is in working order, familiarize yourself with its content and think about your own reactions to this video.

- ☐ Read the DVD Discussion Guide (provided at the end of this section and in the DVD case). Consider key questions and talking points.

- ☐ Review risk factors and warning signs of depression and suicidality as well as protective factors. Print copies of corresponding handouts to distribute during the training. Be prepared to answer questions and clarify information for parents.

- ☐ Understand myths and corresponding facts about depression and suicide. Print related handouts.

- ☐ Review your school's policy for following up with at-risk students, including how and when parents/guardians will be contacted if their child needs further help.

- ☐ Provide parents with school and community-based mental health resources in your community.

- ☐ Prevention themes to stress with parents include:
    - Do not be afraid to talk to your kids about suicide
    - Know the risk factors and warning signs of youth suicide
    - Respond immediately if your child is showing warning signs
    - Reach out to the school for resources
    - Make all firearms in the house inaccessible to kids

- ☐ If applicable, inform parents of date, time and setting of program implementation.

Training Trusted Adults DVD Discussion Guide

BEFORE YOU START

It is important, before you begin this presentation, to acknowledge that you are about to discuss a sensitive and serious matter. There may be people in your audience who have a personal connection to the issues of depression and/or suicide. Some people may even be caught off-guard by their own reactions to the material. Let your audience know that they may leave the room for a few minutes if they feel they need space. You may even appoint someone on your team to stay in the hallway for people who need to talk. If this is the case, let your audience know who this is and where they can be found.

INTRODUCTION

Why do you think the SOS Signs of Suicide® Prevention Program is important for our community to embrace?

- The SOS Program can help you differentiate between normal development and what may be a more serious mental health issue.
- According to the CDC, suicide is the 2nd leading cause of death among people aged 11-18 (CDC, 2013).
- More than 90% of youth who die by suicide have a diagnosable mental disorder, most likely depression and/or substance use, which are treatable.
- 80% of youth with mental illness are not identified or receiving services (Kataoka et al., 2002).
- Half of all mental health disorders start by the age of 14.
- Many people are uncomfortable with the topic of suicide. Implementing a program like SOS can help your community discuss mental health issues, which is an important step in preventing suicide.

WARNING SIGNS

Please review the following definitions with your *Training Trusted Adults* audience. They are not spelled out in detail in the video but are explained and differentiated further in the online module and in your implementation guide.

- A risk factor is any personal trait or environmental quality that is associated with increased risk of suicide. The first step in preventing suicide is to understand the risk factors. They are not necessarily causes.
- A warning sign is an indication that an individual may be experiencing depression or thoughts of suicide. Most suicidal individuals give warning signs or signals of their intentions.
- A precipitating event is a recent life event that serves as a trigger, moving an individual from thinking about suicide to attempting to take his or her own life. Precipitating events are often confused with causing suicide. No single event causes suicide; other risk factors are typically present.

COMMON SYMPTOMS OF DEPRESSION

What are some of the risk factors and warning signs of depression listed in the DVD that stuck out for you?

- Changes that occur over a period of at least two weeks, including: changes in eating or sleeping patterns, increased irritability/moodiness/rapid fluctuation in mood, decreased interest in usual activities/hobbies, and isolation. These changes may be warning signs.
- Risk factors include: history of abuse, use of drugs/alcohol, history of mental illness, previous suicide attempts, access to lethal weapons, exposure to suicidal behavior in others, family history of mental illness, history of significant loss, struggles with sexual orientation/gender or fears of acceptance around sexual orientation/gender.

PROTECTIVE FACTORS

Please review the following definition with your *Training Trusted Adults* audience:
Protective factors are personal traits or environmental qualities that can reduce the risk of suicidal behavior. Protective factors don't imply that anyone is immune to suicide, but help reduce risk.

What are some protective factors you might find in your students?

- Protective factors include: strong problem-solving skills, positive self-image, spiritual faith, close family relationships, strong peer support system, involvement in hobbies/activities, community connectedness, access to treatment, and restricted access to firearms and other means.
- For a more comprehensive list of protective factors, as well as risk factors and warning signs, review SAMHSA's guide, Preventing Suicide: A Toolkit for Schools at http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669

GUIDELINES FOR RESPONSES

Review your school's response protocol with your *Training Trusted Adults* audience. Let parents/school staff/ community members know the steps your school will take to follow up with students seeking help.

In this section, the professionals discuss confidentiality. You also heard Melissa in Elyssa's story say, "It's ok to tell." What are some steps to take if a student discloses the need for help?

- Do not leave the student alone. Keep him/her safe until additional help can be found.
- Be open. Listen and allow the student to feel comfortable sharing their feelings.
- Contact a parent/guardian. If appropriate, facilitate a referral for the individual to get professional help.
- Stay supportive. You may be the first person with whom this individual has discussed these feelings.

BUILDING BRIDGES WITH THE COMMUNITY

Let your audience know that you have a referral plan in place. If appropriate, have your mental health resource list available to distribute.

Remember that you can always provide your community with the phone number for the National Suicide Prevention Lifeline for support: **1-800-273-TALK (8255)**

ACT IN ACTION

Hayley says, "What I would look for in a trusted adult would be somebody who could take me seriously and care about what I'm telling them and has shown an interest in the wellbeing of you and your peers."

- What qualities do you think make you a trusted adult?

Myths About Depression and Suicide

Myths about depression and suicide often separate people from the effective treatments now available and prevent people from supporting suicide prevention efforts. School staff, students and their parents need to know the facts. Some of the most common myths are:

MYTH: It's normal for teenagers to be moody; teens don't suffer from "real" depression.
FACT: Depression can affect people at any age or of any race, ethnicity, or economic group.

MYTH: Teens who claim to be depressed are weak and just need to pull themselves together. There's nothing anyone else can do to help.
FACT: Depression is not a weakness, but a serious health disorder. Both young people and adults who are depressed need professional treatment. A trained therapist or counselor can help them learn more positive ways to think about themselves, change behavior, cope with problems, or handle relationships. A physician can prescribe medications to help relieve the symptoms of depression. For many people, a combination of psychotherapy and medication is beneficial.

MYTH: People who talk about suicide won't really do it.
FACT: Almost everyone who dies by suicide has given some clue or warning. Do not ignore suicide threats. Statements like "You'll be sorry when I'm dead," or "I can't see any way out" (no matter how casually or jokingly said) may indicate serious suicidal feelings.

MYTH: Anyone who tries to kill themselves must be crazy.
FACT: Most suicidal people are not psychotic or insane. They may be upset, grief-stricken, depressed, or despairing, but extreme distress and emotional pain are not necessarily signs of mental illness.

MYTH: If a person is determined to kill themselves, nothing is going to stop them.
FACT: Even the most severely depressed person has mixed feelings about death, wavering until the very last moment between wanting to live and wanting to die. Most suicidal people do not want death; they want the pain to stop. The impulse to end it all, however overpowering, does not last forever.

MYTH: People who complete suicide are people who were unwilling to seek help.
FACT: Studies of suicide victims have shown that more than half had sought medical help within six months before their deaths.

MYTH: Talking about suicide may give someone the idea.
FACT: You don't give a suicidal person morbid ideas by talking about suicide. The opposite is true. Bringing up the subject of suicide and discussing it openly is one of the most helpful things you can do. There is no evidence that screening youth for suicide induces suicidal thinking or behavior.

Section 4: Lesbian, Gay, Bisexual, Transgender & Questioning Resource Guide

LGBTQ Resource Section

(Lesbian, Gay, Bisexual, Transgender, and Questioning Youth)

On any given day, high school-aged youth experience a great deal of stress. Social relationships, schoolwork, family problems, and gender-related development all contribute to this pressure. Additional challenges to what is already on their plate can be overwhelming, especially if the youth is also experiencing mental health problems. Lesbian, gay, bisexual, transgender, and youth questioning their sexual orientation/gender (LGBTQ) often experience further turmoil during their adolescent years, putting them at a greater risk of depression and suicidality. According to the 2009 Massachusetts Youth Risk Behavior Survey, students who self- identified as gay, lesbian, or bisexual, were more than four times more likely to have attempted suicide in the past year than their peers (Massachusetts Department of Education, 2009).

Fortunately, there are action steps that can be taken by students, educators and parents to create a safe and supportive environment for LGBTQ youth. By spreading tolerance and acceptance at home and in schools, you can take an active role in promoting youth resiliency, a key factor in reducing stress and maintaining student mental health.

DEFINITIONS

LGBTQ is a sexual and gender identity-based term used to describe non-heterosexual individuals, or those who are questioning their sexual orientation/gender. The LGBTQ acronym stands for the following:

- **Lesbian/Gay**: Youth self-identifying as lesbian and gay are attracted to members of their respective sex.
- **Bisexual**: Individuals identifying as bisexual can be attracted to both males and females.
- **Transgender**: The term “transgender” is often used to describe individuals whose gender identity (one’s innermost concept of self as male, female, both, or neither) does not match their assigned birth gender. Because the term “transgender” does not denote a specific sexual orientation, a transgender youth may also identify as lesbian, gay, straight, or bisexual (Gender Spectrum, 2014).
- **Questioning**: Youth who are unsure about their sexual orientation or gender identity.

RISK FACTORS FOR LGBTQ YOUTH

LGBTQ youth are susceptible to specific risk factors related to their sexual orientation. Obstacles such as coming out to friends and family, issues of gender non-conformity, and gay-related victimization often affect an LGBTQ teenager. LGBTQ youth also experience unique developmental stressors, particularly when identifying as a transgender youth. These specific stressors are further complicated by normal adolescent development such as going through puberty and understanding sexual and emotional relationships (The Trevor Project, 2011). These competing risk factors can be overwhelming for any youth and can have a negative impact on a student’s mental health.

A NOTE ON LGBTQ VICTIMIZATION AND BULLYING

The statistics related to LGBTQ-specific bullying are startling. According to the 2009 Gay, Lesbian, and Straight Education Network (GLSEN) National School Climate Survey, 86 percent of LGBTQ youth surveyed experienced harassment at school, 60 percent felt unsafe at school because of their sexual orientation, and about one-third of LGBTQ youth skipped a day of school in the past month because they felt unsafe. Most LGBTQ youth are the victims of physical or verbal assault, and more than one-third of LGBTQ youth will lose friends through coming out (D’Augelli et al., 2002).

WHAT TO SAY TO STUDENTS

Students will often turn to their peers during a time of crisis. It is important to teach students the action steps they can use when confronted by a friend suffering from bullying or depression. By sharing the following information with your students, you can empower them to support their LGBTQ peers in both the school and community setting.

Acknowledge, Care and Tell a Trusted Adult When a Friend is In Need

- Educate students on the unique risk factors faced by LGBTQ students and encourage them to always utilize the ACT technique when confronted by a friend in need.

Teach Students to Avoid Anti-Gay Slang

- Homophobic slang words are common vernacular for high school youth. Remind your students that these words are negative and hurtful. Challenge them to think before they speak and to choose words that really express the meaning they intend.

Promote Tolerance

- Small efforts such as supporting a Gay-Straight Alliance, befriending students with varying backgrounds, or sticking up for bullied students, can go a long way. Remind students how scary it can be for a LGBTQ individual to come out, and encourage students to be tolerant and accepting of differing viewpoints.

HOW TO WORK WITH PARENTS OF LGBTQ YOUTH

LGBTQ youth often struggle with the decision of coming out to their parents and fear that their lifestyle and sexual orientation will be rejected by the people closest to them. Lesbian, gay, and bisexual youth who come from highly rejecting families are more than eight times as likely to have attempted suicide than lesbian, gay, and bisexual peers of low rejection/accepting families (Ryan et al., 2010). Even in families where being an LGBTQ child does not create conflict within the family, supportive parents are often unaware of the risk factors faced by their child on a daily basis.

The Family Acceptance Project, an organization aimed at decreasing health and other related risks for LGBTQ youth in the context of their families, suggests the following for parents of LGBTQ youth:

- **Talk Openly With Your Child:** Allow your child to speak freely about their sexual identity, and listen.
- **Demonstrate Acceptance:** Support their identity, regardless of if it causes you discomfort. Express affection freely for your child and allow your child to express their gender freely.
- **Provide Support:** Advocate for your child when he or she is mistreated at school or in the community because they identify as LGBTQ.
- **Spread Tolerance:** Require that other family members respect your LGBTQ child and others of the same sexual orientation.
- **Attend LGBTQ Events:** Bring your son or daughter to LGBTQ-friendly events or organizations to help develop a support network for your child.
- **Believe That Your Child Can Have a Happy Future as an LGBTQ Adult:** Because they can!

Tips to Share With Your Colleagues

Students should feel comfortable around all faculty members at your school. The best way to spread understanding and tolerance is to educate yourself and your colleagues about LGBTQ-related topics and risk factors. The better educated you are, the better you will be at supporting your students in need.

ADVOCATE TOLERANCE

- Speak Up Against Homophobic Comments: Challenge homophobic and anti-gay remarks and slurs you hear in the school setting. It is important to let students know that these sort of remarks will not be tolerated in your presence. Use these instances as opportunities to educate students about the harmful effects of name calling and challenge them think before they speak.
- Encourage School Policies That Support Tolerance and Respect: Work with student council representatives and school boards to implement policies that are tolerant of all students, including LGBTQ youth. Spearhead campaigns and rallies that strive to end bullying and promote safety and respect.

BE A VISIBLE ALLY

- Speak openly to all students, letting them know that you are accepting of LGBTQ students and students from all backgrounds and lifestyles. Schedule specific office hours during which you are available to speak to students. Depending on school protocol, you may want to display national magazines catering to LGBT persons and rainbow flags or stickers as a way of communicating tolerance and acceptance, and that your office is a safe space to discuss LGBT issues.

COUNTERACT BULLYING — DOCUMENT THE 6 W'S FOR EVERY INSTANCE OF HARASSMENT

(The Trevor Project, 2011).

- WHO was involved
- WHAT happened
- WHERE it happened
- WHEN it happened
- WHO it was reported to
- If there were any WITNESSES

BUILD RESILIENCY

- Cultivate Family, Community, and School Support: All youth should be permitted to express themselves and work comfortably in a setting that is free from stigma.
- Provide Positive Media Representations: Ensure that all media pieces that are shared with students are LGBTQ friendly and free of stereotypes.
- Encourage Gay or Gay-Friendly Social and Support Networks: Create and support gay or gay-friendly organizations in your school, such as a Gay-Straight Alliance and/or PFLAG (Parents, Families, & Friends of Lesbians and Gays).
- Promote Healthy Coping Mechanisms: Positive coping skills include using relaxation techniques, keeping a journal, exercising, eating right, keeping a regular sleeping schedule, and accessing professional therapy when needed.

NOTE:
If you do not have a safe space for LGBTQ students, there are free resources available online at http://www.glsen.org.

Resources for Educators, Students, & Parents

The Trevor Project: A nonprofit organization providing suicide prevention, education, and crisis response services to LGBTQ youth.
www.thetrevorproject.org

Family Acceptance Project: A community research, intervention, education, and policy initiative aimed at decreasing health and other related risks for LGBTQ youth in the context of their families.
familyproject.sfsu.edu

It Gets Better Project: Support site for LGBTQ youth documenting that despite the challenges of youth, life for LGBTQ individuals does, in fact, get better.
www.itgetsbetter.org

Suicide Prevention Resource Center (SPRC): Provides prevention resources, support, and training to individuals and organizations dedicated to suicide prevention.
www.sprc.org/library/SPRC_LGBT_Youth.pdf

Gay, Lesbian and Straight Education Network (GLSEN): A leading educational organization that strives to create a safe school environment for all students by emphasizing acceptance, individual contributions, and student diversity.
www.glsen.org

Gay-Straight Alliance Network: Youth leadership organization empowering youth activists to fight homophobia by connecting school-based Gay-Straight alliances to each other and community resources.
www.gsanetwork.org

Parents, Families, and Friends of Lesbians and Gays (PFLAG): A national organization that celebrates diversity and embraces all individuals, regardless of sexual orientation and gender identity.
www.pflag.org

Gay & Lesbian Alliance Against Defamation (GLAAD): A media monitoring organization that promotes understanding, acceptance, and equality by holding the media accountable for their words and images while also encouraging the LGBT voice in the community.
www.glaad.org

Center for Disease Control: Providing articles, resources, and support for related to LGBT health.
www.cdc.gov/lgbthealth

American Psychological Association: Lesbian, Gay, Bisexual, and Transgender Office of Concerns dedicated to improving the health and well-being of LGBT people by increasing understanding and tolerance of gender identity and sexual orientation.
www.apa.org/pi/lgbt

National Gay and Lesbian Task Force: National organization dedicated to securing equality for LGBTQ individuals by encouraging activism and campaigning for advancement of pro-LGBTQ legislation.
www.thetaskforce.org/issues/youth

Advocates for Youth: Nonprofit organization whose mission of rights, respect, and responsibility helps young people make informed and responsible decisions about their sexual and reproductive health.
www.advocatesforyouth.org

Trans Alliance Society: British Columbian nonprofit organization dedicated to supporting transgender education, outreach, and advocacy.
www.transalliancesociety.org

Section 5:
Lesson Plans

Lesson Plan 1

- Program implementer reads "Introduction to the SOS Signs of Suicide Prevention Program" below to class (5 minutes) and explains the screening forms
- Students watch the SOS *Time to ACT* video and a school professional leads the discussion using the accompanying talking points (40 minutes)
- Students complete the SOS Student Screening Form (BSAD)
- Leader reviews scoring instructions with students and answers any questions they may have
- Students score their own Screening Forms or the leader collects them with the student names/ID numbers to be scored by the implementer
- Leader distributes the Student Response Cards and asks students to complete them (See Materials for Reproduction, Section 6)
- Leader collects completed Student Response Cards
- Review signs and symptom list (see Discussion Guide that follows)
- Leader distributes the Student Newsletters and ACT stickers
- Leader asks the class to read and complete the puzzle in the Student Newsletter for homework
- After the class, the designated school staff reviews all completed Student Response Cards to determine who requires follow-up

SAMPLE INTRODUCTION TO THE SOS PROGRAM

This introduction for students may be read aloud by the health professional. Use the introduction in whole or in part, or modify depending on your format.

Today our school is participating in the SOS Middle School Program, which is taking place throughout the country. Our goal today is to help you recognize the symptoms of depression and/or suicide in yourselves, your friends, or your loved ones. The purpose of this program is not to tell whether or not you are suffering from depression, but rather to tell you if you may have symptoms that indicate a need for a further evaluation.

Today's program will include the following [this will vary depending on the screening option you choose; please make appropriate revisions]:

- A video about depression, the signs of suicide and the steps to take if you feel a friend or loved one is at risk
- A depression screening form for you to complete
- Instructions on how to score the screening form
- A Student Newsletter for you to read
- Information for getting further help for yourself or a friend, if necessary

Please be aware that although the DVD outlines the steps to take if you are worried about a friend, you will be filling out the screening form as yourself rather than for a friend or loved one.

Suicide Prevention Program

Video Discussion Guide

DVD Discussion Guide

After the video: Facilitating the group discussion

Talking about the video as a group is a way to ensure that the main teaching points of the SOS Program are learned and integrated. In the course of a discussion, ideas about the video's message crystallize, issues are seen more clearly, different points of view are raised and the stories told take on new dimensions.

You can either show the video in its entirety or stop the video at opportune moments to discuss issues as they emerge. Refer to the Discussion Guide TALKING POINTS for concepts to emphasize and questions to ask. Feel free to expand upon them, and remember, always demonstrate a positive attitude of confidence and trust.

Suggestions for discussion leaders/facilitators:

- Consider arranging the classroom with students sitting in a circle to facilitate discussion.
- The discussion leader should be a facilitator and moderator rather than an "authority."
- The leader provides an introduction on the SOS Program and asks questions that will guide the discussion.
- The leader may answer questions or provide important information, such as where to go to get help.
- Don't be discouraged if students laugh during the video. Some students use humor in an effort to reduce tension around a serious topic.
- View brief silences as a means for students to gather their thoughts.
- Ask open-ended questions that focus on the DVD and open up discussion.
- Suggest and question rather than impose your views.
- Ask questions that you don't know the answers to, such as, "Can you think of other problems that students are facing in our school that weren't covered in the DVD that may cause them to feel depressed?"
- Share your observations.
- Encourage group members to talk to each other, not "through" you as the leader.
- Respond to digressions that contradict the facts presented in the DVD by asking, "Which specific section in the DVD supports the point you are making?"
- Try to redirect other digressions from the topic by saying, "Let's get back to the DVD. How do you think the friend used ACT?"
- Interrupt private conversations and invite those speaking privately to share their thoughts openly with the group.
- Ensure that everyone has a chance to participate and that no one person dominates the discussion.
- Jump in when you must, "We're all talking at once. Can we let each person have their say?" or, when one person dominates, "Kim, that's very interesting. Let's hear what some of the others have to say" or when someone is trying to break in, "Ingrid has been waiting to talk. Let's hear what she has to say" or to bring everyone into the discussion, "Amy's idea is similar to what Mike said earlier. Does anyone want to respond to that issue?" When Keith interrupts Sam, the leader can interrupt Keith and say, "Just a minute, I'd like to hear Sam finish what he was saying."

Remember, implementing the SOS Program is a way that your school is communicating concern and openness to discuss these issues. Invite students to ask questions and ask for help, directing them to whom they can seek help at the school.

NOTE TO DISCUSSION LEADER: Depression and suicide may be extremely sensitive issues for some students. If any student feels overwhelmed and needs to leave the room during the program implementation or video discussion, excuse them and make sure they have someplace safe to go where they may talk with a school professional about their feelings and have someone accompany them.

Talking Points

1. What does ACT stand for?

Answer:

- **Acknowledge** the problem
- **Care**- Let the person know you care
- **Tell** a trusted adult

2. How would you use these steps?

Answer:
If you see signs of depression, suicide, or any other problem in someone you know:

- Tell them in a caring way that you recognize that they are having a problem.
- You can show you care by actively listening. This means putting aside anything else you are doing, making eye contact, sitting down and asking questions.
- Once you listen to your friend, tell him or her that it's important that you speak with an adult, such as a parent, teacher, counselor or someone else you trust, so that the person can get the help they need. You can figure out together who that person may be.
- Offer to go with your friend to tell the adult.

3. What should you do if you are feeling depressed and need help?

Answer:
If you need help for yourself, ACT by telling an adult you trust how you feel so you can get help and feel better.

Dramatization

Sisters discussing being rejected by friends

1. In the case of the girl being rejected by her friends, why was the younger sister's reaction considered troubling and not just a "normal" response to a bad situation?

Answer:
It's not unusual for people to feel sad, upset, and angry about the loss of a relationship they value. These feelings can come and go over time. However, her reaction was much more serious and not a "typical" response to what was going on. What she experienced lasted over two weeks and involved changes in her mood, behavior, physical health, and thinking.

2. What were the signs that this girl was depressed?

Answer:

- She skipped play practice (an activity she usually enjoys)
- She can't sleep
- She feels sick all the time
- She was having negative thoughts and feeling hopeless, saying things like, "I wish I were dead"
- She said she feels, "all alone"

3. What about the older sister's first response made it "wrong"?

Answer:

- She blamed her sister saying, "Just stop whining and give it some time."
- She minimized the problem saying, "Don't you think you're being a little dramatic?"
- She ended the conversation abruptly by leaving the room.

4. How did the older sister use the ACT technique in the "correct" response?

Answer:

- **Acknowledge:** She made eye contact with her sister and said, "I know you're upset but saying that is pretty serious."
- **Care:** The older sister offered to go to their mother together when the younger sister seemed scared. She also emphasized her concern when she said, "I'm really worried about you." At the end, she repeated, "I'll be there with you."
- **Tell:** The older sister would not be sworn to secrecy. When her younger sister asked to promise not to tell, she replied, "I can't do that! I think you're really depressed and we have to talk to somebody." She didn't give up when her sibling didn't want to talk to their mother. She even stated, "Well if you don't, I will." The older sister also provided reassurance that it would be okay and that her younger sister wasn't crazy, she just needed help.

Dramatization

Angry boy

1. Do you think this angry boy may be depressed?

Answer:
He may be. One of the main signs/symptoms of depression for adolescents can be irritability or anger, rather than a sad or down mood. Teens that are more irritable and angry are sometimes seen as troublemakers or as having behavioral problems when they may actually be depressed. These teens may have more difficulty with relationships, may be frequently absent from school, may be involved in fights, and may be doing poorly in school. Depressed youth may also be more likely to run away or have problems with the law.

2. The angry boy's friend made the right decision to ask for help from Mr. Hull. Who else might they have turned to in this situation?

Answer:
School counselor, psychologist, nurse, teacher, parent, a friend's parent, coach, etc.

3. What if the angry boy said he was suicidal? Would you feel okay to leave him alone?

Answer:
No. Never leave someone alone who may be at risk for suicide. Suicide is unpredictable, so don't wait to ask for help. ACT NOW!

Dramatization

Girls in the bathroom discussing bullying

1. What makes you concerned for Becca, the girl being bullied?

Answer:

- She said she would rather be dead than put up with the bullying.
- The boys are bullying her online at home and now in school as well.
- The bullies are threatening that if she tells on them, they will get other students to participate in the bullying as well.
- She has what we refer to as "tunnel vision." She sees only one way to deal with the problem: suicide.

2. How did Becca's friend use the ACT technique in the correct response?

Answer:

- **Acknowledge:** She seemed upset by what her friend was going through. She said, "You just said you would rather be dead, I'm worried about you." She knew that it was more than just a passing mood.

- **Care:** She said that what Max and Adam were saying wasn't ok. She added that asking for help is not pathetic and that Becca doesn't have to put up with the bullying anymore.
- **Tell:** Becca's friend says that she is going to talk to Mr. Michaels.
  - o When Becca says that she doesn't want Mr. Michaels to tell her parents, her friend insists that, "If it's so bad that you're hiding in the bathroom, you need to get help."
  - o She gave Becca hope that by telling a trusted adult, she could feel better. She used her cousin as an example of how talking to someone can help.
  - o She added that Mr. Michaels "can help us figure this out."

3. What are some things you could do if you are being bullied online?

Answer:

- Never respond to an email or IM from a bully.
- Save the message or post and show it to a parent or trusted adult, such as a teacher or guidance counselor.
- Make a buddy list of your friends' screen names and email addresses. Anyone who's not on that list won't be able to talk to you without getting your permission first.
- Never share your password.
- Think carefully about what you say online. Could what you say be taken the wrong way?
- Make sure what you say is not going to hurt or scare someone.

4. What are the signs that Becca is not just angry or sad about being bullied, but may be suffering from depression?

Answer:
Becca was thinking about killing herself and seemed to think that was her only option to avoid further bullying.

Did You Know…Facts about Bullying (SPRC, 2011)

- *Both victims of bullying and bullies are at higher risk for suicide than their peers (That's twice as many people you can help protect by reporting what you see and hear).*
- *Kids who are bullied are at a higher risk of anxiety, depression, and other problems associated with suicidal behavior.*
- *Bullying, and especially chronic bullying, has long-term effects on suicide risk and mental health that can last into adulthood.*

Whether it's in-person or online, if you're a witness to bullying, don't be a bystander. Acknowledge, Care, and Tell.

Optional Military-Specific Questions

1. What might make a student who has a deployed parent at increased risk for depression and suicide?

Answer:
Loss and stress are two common triggers for depression. Parental deployment places school-age children and adolescents at higher risk for a range of difficult mood and behavioral changes. Below are several situations that can contribute to a feeling of hopelessness:

- Break-ups
- Family problems
- Sexual, physical or emotional abuse
- School or work problems
- Feeling like you don't belong anywhere
- Drug or alcohol addiction
- Mental illness
- The death of a loved one
- Any problem that seems hopeless

2. You notice that a friend seems to be struggling because of their dad's pending or current deployment. They are distracted and having trouble focusing. They tell you they are constantly fighting with their mother and not doing well in school. They express that their family would "probably be a lot less stressed" if they were not here anymore. How might the ACT technique be used to support the student?

Answer:

- Acknowledge: You can tell them that you have "been there" and "It sounds like you're really having a hard time with this."
- Care: Provide support. "Hang in there. I know it seems rough now, but things will get better," and ask, "How long have you been feeling like this?"
- Tell: Identify an adult that you both feel comfortable talking to and offer to talk with the adult together.

General Discussion Questions

1. What's the difference between being sad and depressed?

Answer:

- Depression is more than the blues or the blahs; it is more than the normal, everyday ups and downs. When that "down" mood, along with other symptoms, lasts for more than a couple of weeks, the condition may be what's referred to as depression.
- Depression is a serious health problem that affects the whole person, mind and body. In addition to feelings, it can change or affect behavior, physical health and appearance, academic performance, thinking, social activity, and the ability to handle everyday decisions and pressures.
- Depression can lead someone to isolate themselves from their friends and lose interest in activities they once enjoyed doing.
- Depression can lead to thoughts of death or suicide.

2. According to the school counselor, why do people get depressed?

Answer:

- Depression can come from a chemical imbalance in your brain.
- Depression can run in families.
- Sometimes life stressors cause depression.
- Sometimes it's a combination of reasons.

NOTE: Although the counselor does not say this, you may want to add:

- Depression can occur in response to a recent stress or loss, such as problems at school or with the law, the death of a loved one, or relationship troubles.
- Sometimes people experience depression and don't know exactly why or what's causing it. You don't have to know why: if you think that you or someone you care about needs help, it's time to ACT!

3. How can drugs and alcohol make things worse for someone who is depressed?

Answer:

- A lot of depressed people, especially teenagers, also have problems with alcohol or other drugs. Alcohol is a drug, too. Sometimes the depression comes first and people try drugs as a way to escape it. In the long run, drugs or alcohol just make things worse. Other times, the alcohol or other drug use comes first, and depression is caused by:
    - the drug itself
    - withdrawal from it
    - the problems that substance use causes (academic trouble, arguments with parents, results of bad decisions)
    - and sometimes you can't tell which came first...the important point is that when you have both of these problems, the sooner you get treatment, the better

- Alcohol, which initially may make people feel good, acts as a downer in the body and drinking can contribute to feelings of depression and make one's moods unstable.
- Alcohol increases the risk of suicide. Alcohol is involved in half of all suicides, murders, and accidents.
- Alcohol takes away good judgment and safe behavior. Alcohol can make people do things they don't want to do, say things they don't want to say, and can lead to dangerous, risky behavior.
- Some drugs, like alcohol or street drugs, may reduce the effectiveness of medication used to treat depression.

NOTE: One warning sign of depression or suicide risk is when someone you know suddenly starts drinking alcohol.

4. What would you do if the adult you share your concerns with does not respond to you or take your concerns seriously?

Answer:

- Don't give up!
- State your concerns again and the reasons why you are worried until the person responds.
- Share your concerns with someone else: a parent, teacher, school counselor or other trusted adult.

5. Why should you be confident you are not betraying a friend when you tell an adult that your friend may be depressed or suicidal?

Answer:
Depression can interfere with a person's ability or wish to get help. It is an act of true friendship to share your concerns with an adult who can help.

Remember:
Depression is also common: if you're struggling, you're not alone! Depression is treatable: if you need help, help is available.

Self-Injury Discussion Questions

NOTE TO DISCUSSION LEADER: Keep information about self-injury very general and within the context of seeking help from a trusted adult.

Focus on:

- Self-injury as a mental health problem that can be treated.
- The signs of emotional stress and risk factors that can contribute to self-injury.
- Those in the school who are trained to help students who self-injure.

1. What is self-injury?

Answer:

- Self-injury is when a person hurts their body on purpose without the intention to die.
- Self-injury is a mental health problem that must be treated by a professional.

2.What should you do if you know someone who is self-injuring?

Answer:
If you know someone who is hurting himself or herself on purpose, do the same thing you would do if you knew they were depressed or suicidal: ACT. **Acknowledge** the problem, let the person know you **Care** and **Tell** a trusted adult.

NOTE TO DISCUSSION LEADER: As a classroom exercise, ask students to recall the signs of depression and suicide to reinforce learning. Add those that are not recalled to the end of the lesson.

SIGNS (SYMPTOMS) OF DEPRESSION

- Frequent sadness, tearfulness, crying
- Hopelessness
- Decreased interest in activities; or inability to enjoy previously favorite activities
- Persistent boredom, low energy
- Social isolation, poor communication
- Low self-esteem and guilt
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses, such as headaches and stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of/or efforts to run away from home
- Thoughts or expressions of suicide or self-destructive behavior

WARNING SIGNS FOR SUICIDE

- Talking, reading or writing about suicide or death
- Talking about feeling worthless or helpless
- Saying things like, “I’m going to kill myself,” “I wish I were dead,” or “I shouldn’t have been born”
- Visiting or calling people to say goodbye
- Giving things away
- Organizing or cleaning one’s bedroom “for the last time”
- Developing a sudden interest in drinking alcohol
- Purposely putting oneself in danger
- Obsessing about death, violence and guns or knives
- Previous suicidal thoughts or suicide attempts

Suicide Prevention Program

Follow Up Lesson Plans

Follow Up Lesson Plans

Introduction

Classroom games serve as a way of increasing both knowledge and skills in students. The games included in this packet are a cognitively complex way of reviewing key material presented in the SOS *Time to ACT* video and the Student Newsletter. Games that have learning complexity and are successfully infused into the curriculum are a highly effective strategy in getting students to move the knowledge and skills they received into long-term memory.

These units of instruction are designed to help those implementing the SOS Program offer an additional set of lessons that build on the essential knowledge and skills in depression awareness and suicide prevention. Before implementing these lessons, students should have already seen the SOS *Time to ACT* video and reviewed the Student Newsletter.

The following pages contain four ideas for activities:

- Lights, Camera, ACT!
- The Categories Game
- Connections
- Jeopardy!

Lights, Camera, ACT!

Instructions: Explain to the students that the goal of the exercise is to engage them in a role playing activity to help them develop and practice effective ways to handle situations that involve being concerned for a depressed or suicidal friend.

1. Engage students in a process to identify their own experiences with being concerned for a friend. One effective method is to ask students to write down an experience that they have had or witnessed and submit these privately to the teacher or group leader. These scenarios can then be reviewed, combined and/or re-written to produce some realistic scenarios in addition to the ones provided below. Including scenarios created by students will ensure that a range of examples are represented and that each is written in a way that offers itself to acting/presentation format.
2. Review the "Dos" and "Don'ts" below with students before they start creating their dialogue.
3. Divide students into groups of 4 to 5 students. Each group will designate 2 actors to role play the scenario, but the entire group will work together to create a script that shows how to effectively respond to a situation involving a friend who might be depressed or suicidal.
4. After a team has presented their dialogue, lead the entire class in a discussion on how the situation was handled; what warning signs were presented, what could have made it a more effective conversation, how was ACT used, etc.

When talking to a friend who might be suicidal:
Do:

- Be yourself. Let the person know you care, that he/she is not alone.
- Listen. Let your friend vent and talk about how they're feeling. No matter how negative the conversation seems, the fact that it is happening is a positive sign.
- Be sympathetic, non-judgmental, patient, calm and accepting.
- Offer hope. Reassure the person that help is available and that the suicidal feelings are temporary.
- Tell a trusted adult. These problems are bigger than something you can fix on your own.

Don't:

- Argue with the suicidal person. Avoid saying things like: "You have so much to live for," "Your suicide will hurt your family," or "Look on the bright side."
- Act shocked or angry at them for feeling suicidal.
- Promise to keep it a secret. A life is at stake and you may need to speak to a mental health professional in order to keep the suicidal person safe. If you promise to keep your discussions secret, you will have to break your word.
- Offer ways to fix their problems, give advice, or make them feel like they have to justify their suicidal feelings.
- Blame yourself. You can't "fix" someone's depression.

(http://www.helpguide.org/mental/suicide_prevention.htm)

Some Ideas for Scenarios:

Sam is hanging out at her friend Sasha's house one weekend. Sasha has been acting strange lately at school; not caring about grades, skipping class and avoiding her normal group of friends at lunch, so Sam is excited to finally hang out and see what's been going on with her friend lately. Right when Sam gets to her house, Sasha drags her to her room and pulls a water bottle full of alcohol out of her dresser and takes a couple gulps. Sam is surprised because she's never seen or heard anything about her friend's drinking habits. "I just can't take all this stress anymore. Tests, papers, practice. It's too much. I want to be done with everything," Sasha says.

It's the end of the school day, and Shawn is talking to Marcus about the upcoming weekend. They usually make plans to hang out and play basketball on Saturdays with some other guys, but Marcus hasn't shown up for the last couple months. Shawn asks Marcus about it, but he becomes annoyed and angry and tells him to just back off. Shawn thinks it's strange considering Marcus is typically energetic, happy and always up for shooting hoops.

Maria calls her friend Alex to see if she's still coming to her birthday dinner on Friday night. Alex has known about it for months, and was initially excited for a fun night out. But ever since her parents split up a few months ago, she's been crying non-stop; at school, during track practice, and has been quiet and withdrawn around her best friends. Maria has a feeling that Alex will not want to come to her birthday, but she's unsure how to let her know that she's worried.

Theresa is on Facebook one night when she notices her friend, Laura, posted a status saying "I can't live this kind of life anymore. I'm ready for it to end." Theresa is not sure if it's too late to call her, but this post is really worrying her.

Ever since Christina and her boyfriend broke up, his friends have been sending her harassing text messages and messages online. At first she responded to them, asking them to stop, but that seemed to make it worse. Rumors have started spreading around the school, and Devon overhears Christina telling someone "I guess I deserved it anyway. I was never good enough for him." Devon is concerned about her because it's unlike her to be so negative.

The Categories Game

What do these have in common?
A review strategy

Requirements: All the students will be involved in this review game. The instructor can divide the class into teams of 4-6 students. Each group can choose a 100 to 500 point question. There are six items at each point value.

Time: 30 minutes or less during one class period, recommended at the end of the unit of study.

Instructions: The task for the students is to determine what the three terms have in common. Some will be closely related to the information and skill presented in the SOS Program while some will have to connect a single term related to depression and suicide to seemingly unrelated words. If the team that chooses a question misses the question the next team can get those points if they get the answer correct. The rotation continues until every team has a chance to give the right answer. The team that accumulates the most points by the end of the game is declared the winner.

100 Point Items

1. Counselors
2. Coaches
3. Parents

Examples of trusted adults

1. “You can save a”
2. “is too short”
3. “Setting goals can change your”

Sayings that have the word life in them

1. Happy
2. Mad
3. Ashamed

Moods or feelings

1. A
2. C
3. T

Initials for acknowledge, care and tell

1. S
2. O
3. S

A call or signal for help / the name of the Signs of Suicide Prevention Program

200 Point Items

1. Suddenly beginning to drink alcohol
2. Cutting classes
3. Someone losing interest in their favorite hobbies

Sudden changes in behavior; warning signs of depression or suicide

1. Worthlessness
2. Hopelessness
3. Helplessness

Feelings can be warning signs for suicidal thinking

1. Taking your friend seriously
2. Being willing to listen
3. Telling an adult

Ways to show a friend that you are concerned

1. Extreme changes in mood
2. Not wanting to do anything
3. Saying that life is meaningless

Warnings signs of depression or suicide

1. Not responding to emails/texts/posts with gossip
2. Not responding to negative comments about someone online
3. Telling a trusted adult

Ways to fight (cyber)bullies

300 Point Items

1. Giving belongings away
2. Visiting or calling friends to say goodbye
3. Asking if you would attend their funeral

Signs that someone might have a suicide plan

1. Tell them to snap out of it
2. Keep it a secret
3. Leave the person alone

Things you should NOT do when trying to help someone.

1. “Nobody would miss me anyway.”
2. “I won’t be around much longer.”
3. “Things will never get better.”

Examples of threats

1. Someone struggling with their sexuality
2. Someone dealing with loss of a family member
3. Someone who has an unsafe home life

People who might need extra support

1. Eat healthy foods
2. Get plenty of sleep
3. Drink a lot of water

Things you can do to take care of yourself

400 Point Items

1. Posting lies online
2. Making threats to others on the way to school
3. Spreading rumors by sending mass texts/public posts

Behaviors done by bullies; behaviors that should be shared with a trusted adult

1. Calling the national suicide hotline number
2. Talking to the school counselor
3. Talking to the coach after practice

Ways to get help for yourself or a friend

1. “Everyone would be better off without me.”
2. “I wish I could go to sleep and never wake up.”
3. “Life isn’t worth living anymore.”

Thoughts that express suicidal thinking

1. Involved in half of all suicides
2. Slows down the body and the mind
3. Slows clear thinking and judgment

Ways alcohol can be related to suicide

1. “Are you OK?”
2. “I’m worried about you.”
3. “I want to go with you to get help.”

Ways to Acknowledge and Care for a friend.

500 Point Items

1. Suicide threats
2. Car accidents
3. A world record

Things that should be reported

1. Understanding
2. Good listener
3. Expresses concern and wants to help

Qualities in a trusted adult or good friend

1. Unreasonable anger and aggression towards friends
2. Taking dangerous risks
3. Feeling sad & blue almost all the time

Warning signs of depression

1. Talk to a friend when you have a problem
2. Play a sport or get some exercise
3. Take slow, deep breaths

Things you can do to relieve stress (in a healthy way!)

1. Counselors
2. Psychologists
3. Social workers

People who can provide mental health support

Connections

Instructions: - Can be played as full class or in small groups.

- This review game is similar to Apples to Apples and can be played in teams of four or five students. Each player will receive four descriptor cards. There is one judge of the round. The judge position rotates, like the dealer for a hand of cards, so there is a new judge each round. The judge picks up a noun card (noun cards on second two pages of words to follow) from the noun pile and all the teams/players, except the judge, play one descriptor card face down that the team believes fits the noun best.

- The judge uses the first four cards on the table to make his/her decision as to what descriptor card most closely fits the noun. The judge mixes up the cards so she/he doesn't know who played which card. The judge mentally connects all four descriptors to the noun in some way. Then the judge explains why he/she chose the card he/she did.

- Players are encouraged to try to convince the judge to change his/her answer. Ultimately, the final decision is up to the judge of that round. The person whose descriptor was chosen keeps the noun card. Each team must make sure they have four descriptor cards in their hand at the beginning of each round. If not, they pick from the pile. The judging position then moves to the next person. The first team to collect five cards (or a number of cards designated by the instructor) is the winner.

Materials:

- Noun Cards
- Descriptor Cards

(Both can be printed on heavier cardstock paper and/or laminated to increase longevity)

Modifications:

- The instructor can create new descriptors and nouns to add to the card deck. It is also a great activity to get students involved, giving them the opportunity to express how feelings/moods relate to specific events/ activities. This would allow for group discussion around perceptions of suicide and depression.

- Individually or as a part of a team, students can pick a descriptor card and a noun card, and using the matched cards create a story or dialogue surrounding the topic. Students should focus efforts on creating a piece that effectively uses ACT, shows how students have benefited from the help of a friend or trusted adult, gives examples of ways for students to combat issues and concerns as they arise, etc. Students could then present their stories/dialogues to the class.

Descriptor Cards

Worried	Isolated	Aggression	Detailed
Anger	Positive	Communication	Guilt
Slow	Urgent	Suicidal	Emptiness
Inconsistent	Healthy	Personality	Reckless
Worthlessness	Isolation	Helpful	Loving

Descriptor Cards

Happy	Dangerous	Useful	Sad
Supportive	Safe	Crazy	Dysfunctional
Vulnerable	Lethal	Trustworthy	Traumatic
Courageous	Negative	Fast	Hopeless
Risky	Abusive	Alone	Important

Noun Cards

S.O.S	Friends	Text Messages	Risk Factors
A.C.T	Family	Knife	Conflicts
Suicide	Intervention	Gun	Secrets
Prevention	Hot Lines	Self-Esteem	Life
Psychologist	Counselors	Myths	Death

Noun Cards

Drugs	Stress	Help	You
School	Bully	Friend	Life Skills
Teenagers	Relationships	Overdose	Break Ups
Conflict	Depression	Treatment	Alcohol
Communication			

Jeopardy!

Requirements: All the students will be involved in this review game. The instructor divides the class into teams of 4-6 students. Team One will start by choosing a category and then a corresponding point value question.

Instructions:

- Students work together in their teams to come up with the answer to the question. Display categories on the board (samples provided at the end of this lesson). Questions can be projected up on the board or presented in a PowerPoint; whichever is easiest for the instructor.
- Designate a scorekeeper to keep track of points for each group as questions are correctly answered. The team must have their answer fully written down before they can raise their hand to answer. All teams will participate in each question and have the opportunity to answer. The team that answers the question correctly first will pick the next category and point value question. Tally points as the game continues.

Myth Or Truth?
(After each question, initiate class discussion on why it's a myth or fact)

1. Teenagers don't get depressed, they can just be moody at times (**MYTH**)

2. Depression can affect people of any age, race, ethnicity or economic group (**TRUTH**)

3. Almost everyone who dies by suicide has given some type of warning or clue (**TRUTH**)

4. There is no way to treat depression (**MYTH**)

Choose The Correct Phrase:

1. If a friend has lost a loved one, they are _____ to be at risk for depression and/or suicide.
    a. More likely
    b. Less likely

2. Teenagers who use alcohol and illegal drugs are _____ to be at risk for depression and/or suicide.
    a. More likely
    b. Less likely

3. If a friend tells you to keep their suicidal thoughts a secret, you should:
    a. Follow their wishes. You don't want them to be mad at you.
    b. Tell a trusted adult. Their safety is most important.

4. You notice your friend has been skipping practice and doesn't care about their school work anymore. You should:
    a. Text the other students on the team. You need to vent because your friend is annoying you.
    b. Tell your friend you're worried about them. You want to be supportive.

Warning Signs of Suicide:

Review: what is a warning sign, how should students respond if they see these behaviors or characteristics in a friend?

1. Which of the following is NOT a warning sign of suicide:
    a. Loss of interest in hobbies or work
    b. Threats, like saying "I won't be around much longer"
    c. Trying out for a new fall sport (**CORRECT**)
    d. Feelings of self-hatred and shame

2. How would you define "warning signs of suicide"?
    a. When you notice someone has been acting weird for the last couple days
    b. When you notice visible changes, behaviors, or comments that directly or indirectly show someone is thinking about suicide (**CORRECT**- what are some examples of these changes, behaviors, comments?)
    c. When you notice someone crying after they got a "D" on their history paper
    d. When you notice someone talking to the guidance counselor during lunch

3. What is NOT an example of a suicidal threat?
    a. Someone saying, "I won't be around much longer"
    b. A friend saying they want to take a bunch of pills to forget about everything wrong in their life
    c. Someone giving away the possessions they care about the most
    d. A friend saying that they're ready to be done with middle school because they're so excited to get to high school (**CORRECT**)

4. What should you do if you are worried about a friend but no one else seems to notice anything to be concerned about?
    a. Agree with everyone else; you're just imagining it
    b. Post your concerns on Facebook and Twitter
    c. Talk to them and let them know you've been worried (**CORRECT**)
    d. Ignore it and focus on different friends

How To Help A Friend:

1. **100 Points**: Name 3 types of trusted adults you could go to with a friend that needs help. (Teacher, coach, nurse, counselor, etc.).

2. **200 Points**: A friend tells you that they're struggling with depression and you immediately ACT – what does this stand for? (Acknowledge that your friend has a problem, Care for them by listening and being supportive, Tell a trusted adult).

3. **300 Points**: A friend who recently lost her father tells you that she doesn't think life is worth living without her dad around anymore. When you suggest talking to a trusted adult, she gets angry and refuses, making you promise not to tell anyone. What should you do? (Since your friend is making suicidal threats, you need to follow the ACT message and tell a trusted adult. They might get angry with you, but it is better to have your friend safe and getting the help they need).

4. **400 Points**: You're hanging out in your friend's room, when you notice a small handgun inside of his open dresser drawer. It seems weird, but you decide to brush it off. As the weeks go by, you notice he's getting into trouble at school and was caught stealing a video game from the mall. When you ask him what's been going on lately, he gets annoyed and says, "Why should you care what I do? It's not like it will even matter in a couple days." You get frustrated and decide to leave him alone because he's not fun to be around anymore. This is the wrong way to respond. Following the ACT message, what would be the correct way to respond? (Acknowledge that your friend has a problem, Care for them by listening and being supportive, Tell a trusted adult).

MYTH OR TRUTH?	CHOOSE THE CORRECT WORD:	WARNING SIGNS OF SUICIDE:	HOW TO HELP A FRIEND:
100 Points	100 Points	100 Points	100 Points
200 Points	200 Points	200 Points	200 Points
300 Points	300 Points	300 Points	300 Points
400 Points	400 Points	400 Points	400 Points

Section 6: Materials for Reproduction

Suicide Prevention Program

Materials for Staff

- **Disclosure Template for School Staff to Use When Approached by Students Asking for Help**
  This template is meant as a guide to steer school personnel through situations that might arise so that they might be prepared for and comfortable with handling students asking for help.

- **Student Follow-Up Form**
  Using the template provided in your kit to make copies, complete a form for each student seeking help as a result of the program.

- **Sample Active & Passive Parental Consent Letters**
  If parental consent is required to implement a suicide prevention program, you may adapt one of the following letters (for either Active or Passive Consent) and send it to parents on school letterhead, accompanied by the Parent Screening Form and Referral Resource List.

- **Sample Parental Permission Slips**
  Active and passive examples provided on the back of each consent letter.

- **Maximizing Parent Consent Returns**
  Thanks to the Suicide Prevention Resource Center www.sprc.org for permission to reproduce this article.

- **Building a Supportive School Environment**

- **Sustaining Prevention Efforts**

- **Pre-/Post- Test (long version)**
  Use this tool to measure the knowledge students gain in suicide prevention.

- **Pre-/Post- Test (short version)**
  Use this tool to measure the knowledge students gain in suicide prevention.

Disclosure Template for School Staff to Use When Approached by Students Asking for Help

WHAT TO DO WHEN APPROACHED BY STUDENTS ASKING FOR HELP

- Once a student has disclosed the need for help (whether directly, or indirectly through someone else, or even in a written assignment) **do not leave the student alone.**
- Listen to what the student has to say; observe his or her demeanor and avoid making the student feel embarrassed or guilty. The program team may want to brainstorm some appropriate phrases to review with all staff beforehand or include with this template.
- Offer words of encouragement, but **do not promise confidentiality**. Acting to prevent a potential suicide always overrides the need to honor confidentiality between that individual and the student.
- Advise the student that you are going with him/her to Mr./Ms. [insert name of the individual designated in your high school procedure] office. He/She knows what needs to be done to make sure that you will get the professional help you need to deal with these feelings safely.
- The appropriate person (designated in school procedure) should immediately **contact the student's parent(s) or guardian** and work with them to make whatever treatment referral is necessary.

SIGNS (SYMPTOMS) OF DEPRESSION

- Depressed mood (can be sad, down, grouchy, or irritable)
- Changes in sleeping patterns (too much, too little, or disturbed)
- Change in weight or appetite (decreased or increased)
- Speaking and/or moving with unusual speed or slowness
- Loss of interest or pleasure in usual activities
- Withdrawal from family and friends
- Feelings of worthlessness, self-reproach, or guilt
- Diminishing ability to think or concentrate, slowed thinking or indecisiveness
- Thoughts of death, suicide, or wishes to be dead

OTHER INDICATIONS OF DEPRESSION

- Extreme anxiety, agitation, or enraged behavior
- Excessive drug and/or alcohol use
- Neglect of physical health and/or appearance

Student Follow-Up Form

Date of Initial Contact: _____ **Student Name:** _____

How did the student come to the attention of school staff (check all that apply)?
☐ Student self-referred ☐ Student was accompanied by a friend/another student ☐ Parent ☐ School staff
☐ Other (specify): _____
Was this considered an emergency? ☐ Yes ☐ No
Was alcohol use assessed? ☐ Yes ☐ No

RECOMMENDATION (Check all that apply):
☐ Needs further evaluation ☐ Suicidal ☐ With intent or plan ☐ Without intent or plan
☐ Completed full psychiatric evaluation ☐ Does not require further evaluation ☐ Other (Specify):_____

PARENT/GUARDIAN NOTIFICATION AND INVOLVEMENT
Was the Parent/Guardian Contacted? ☐ Yes, date of contact:_____ (day/month/year) ☐ No

In those cases when the parent/guardian was contacted, the parent/guardian was:
☐ In agreement with the recommendation for follow up and did bring the child for follow up
☐ In agreement with the recommendation for follow up but did not bring the child for follow up
☐ Disagreed with the recommendation for follow up and did bring the child for follow up
☐ Disagreed with the recommendation for follow up and did not bring the child for treatment
☐ Other (specify):_____

In the case when parents **disagreed** with the need for referral and **did not** follow through, was a child protective agency contacted? ☐ Yes ☐ No
If yes, describe outcome: _____

REFERRAL INFORMATION
Was the child referred for follow-up evaluation/treatment? ☐ Yes ☐ No
If yes, was the child referred to:
☐ Local Emergency Room ☐ Local Crisis Team ☐ School Counseling Staff ☐ Pediatrician
☐ School Support Group ☐ Outpatient Referral (outside of school) ☐ Inpatient Referral
☐ Partial Hospital /Intensive Outpatient Program ☐ Other (specify): _____

A follow up appointment was made (where indicated):
☐ Immediately ☐ Within 24 hours ☐ Within 48 hours ☐ Within 72 hours
☐ Within a week ☐ Within a month ☐ Other (specify): _____

Did you have any problems making referrals for counseling or treatment? ☐ Yes ☐ No
If yes, what problems did you experience? (Check all that apply):
☐ Didn't have a place to refer student to ☐ Student left the school before a referral could be made
☐ Long wait list ☐ No providers accepted insurance ☐ Other (specify): _____
Indicate how you resolved the problem: _____

Staff Signature: _____ Date: _____
FOLLOW UP Date of Follow Up: _____

For those who followed through with treatment, was the child still in treatment within:
1 month within the referral being made ☐ Yes ☐ No ☐ Don't know
3 months of the referral being made ☐ Yes ☐ No ☐ Don't know

Child terminated treatment:
☐ Against medical advice ☐ Completed treatment recommendations ☐ Ran out of insurance coverage
☐ Don't know ☐ Other (specify): _____

Staff Signature: _____ **Date:** _____

Sample Active Consent Letter (accompanied by Parent Newsletter)

Dear Parent or Guardian:

The adolescent years are marked by a roller-coaster ride of emotions—difficult for students and their parents. It is easy to misread depression as normal adolescent turmoil; however, depression (among the most common of mental illnesses) does occur in some adolescents. Depression—which is treatable—is a leading risk factor for suicide. In addition, self-injury has become a growing problem among youth.

To proactively address these issues, [our school] is offering depression awareness and suicide prevention training as part of the SOS Signs of Suicide® Prevention Program. The program aims to increase help-seeking by students concerned about themselves or a friend. SOS is listed on Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices and in a randomized control study, the SOS High School Program showed a reduction in self-reported suicide attempts by 40% (BMC Public Health, July 2007).

Our goals in participating in this program are straightforward:

- To help our students understand that depression is a treatable illness
- To explain that suicide is a preventable tragedy that often occurs as a result of untreated depression
- To provide students training in how to identify serious depression and potential suicidality in themselves or a friend
- To impress upon youth that they can help themselves or a friend by taking the simple step of talking to a responsible adult about their concerns
- To help students know whom in the school they can turn to for help, if they need it

[Insert a brief description of how your school intends to implement the program, including whether or not the students will take the screening]

We are enclosing a copy of the Parent Newsletter and Referral Resource List so that you have information and resources about depression and its related risks.

Please sign the enclosed permission slip allowing your child to participate in SOS Middle School Program in school, and return this form to [address] to the attention of [designated school administrator].

If you have any questions or concerns about this program please do not hesitate to contact me at [include phone number, e-mail, best times to be reached].

Sincerely,

[Designated administrator, title]

Sample Passive Consent Letter (accompanied by Parent Newsletter)

Dear Parent or Guardian:

The adolescent years are marked by a roller-coaster ride of emotions—difficult for students and their parents. It is easy to misread depression as normal adolescent turmoil; however, depression (among the most common of mental illnesses) does occur in some adolescents. Depression—which is treatable—is a leading risk factor for suicide. In addition, self-injury has become a growing problem among youth.

To proactively address these issues, [our school] is offering depression awareness and suicide prevention training as part of the SOS Signs of Suicide® Prevention Program. The program aims to increase help-seeking by students concerned about themselves or a friend. SOS is listed on Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices and in a randomized control study, the SOS High School Program showed a reduction in self-reported suicide attempts by 40% (BMC Public Health, July 2007).

Our goals in participating in this program are straightforward:

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- To provide students training in how to identify serious depression and potential suicidality in themselves or a friend
- To impress upon youth that they can help themselves or a friend by taking the simple step of talking to a responsible adult about their concerns
- To help students know whom in the school they can turn to for help, if they need it

[Insert a brief description of how your school intends to implement the program, including whether or not the students will take the screening]

We are enclosing a copy of the Parent Newsletter and Referral Resource List so that you have information and resources about depression and its related risks.

If you do **NOT** wish your child participating in SOS Middle School Program in school, please complete the enclosed form and return it to [address] to the attention of [designated school administrator]. If we do not hear from you, we will assume your child has permission to participate in this program.

Sincerely,

[Designated administrator, title]

Sample Parental Permission Slips

Active

I, [*Name of Parent/Guardian*], **give permission** for [*Name of Student*]
to participate in the SOS Signs of Suicide Prevention Program, to take place on [*Month, Day(s), Time(s)*].

(X) [*Signature of Parent/Guardian*]

Passive

I, [*Name of Parent/Guardian*], **do not give permission** for [*Name of Student*]
to participate in the SOS Signs of Suicide Prevention Program, to take place on [*Month, Day(s), Time(s)*].

(X) [*Signature of Parent/Guardian*]

Maximizing the Return of Parent Consent Forms

Philip Rodgers, Ph.D.
Evaluation Specialist
American Foundation for Suicide Prevention
Suicide Prevention Resource Center

Introduction

Garrett Lee Smith Memorial Act (PL 108-355) grantees are required to obtain active parent consent prior to allowing children to participate in grant-related programming. This requirement has been extended to Linking Adolescents at Risk to Mental Health Services (RFA No. SM-05-019) grantees. Active parent consent is commonly obtained by sending permission forms home with students. The parent or legal guardian must indicate whether they do or do not give permission for their child to participate in the program, sign the form, then return the form to the school prior to their child's participation in program activities.

Unfortunately, the return rate for consent forms often falls below 50%, regardless of whether parents give consent or not (Tigges, 2003). A low return rate results in students not receiving services and lessens the credibility of evaluation results. The former is particularly troubling because non-respondents are often those who need services the most (Anderman et al., 1995; Noll et al., 1997; Unger et al., 2004). However, with awareness of the problem and careful planning consent rates can be significantly increased.

This paper provides practical and research-based recommendations to improving the return rates of parental consent forms. It does not address the content of consent forms. Programs should comply with any relevant federal or state regulations that govern obtaining consent from parents. (U.S. Department of Health and Human Services policy guidance on informed consent can be found at this webpage: http://www.hhs.gov/ohrp/policy/index.html). It is also important that programs exert no undue influence or coercion upon parents to return only affirmative consent forms; the methods outlined here are meant to increase the return rate of consent forms regardless of whether consent is provided or not. In addition, programs may want to actively collaborate with parents and families so that the process of seeking consent is acceptable to the community in which the programs operate.

Recommendations

The following recommendations were culled from the literature.

1. Engage parents and school personnel. High consent rates cannot be obtained without the support of parents, school administrators, and teachers. Support can be increased by engaging parents, parent groups (e.g. community and school advisory boards, and parent-teacher organizations), and school personnel from the beginning of program planning and keeping them fully informed.
    - While the process of obtaining active parent consent is required, it should also be seen as an opportunity for constructive interactions among parents, school staff and researchers. Such interactions are credited, in part, for achieving an 89% response rate from middle school parents (O'Donnell et al., 1997). Culturally appropriate communications should be used with families and should detail all aspects of the program and data collection (Ross, Sundberg, & Flint, 1999).
    - When middle and high schools used their own resources and staff to collect consent forms, they had a significantly higher return rate (80% v. 59%) compared to schools that requested or required that researchers collect forms (Ji et al., 2004).
    - Administrator and teacher support was credited as being the difference between low and high response schools in a middle school population in one study: "The schools that had high completion rates…typically had administrators who were personally invested in the study and worked closely with teachers to monitor the consent process…teachers were provided support and encouragement to obtain high return rates" (Pokorny et al., 2001; p. 574).

- Including a cover letter from the school's principal has also been recommended by researchers (Esbensen et al., 1996; Ji et al., 2004; Knowlton et al., 1999). Such letters should include a description of the program and research, stress the importance of participation in the research, describe confidentiality assurances, and examples of the types of questions asked (Knowlton et al., 1999).

2. "Piggyback" with existing form collection. Many schools require parents to complete and return a variety of forms at the beginning of the school year. Consent forms can be included with these other forms. (Unfortunately, this may not fit all intervention/research timelines). If report cards are required to be signed and returned by parents, this may provide a more frequent opportunity to obtain consent.

- Higher return rates were found for middle school students when consent forms were attached to student report cards as compared to forms that were mailed and asked parents to return the form to the school with their child (Pokorny et al., 2001).
- In addition to piggybacking, having parents complete consent forms while attending school functions may also be effective. Ji et al., (2004) examined a variety of methods to increase return rates for middle and high-school students and found that "the highest return rate occurred when a consent form was attached to an existing school form that parents had to sign and return to the school" and that "The second highest return rate was obtained by using procedures where parents attended a school-based function and project or school staff was stationed at a location that parents had to stop to complete school-related forms" (p. 588).

3. Provide incentives. Return rates are increased by providing incentives to students, parents, teachers and schools. Student rewards can be individual (candy, pencils, t-shirts) or class-based (pizza parties). Parent incentives have included gift certificates for local grocery stores or entry into drawings for other prizes. Teachers can be given incentives based on the number of individual returns (e.g., $5 gift certificate for each return) or based on a percentage of returns (e.g., $25 gift certificate for a 90% return rate). School incentives can be supplies or gift certificates. Note that incentives should be provided for returning a completed consent form regardless of whether consent is granted or denied by the parent.

- Fletcher and Hunter (2003) obtained a 95% return rate from elementary school parents. They credited the high return rate to three factors: rewarding teachers with $5 gift certificates for every consent form returned, developing a strong relationship with school-level administrators and teachers, and "attention grabbing" forms.
- Classroom pizza parties contributed to a 90% return rate for middle school students (Leakey et al., 2004).

4. Use simple "eye-catching" forms. Consent forms should be easy to read, simple to complete, and catch parents' attention. Parents should not be required to fill in any unnecessary information or information that can be filled in by the school. Forms should "catch" parent's attention through a combination of color and text. Cover sheets should be printed on color paper.

- Fletcher and Hunter (2003) used a cover sheet that exclaimed: "Important! Please complete and return to school tomorrow. Your child's class receives a donation for each form returned--whether you check yes or no!" They also found a more rapid response when bright neon orange paper was used for the cover sheet.

5. Be prepared to follow-up. Sending additional forms to non-respondents will increase return rates. Follow-ups should be spaced one to two weeks apart. Follow-ups can also be conducted by phone with direct requests to return the consent form.

- Using a single follow-up coupled with a "Tootsie Pop" incentive, (Leakey et al.,2004) increased return rates by 18% for middle school students.
- Fletcher and Hunter (2003) recommend the following schedule of follow-ups: (1) initial consent request and form sent home with the student, (2) one week later a second request and consent form is sent home, (3) one week after the second request a third request is sent, this time with a sticker placed on the child's shirt notifying parents that they should look for an important form in their child's bookbag (for elementary students); and, (4) if a consent form has still not been returned, parents should be called at home to see if they've received the form and, if so, could they return it to school the next day.

*Thank you to the Suicide Prevention Resource Center www.sprc.org for permission to reproduce this article. For references, see Section 7 of this manual.

Building a Supportive School Environment Year-Round

Listed below are some suggestions for broad-based suicide prevention strategies that administrators can implement in their schools and communities as a way of addressing depression awareness and youth suicide and breaking down the stigma associated with both:

- Research shows that a positive relationship with an adult, not necessarily a teacher, is one of the most critical factors in preventing student violence, suicide, and bullying. Work to ensure that every student has a perceived caring relationship with a competent adult in the school.
- Strengthen parent involvement with your school by creating forums involving parents and facilitating parent-school communications.
- Develop positive, productive relationships with community-based mental health providers to better serve students by working with mental health facilities, hospitals, and teen programs in your area.
- Incorporate stress management classes that teach teens the warning signs that differentiate normal life stress from clinical depression into your school's curriculum.
- Identify historical stressors in students' lives, such as the transition from middle to high school, and take proactive steps to ease the transition. Guide student groups to develop a "welcoming committee" or "buddy system" to turn these transitions into positive experiences.
- Plan programs that teach students skills that build resiliency, such as problem solving skills, managing intense feelings, communication skills, and goal setting.
- Educate school staff year round about the problems of depression and suicide by periodically distributing educational materials in staff mailboxes and at events.
- Inform your community about your suicide prevention efforts to gain public support and reduce stigma by initiating a public dialogue about the problems of youth depression and suicide. Submit a story about your prevention efforts to your local paper or town website.

Sustaining Your Prevention Efforts

Maintaining the momentum and assuring sustainability involves "institutionalizing" programs into schools, agencies, and communities—work that requires making permanent changes in systems.

The key ingredient to sustaining your prevention program is the presence of committed leaders to the effort. We suggest the following tips to sustain your suicide prevention efforts:

- Find a champion to bring your program together—someone with influence who would make it a priority.
- Get the need for your prevention efforts and resources in writing.
- Plan ahead for sustainability challenges.
- Include your prevention efforts in your department budget.
- Continue to broaden your project team of supporters of the program by recruiting new partners in your prevention effort.
- Foster, maintain, and enhance partnerships with other organizations and agencies and link with groups already working on issues connected to suicide (e.g., anti-bullying campaigns).
- Maintain regular communication with community partners and develop the relationships as needs change.
- Maintain continuity of leaders and staff, and develop a plan to build the capacity of new leaders that can fulfill these roles in the future.
- Welcome late adopters.
- Provide feedback and gratitude to implementers.
- Remind partners in your prevention efforts of the importance of their contribution.
- Build on other efforts. Youth suicide prevention efforts may have broader appeal if carried out in conjunction with prevention efforts aimed at other issues affecting youth.
- Disseminate data and statistics including rates of suicidal ideation and attempts and how this impacts a community, in order to boost community support.
- Promote a constructive media focus on the issue. Spread the word about the efforts underway, and continue to increase knowledge through education.
- Seek out opportunities for pooling resources across departments that provide a "win-win" situation for both.

Pre/Post SOS Program Questionnaire – Long Version

While this survey is not a formal component of the SOS Program, we know many schools look to assess learning in their students when implementing programming.

We offer two versions of this pre- and post-test. You may consider using this longer version to gain a more comprehensive understanding of your students' education, including Likert scale questions to measure attitudes and feelings. The pre- and post-test questions are identical; you may wish to print them on different color paper to quickly identify which answers you are reviewing. This version would be particularly useful if your school has received and/or is implementing this program due to grant funding, and you are looking for a more detailed evaluation tool for reporting.

The shorter version is also available on this resource page if you are looking for a brief assessment to determine the extent to which students have retained the general learning concepts.

Introduction to Students

Before we start, let me tell you a few things about this survey:

- I am going to read the questions out loud. You should follow along with me and fill in the appropriate answer to each question.
- It's very important that you answer as honestly and accurately as you can.
- Please do not skip ahead so that we can be sure that each person has the same amount of time to answer each question.
- DO NOT write your name on this survey. All your answers will be completely anonymous.
- Completing the survey is voluntary. Whether or not you answer the questions will not affect your grade in this class. If you are not comfortable answering a question, just leave it blank.
- When you have completed the survey, please keep it until I collect it from you.

Does anyone have any questions before we start?

This survey is not a formal component of the SOS Signs of Suicide Prevention Program. Questions come from the University of Connecticut Health Center's Health Behavior Survey. The Introduction to Students was also adapted from the survey.

Part I: *True or False:*

Please answer the following questions as best you can.

1. People who talk about suicide don't really kill themselves. TRUE FALSE
2. People who commit suicide are usually suffering from depression or some other mental illness. TRUE FALSE
3. Most suicide attempts occur without any warning signs or clues. TRUE FALSE
4. Depression is an illness that doctors can treat. TRUE FALSE
5. The best thing to tell a suicidal friend is to "pull yourself together and things will get better." TRUE FALSE
6. If I talk to someone about their suicidal feelings, it may cause them to commit suicide. TRUE FALSE
7. Alcohol use is not related to suicidal behavior. TRUE FALSE

Part II

Now I'm going to read some statements about depression and suicide, and I'd like to know whether you agree or disagree with them.

1. Sometimes young people have so many personal problems they have no other options besides suicide.

STRONGLY DISAGREE	*DISAGREE*	*NEITHER AGREE OR DISAGREE*	*AGREE*	*STRONGLY AGREE*
1	*2*	*3*	*4*	*5*

2. If someone really wants to kill himself/herself, there is not much anyone can do about it.

STRONGLY DISAGREE	*DISAGREE*	*NEITHER AGREE OR DISAGREE*	*AGREE*	*STRONGLY AGREE*
1	*2*	*3*	*4*	*5*

3. It's none of my business if a friend says he/she wants to kill himself/herself.

STRONGLY DISAGREE	*DISAGREE*	*NEITHER AGREE OR DISAGREE*	*AGREE*	*STRONGLY AGREE*
1	*2*	*3*	*4*	*5*

4. If I were feeling really down, I would try to talk to a counselor or some other adult about my problems.

STRONGLY DISAGREE	*DISAGREE*	*NEITHER AGREE OR DISAGREE*	*AGREE*	*STRONGLY AGREE*
1	*2*	*3*	*4*	*5*

Part III

If a friend told me he/she is thinking about committing suicide:

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
I wouldn't know what to do.					
I would keep it to myself.					
I would wish that I had not found out about it.					
I would keep it a secret if my friend made me promise not to tell.					
I would tell an adult.					

Pre/Post SOS Program Questionnaire – Short Version

While this survey is not a formal component of the SOS Program, we know many schools look to assess learning in their students when implementing programming.

We offer two versions of this pre- and post-test. You may consider using this shorter version if you prefer a brief assessment to determine the extent to which students have retained the general learning concepts. The first page is the pre-test, which includes twelve true/false questions. The post-test includes the same 12 questions plus an opportunity for the student to identify the words of the ACT acronym and provide feedback on further learning interests.

The longer version of the pre- and post-test is also available on this resource page. It includes a Likert scale to additionally measure attitudes and feelings. This version would be particularly useful if your school has received and/or is implementing this program due to grant funding, and you are looking for a more detailed evaluation tool for reporting.

Introduction to Students

Before we start, let me tell you about this survey:

- I am going to read the questions out loud. Follow along with me and fill in the appropriate answer to each question.
- It is very important that you answer as honestly and accurately as you can.
- Please do not skip ahead so that we can be sure that each person has the same amount of time to answer each question.
- DO NOT write your name on this survey. All your answers will be completely anonymous.
- Completing the survey is voluntary. Whether or not you answer the questions will not affect your grade in this class. If you are not comfortable answering a question, just leave it blank.
- I will collect all surveys at the end.

Does anyone have any questions before we start?

This survey is not a formal component of the SOS Signs of Suicide Prevention Program. Questions adapted from the University of Connecticut Health Center's Health Behavior Survey. The Introduction to Students was also adapted from the survey

Part I: Pretest: SOS Signs of Suicide Prevention Program

1. Depression is an illness that doctors can treat.	TRUE	FALSE
2. Most suicide attempts occur without any warning signs or clues.	TRUE	FALSE
3. The best thing to tell a suicidal friend is to "pull yourself together and things will get better."	TRUE	FALSE
4. People who kill themselves are usually suffering from depression or another mental illness.	TRUE	FALSE
5. People who talk about suicide don't really kill themselves.	TRUE	FALSE
6. If I talk to someone about their suicidal feelings, it may give them the idea to kill themselves.	TRUE	FALSE
7. Drug and/or alcohol use is a sign that a person might be depressed and/or suicidal.	TRUE	FALSE
8. If someone really wants to kill himself/herself, there is not much anyone can do about it.	TRUE	FALSE
9. It's none of my business if a friend says he/she wants to kill himself/herself.	TRUE	FALSE
10. Withdrawal from family and friends is a warning sign of depression.	TRUE	FALSE
11. A person who is grouchy or irritable cannot be depressed.	TRUE	FALSE
12. If a friend tells me they are thinking about killing themselves, I should tell a trusted adult.	TRUE	FALSE

Part II: Posttest: SOS Signs of Suicide Prevention Program

1. Depression is an illness that doctors can treat.	TRUE	FALSE
2. Most suicide attempts occur without any warning signs or clues.	TRUE	FALSE
3. The best thing to tell a suicidal friend is to "pull yourself together and things will get better."	TRUE	FALSE
4. People who kill themselves are usually suffering from depression or another mental illness.	TRUE	FALSE
5. People who talk about suicide don't really kill themselves.	TRUE	FALSE
6. If I talk to someone about their suicidal feelings, it may give them the idea to kill themselves.	TRUE	FALSE
7. Drug and/or alcohol use is a sign that a person might be depressed and/or suicidal.	TRUE	FALSE
8. If someone really wants to kill himself/herself, there is not much anyone can do about it.	TRUE	FALSE
9. It's none of my business if a friend says he/she wants to kill himself/herself.	TRUE	FALSE
10. Withdrawal from family and friends is a warning sign of depression.	TRUE	FALSE
11. A person who is grouchy or irritable cannot be depressed.	TRUE	FALSE
12. If a friend tells me they are thinking about killing themselves, I should tell a trusted adult.	TRUE	FALSE

What does ACT stand for?
A _____
C _____
T _____

Regarding teen depression and suicide, I would like to learn more about… _____
_____
_____

Suicide Prevention Program

Materials for Students

- **Sample Student Response Cards**

- **How and Why to Get Help for Yourself or a Friend**
  Distribute this sheet to students along with other educational materials and take-aways

- **Brief Screen for Adolescent Depression**
  Screening tool used to assess for follow-up

- **Brief Screen for Adolescent Depression with Alcohol Questions**
  Screening tool used to assess for follow-up

Sample Student Response Cards

On the following page you will find a template of the Student Response Card. There are also hard copies in your program.

We **strongly** recommend use of the Student Response Card, whether you choose to use the screening forms as well or use them alone. This is a simple and practical way for students to let you know they would like to speak to someone.

You may also choose to use the Student Response Card at other times of the year when in a classroom speaking to students about other sensitive topics. We encourage you to use this tool as a way for students in your school to understand that you, and other staff, are trusted adults in their lives.

Have each student complete and sign the card and have school staff collect them (to protect anonymity, do not ask students to pass cards forward). Be sure to set expectations about staff response time on the card on the blank line provided. While it is recommended that follow-up be provided the day of your program, if this is not feasible, indicate realistic expectations of follow-up on the bottom of the card before reproducing and distributing it to students. Consider the following example, "If you wish to speak with someone, you will be contacted within 24 hours. If you need to speak with someone sooner, please ask for help immediately."

BASED ON THE VIDEO AND/OR SCREENING, I FEEL

- ☐ **I need to talk to someone…**
- ☐ **I do not need to talk to someone…**

ABOUT MYSELF OR A FRIEND.

NAME (PRINT) ____

COUNSELOR/HOMEROOM TEACHER____

IF YOU WISH TO SPEAK WITH SOMEONE, YOU WILL BE CONTACTED WITHIN 24 HOURS. IF YOU WISH TO SPEAK WITH SOMEONE SOONER, PLEASE APPROACH STAFF IMMEDIATELY.

BASED ON THE VIDEO AND/OR SCREENING, I FEEL

- ☐ **I need to talk to someone…**
- ☐ **I do not need to talk to someone…**

ABOUT MYSELF OR A FRIEND.

NAME (PRINT) ____

COUNSELOR/HOMEROOM TEACHER____

IF YOU WISH TO SPEAK WITH SOMEONE, YOU WILL BE CONTACTED WITHIN 24 HOURS. IF YOU WISH TO SPEAK WITH SOMEONE SOONER, PLEASE APPROACH STAFF IMMEDIATELY.

BASED ON THE VIDEO AND/OR SCREENING, I FEEL

- ☐ **I need to talk to someone…**
- ☐ **I do not need to talk to someone…**

ABOUT MYSELF OR A FRIEND.

NAME (PRINT) ____

COUNSELOR/HOMEROOM TEACHER____

IF YOU WISH TO SPEAK WITH SOMEONE, YOU WILL BE CONTACTED WITHIN 24 HOURS. IF YOU WISH TO SPEAK WITH SOMEONE SOONER, PLEASE APPROACH STAFF IMMEDIATELY.

BASED ON THE VIDEO AND/OR SCREENING, I FEEL

- ☐ **I need to talk to someone…**
- ☐ **I do not need to talk to someone…**

ABOUT MYSELF OR A FRIEND.

NAME (PRINT) ____

COUNSELOR/HOMEROOM TEACHER____

IF YOU WISH TO SPEAK WITH SOMEONE, YOU WILL BE CONTACTED WITHIN 24 HOURS. IF YOU WISH TO SPEAK WITH SOMEONE SOONER, PLEASE APPROACH STAFF IMMEDIATELY.

How and Why to Get Help for Yourself or a Friend

- Many people are available to help you, including health professionals, teachers, guidance counselors and coaches.
- You are not a “bad” person for being depressed. You did not choose to feel the way you do.
- You are not alone; there are many other people who share your feelings and issues.
- The entire school does not have to know.

WHAT TO EXPECT FROM TREATMENT FOR DEPRESSION

- Treatment is very effective and can include psychotherapy, or “talk therapy,” medication, or often, a combination of both. Short-term psychotherapy means talking about feelings with a trained professional who can help you change the relationships, thoughts, or behaviors that contribute to depression. It is important to find someone you are comfortable talking with who will work with you to develop the very best treatment plan.
- Medications have been developed that effectively treat depression. Antidepressant medications are not “uppers” and are not addictive. If medication is indicated, you may need to try more than one type of medication before you and your doctor find the one that works best.
- With treatment, whether it is talk therapy, medication, or a combination of both, most depressed people start to feel better in just a few weeks.

GUIDELINES FOR STUDENTS WHO MAY BE AFRAID TO TALK TO PARENTS OR CAREGIVERS ABOUT DEPRESSION

- If you are worried about speaking to your parents about depression, there are other people you can talk to who can educate you about depression. Find an adult you trust — such as a coach, school nurse, teacher, minister, priest or rabbi — and ask them to meet with you and your parents.
- Ask one of your best friends to come with you to talk to your parent or guardian. Practice the conversation with your friend first, then you can decide exactly what you want to say.
- Remember that **there is always someone you can find to help** you and your family. Seek out the resources at your school to find out more information.

SOS Signs of Suicide® Prevention Program

Student Screening Form

- Age: _____
- Gender:

☐ Female ☐ Male

☐ Transgender

- Grade in School:

☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ 11 ☐ 12 ☐ GED Program

☐ Other: _____

- Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
- Race: *(Check all that apply)*

☐ American Indian/Alaska Native ☐ Asian

☐ Native Hawaiian/Other Pacific Islander ☐ White

☐ Black/African American ☐ Other/Multiracial

- Are you currently being treated for depression?

☐ Yes ☐ No

Brief Screen for Adolescent Depression (BSAD)*

These questions are about feelings that people sometimes have and things that may have happened to you. Most of the questions are about the **LAST FOUR WEEKS.**

Read each question carefully and answer it by circling the correct response.

1.	In the last four weeks, has there been a time when nothing was fun for you and you just weren't interested in anything?	**Yes No**
2.	Do you have less energy than you usually do?	**Yes No**
3.	Do you feel you can't do anything well or that you are not as good-looking or as smart as most other people?	**Yes No**
4.	Do you think seriously about killing yourself?	**Yes No**
5.	Have you tried to kill yourself ***in the last year?***	**Yes No**
6.	Does doing even little things make you feel really tired?	**Yes No**
7.	In the last four weeks has it seemed like you couldn't think as clearly or as fast as usual?	**Yes No**

Identifying Trusted Adults

List a trusted adult you could turn to if you need help for yourself or a friend (example: "My English teacher," "counselor," "my mother," "uncle," etc.)

In school _____

Out of school _____

SOS Signs of Suicide® Prevention Program - Your BSAD Score and What It Means

The BSAD (Brief Screen for Adolescent Depression) is a self-survey so you can check yourself for depression and suicide risk. Your BSAD survey score will tell you whether you should see a school health professional (psychologist, nurse, counselor or social worker) for a follow-up discussion.

To find out your BSAD score, add up the number of "Yes" answers to questions 1-7. Use the table below to find out what your score means and what you should do.

SCORE	MEANING
0-2	It is ***unlikely*** that you have depression. However, if you often have feelings of sadness you should talk to a trusted adult (parents/guardians/school staff person) to try to figure out what you should do. Even though your score says that you are not depressed you might still want to talk to a healthcare professional if your feelings of sadness do not go away.
3	It is ***possible*** that you have depression. You ***should talk with a healthcare professional***. Tell a trusted adult (parent/guardian/school staff person) your concerns and ask if they could help you connect with a mental health professional. If it makes you feel more comfortable, bring a friend with you. Tell the adult that you ***may be*** clinically depressed and that you might need to see a mental health professional.
4-7	It is ***likely*** that you have depression. You probably have some significant symptoms of depression and you ***should talk to a mental health professional*** about these feelings. Tell a trusted adult (parent/guardian/school staff person) about your feelings and ask if they could help you see a mental health professional.

Questions 4 and 5	These two questions are about ***suicidal*** thoughts and behaviors. If you answered **"Yes"** to ***either*** question **4** or **5,** you should see a mental health professional immediately - ***regardless of your total BSAD score.***

Identifying Trusted Adults	
Concerned about yourself or a friend?	It's important to know who you can turn to if you need to talk. If you had trouble identifying a trusted adult, ask to speak with the person implementing the SOS Program. Let someone know you need help building this important connection. If you are worried about your friend but your friend refuses to speak to someone, ask your trusted adult to help get your friend the assistance he or she needs.

Bottom line: Take these screening results seriously and get help. You or your friend deserves to feel better, and help and support are available to you. **If you are worried about yourself or someone else, call the National Suicide Prevention Lifeline, at 1-800-273-TALK (8255).**

SOS Signs of Suicide® Prevention Program

with Alcohol Use Questions Included

Student Screening Form

- Age: _____
- Gender: □ Female □ Male □ Transgender
- Grade in School:

□ 6 □ 7 □ 8 □ 9 □ 10

□ 11 □ 12 □ GED Program

□ Other: _____

- Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino
- Race: *(Check all that apply)*

□ American Indian/Alaska Native □ Asian

□ Native Hawaiian/Other Pacific Islander □ White

□ Black/African American □ Other/Multiracial

- Are you currently being treated for depression? □ Yes □ No

Brief Screen for Adolescent Depression (BSAD)*

These questions are about feelings that people sometimes have and things that may have happened to you. **Most** of these questions are about the ***LAST FOUR WEEKS.***

Read each question carefully and answer it by circling the correct response.

1. In the last four weeks, has there been a time when nothing was fun for you and you just weren't interested in anything?	**Yes**	**No**
2. Do you have less energy than you usually do?	**Yes**	**No**
3. Do you feel you can't do anything well or that you are not as good-looking or as smart as most other people?	**Yes**	**No**
4. Do you think seriously about killing yourself?	**Yes**	**No**
5. Have you tried to kill yourself ***in the last year?***	**Yes**	**No**
6. Does doing even little things make you feel really tired?	**Yes**	**No**
7. In the last four weeks has it seemed like you couldn't think as clearly or as fast as usual?	**Yes**	**No**

Alcohol Use

a. In the past year, has there been a time when you had five or more alcoholic drinks in a row? (By "drinks" we mean any kind of beer, wine, or liquor)	**Yes**	**No**
b. In the past year, have you used alcohol because you were feeling down?	**Yes**	**No**

Identifying Trusted Adults

List a trusted adult you could turn to if you need help for yourself or a friend (example: "My English teacher," "counselor," "my mother," "uncle," etc.) in school _____ Out of school _____

SOS Signs of Suicide® Program - Your BSAD Score and What It Means

The BSAD (Brief Screen for Adolescent Depression) is a self-survey so you can check yourself for depression and suicide risk. Your BSAD survey score will tell you whether you should see a school health professional (psychologist, nurse, counselor or social worker) for a follow-up discussion.

To find out your BSAD score, add up the number of "Yes" answers to questions 1-7. Use the table below to find out what your score means and what you should do.

SCORE	MEANING
0-2	It is ***unlikely*** that you have depression. However, if you often have feelings of sadness you should talk to a trusted adult (parents/guardians/school staff person) to try to figure out what you should do. Even though your score says that you are not depressed you might still want to talk to a healthcare professional if your feelings of sadness do not go away.
3	It is ***possible*** that you have depression. You ***should talk with a healthcare professional***. Tell a trusted adult (parent/guardian/school staff person) your concerns and ask if they could help you connect with a mental health professional. If it makes you feel more comfortable, bring a friend with you. Tell the adult that you ***may be*** clinically depressed and that you might need to see a mental health professional.
4-7	It is ***likely*** that you have depression. You probably have some significant symptoms of depression and you ***should talk to a mental health professional*** about these feelings. Tell a trusted adult (parent/guardian/school staff person) about your feelings and ask if they could help you see a mental health professional.

Questions 4 and 5	These two questions are about ***suicidal*** thoughts and behaviors. If you answered **"Yes"** to ***either*** question **4** or **5**, you should see a mental health professional immediately - ***regardless of your total BSAD score*.**

Alcohol Use Questions:	
Questions a and b	If you answered, **"Yes"** to question **a or b** concerning alcohol use, you may be using alcohol in a way that is dangerous to your health. We recommend that you speak with a trusted adult or mental health professional about your behavior and feelings.

Identifying Trusted Adults	
Concerned about yourself or a friend?	It's important to know who you can turn to if you need to talk. If you had trouble identifying a trusted adult, ask to speak with the person implementing the SOS Program. Let someone know you need help building this important connection. If you are worried about your friend but your friend refuses to speak to someone, ask your trusted adult to help get your friend the assistance he or she needs.

Bottom line: Take these screening results seriously and get help. You or your friend deserves to feel better, and help and support are available to you. **If you are worried about yourself or someone else, call the National Suicide Prevention Lifeline, at 1-800-273-TALK (8255).**

Materials for Parents

- **Sample Referral List for Parents**
  Use this form as a template and make copies to include in your mailing to parents and/or to distribute at your parent night event.

- **Parent Screening Form**
  This screening form allows parents to consider if their child is exhibiting warning signs for depression.
    - For information on hard copies, pdf, and online screening options, please refer to Section 3.

- **American Academy of Child & Adolescent Psychiatry: Facts for Families**
  These handouts are for use with parents and staff
    - The Depressed Child
    - Teen Suicide
    - Bullying
    - Bipolar Disorder in Children & Teens

Sample Referral Resource List for Parents

As part of your program, provide parents with a referral list for mental health services in your community. Wherever possible, include phone numbers, addresses, fee schedules, accepted insurance plans, services, and hours, which are helpful in directing people to an appropriate facility. Be sure to include publicly funded facilities and those with sliding fee scales for individuals without insurance. Use this form as a template and make copies to include in your mailing to parents and/or to distribute at your parent night event.

One Call Can Make a Difference

You can get help for your child at the following community facilities or individual practitioners. You may need to call several facilities in order to determine the one that best meets your needs.

List of Community Mental Health Resources

- Mental health center(s)
- General hospital(s) with psychiatric services
- Psychiatric hospital(s)
- State, county, or local facilities providing free and/or sliding scale treatment
- Your state's Psychological Association or Social Work chapter
- Local pastoral counseling centers
- Self-help groups
- Advocacy groups (Mental Health Association, National Alliance for the Mentally Ill)
- Private practitioners

SOS Signs of Suicide® Prevention Program

Parent Screening Form

- Child's Age: _____
- Child's Gender:
  ☐ Female ☐ Male
  ☐ Transgender
- Child's Grade in School:
  ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
  ☐ 11 ☐ 12 ☐ GED Program
  ☐ Other: _____
- Child's Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
- Child's Race: *(Check all that apply)*
  ☐ American Indian/Alaska Native
  ☐ Native Hawaiian/Other Pacific Islander
  ☐ Black/African American
  ☐ Asian
  ☐ White
  ☐ Other/Multiracial
- Is your child currently being treated for depression?
  ☐ Yes ☐ No

Brief Screen for Adolescent Depression (BSAD)* Parent Version

These questions are about feelings that people sometimes have and things that may have happened to your child. Most of the questions are about the **LAST FOUR WEEKS.**

Read each question carefully and answer it by circling the correct response.

1.	In the last four weeks, has there been a time when it seemed like nothing was fun for him/her?	**Yes**	**No**
2.	Has he/she seemed to have less energy than he/she usually does?	**Yes**	**No**
3.	In the last four weeks, has it seemed like he/she couldn't think as clearly or as fast as usual?	**Yes**	**No**
4.	In the last four weeks, has he/she talked seriously about killing him/herself?	**Yes**	**No**
5.	Has he/she tried to kill him/herself ***in the last year?***	**Yes**	**No**
6.	In the last four weeks, has he/she had trouble sleeping — that is trouble falling asleep, staying asleep, or waking up too early?	**Yes**	**No**
7.	Has there been a time when your child seemed to do things, like walking or talking, much more slowly than usual?	**Yes**	**No**
8.	In the last four weeks, has he/she often seemed to have trouble keeping his/her mind on his/her schoolwork or other things?	**Yes**	**No**
9.	Has he/she said he/she couldn't do anything well or that he/she wasn't as good looking or as smart as other people?	**Yes**	**No**

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SOS Signs of Suicide® Prevention Program
Scoring Instructions and Interpretation for Parents

The Brief Screen for Adolescent Depression (BSAD) is a depression screening tool for teens and adolescents. In the Parent version, you are asked to answer questions about your child. The BSAD **does not** diagnose a teen or adolescent as depressed, but it does give an indication of whether he or she should be referred to a health care professional (medical doctor, psychiatrist, psychologist, nurse, counselor or social worker) for further evaluation.

The score on the BSAD is achieved by adding up the number of "Yes" answers to the 9 questions on the scale.The following guidelines are ***estimates*** of the likelihood that your child may be depressed:

SCORE	MEANING
0-2	Scores of 2 or lower (two or fewer "Yes" answers) indicate that it is ***unlikely*** that a teen is depressed.
3	Scores of 3 (three "Yes" answers) indicate that a teen may be depressed, and he or she might benefit from further screening by a mental health professional.
4-9	Scores of 4 or higher (four or more "Yes" answers) indicate that is likely that a teen is depressed. He or she probably has some significant symptoms of depression and would benefit from talking to a mental health professional about these feelings.

Questions 4 and 5	These two questions are about suicidal thoughts and suicide attempts. If you answered "Yes" to *either* of these questions, it is ***strongly recommended*** that your teen see a mental health professional for further evaluation, ***regardless of his or her score***.

If you are worried about yourself or someone else,
call the National Suicide Prevention Lifeline, at 1-800-273-TALK (8255).

Facts *for* Families

The Depressed Child

No. 04; Updated July 2013

Not only adults become depressed. Children and teenagers also may have depression, as well. The good news is that depression is a treatable illness. Depression is defined as an illness when the feelings of depression persist and interfere with a child or adolescent's ability to function.

About 5 percent of children and adolescents in the general population suffer from depression at any given point in time. Children under stress, who experience loss, or who have attentional, learning, conduct or anxiety disorders are at a higher risk for depression. Depression also tends to run in families.

The behavior of depressed children and teenagers may differ from the behavior of depressed adults. Child and adolescent psychiatrists advise parents to be aware of signs of depression in their youngsters.

If one or more of these signs of depression persist, parents should seek help:

- Frequent sadness, tearfulness, crying
- Decreased interest in activities; or inability to enjoy previously favorite activities
- Hopelessness
- Persistent boredom; low energy
- Social isolation, poor communication
- Low self-esteem and guilt
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses such as headaches and stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self-destructive behavior

A child who used to play often with friends may now spend most of the time alone and without interests. Things that were once fun now bring little joy to the depressed child. Children and adolescents who are depressed may say they want to be dead or may talk about suicide. Depressed children and adolescents are at increased risk for committing suicide. Depressed adolescents may abuse alcohol or other drugs as a way of trying to feel better.

Children and adolescents who cause trouble at home or at school may also be suffering from depression. Because the youngster may not always seem sad, parents and teachers may not realize that troublesome behavior is a sign of depression. When asked directly, these children can sometimes state they are unhappy or sad.

Early diagnosis and treatment are essential for depressed children. Depression is a real illness that requires professional help. Comprehensive treatment often includes both individual and family therapy. For example, cognitive behavioral therapy (CBT) and interpersonal psychotherapy (IPT) are forms of individual therapy shown to be effective in treating depression. Treatment may also include the use of antidepressant medication. For help, parents should ask their physician to refer them to a qualified mental health professional, who can diagnose and treat depression in children and teenagers.

If you find Facts for Families© helpful and would like to make good mental health a reality for all children, please consider donating to the **Campaign for America's Kids.** Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to **Campaign for America's Kids**, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,000 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

Facts *for* Families

Teen Suicide

No. 10; Updated October 2013

Suicides among young people continue to be a serious problem. Each year in the U.S., thousands of teenagers commit suicide. Suicide is the third-leading cause of death for 15-to-24-year-olds, and the sixth leading cause of death for 5-to-14-year-olds.

Teenagers experience strong feelings of stress, confusion, self-doubt, pressure to succeed, financial uncertainty, and other fears while growing up. For some teenagers, divorce, the formation of a new family with step-parents and step-siblings, or moving to a new community can be very unsettling and can intensify self-doubts. For some teens, suicide may appear to be a solution to their problems and stress.

Depression and suicidal feelings are treatable mental disorders. The child or adolescent needs to have his or her illness recognized and diagnosed, and appropriate treatment plans developed. When parents are in doubt as to whether their child has a serious problem, a psychiatric examination can be very helpful.

Many of the signs and symptoms of suicidal feelings are similar to those of depression.

Parents should be aware of the following signs of adolescents who may try to kill themselves:

- change in eating and sleeping habits
- withdrawal from friends, family, and regular activities
- violent actions, rebellious behavior, or running away
- drug and alcohol use
- unusual neglect of personal appearance
- marked personality change
- persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- loss of interest in pleasurable activities
- not tolerating praise or rewards

A teenager who is planning to commit suicide may also:

- complain of being a bad person or feeling rotten inside
- give verbal hints with statements such as: "I won't be a problem for you much longer," "Nothing matters," "It's no use," and, "I won't see you again"
- put his or her affairs in order, for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.
- become suddenly cheerful after a period of depression
- have signs of psychosis (hallucinations or bizarre thoughts)

If a child or adolescent says, "I want to kill myself," or "I'm going to commit suicide," always take the statement seriously and immediately seek assistance from a qualified mental health professional. People often feel uncomfortable talking about death. However, asking the child or adolescent whether he or she is depressed or thinking about suicide can be helpful. Rather than putting thoughts in the child's head, such a question will provide assurance that somebody cares and will give the young person the chance to talk about problems.

If one or more of these signs occurs, parents need to talk to their child about their concerns and seek professional help from a physician or a qualified mental health professional. With support from family and appropriate treatment, children and teenagers who are suicidal can heal and return to a more healthy path of development.

If you find *Facts for Families*© helpful and would like to make good mental health a reality for all children, please consider donating to the Campaign for America's Kids. Your support will help us continue to produce and distribute *Facts for Families*, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to Campaign for America's Kids, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 7,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

The information on this website is provided for general reference purposes. It does not constitute medical or other professional advice and should not be used as a substitute for the medical care and advice of your child and adolescent psychiatrist or other physician. Only a qualified, licensed physician can determine the individual treatment that is appropriate for your particular circumstances. All decisions about clinical care should be made in consultation with a physician.

If you need immediate assistance, please dial 911.

Facts *for* Families

Bullying

No. 80; Updated March 2011

Bullying is a common experience for many children and adolescents. Surveys indicate that as many as half of all children are bullied at some time during their school years, and at least 10% are bullied on a regular basis.

Bullying behavior can be physical or verbal. Boys tend to use physical intimidation or threats, regardless of the gender of their victims. Bullying by girls is more often verbal,usually with another girl as the target. Bullying has even been reported in online chat rooms, through e-mail and on social networking sites.

Children who are bullied experience real suffering that can interfere with their social and emotional development, as well as their school performance. Some victims of bullying have even attempted suicide rather than continue to endure such harassment and punishment.

Children and adolescents who bully thrive on controlling or dominating others. They have often been the victims of physical abuse or bullying themselves. Bullies may also be depressed, angry or upset about events at school or at home. Children targeted by bullies also tend to fit a particular profile. Bullies often choose children who are passive, easily intimidated, or have few friends. Victims may also be smaller or younger, and have a harder time defending themselves.

If you suspect your child is bullying others, it's important to seek help for him or her as soon as possible. Without intervention, bullying can lead to serious academic, social, emotional and legal difficulties. Talk to your child's pediatrician, teacher, principal, school counselor, or family physician. If the bullying continues, a comprehensive evaluation by a child and adolescent psychiatrist or other mental health professional should be arranged. The evaluation can help you and your child understand what is causing the bullying, and help you develop a plan to stop the destructive behavior.

If you suspect your child may be the victim of bullying ask him or her to tell you what's going on. You can help by providing lots of opportunities to talk with you in an open and honest way.

It's also important to respond in a positive and accepting manner. Let your child know it's not his or her fault, and that he or she did the right thing by telling you. Other specific suggestions include the following:

- Ask your child what he or she thinks should be done. What's already been tried? What worked and what didn't?
- Seek help from your child's teacher or the school guidance counselor. Most bullying occurs on playgrounds, in lunchrooms, and bathrooms, on school buses or in unsupervised halls. Ask the school administrators to find out about programs other schools and communities have used to help combat bullying, such as peer mediation, conflict resolution, and anger management training, and increased adult supervision.
- Don't encourage your child to fight back. Instead, suggest that he or she try walking away to avoid the bully, or that they seek help from a teacher, coach, or other adult.
- Help your child practice what to say to the bully so he or she will be prepared the next time.
- Help your child practice being assertive. The simple act of insisting that the bully leave him alone may have a surprising effect. Explain to your child that the bully's true goal is to get a response.
- Encourage your child to be with friends when traveling back and forth from school, during shopping trips, or on other outings. Bullies are less likely to pick on a child in a group.

If your child becomes withdrawn, depressed or reluctant to go to school, or if you see a decline in school performance, additional consultation or intervention may be required. A child and adolescent psychiatrist or other mental health professional can help your child and family and the school develop a strategy to deal with the bullying. Seeking professional assistance earlier can lessen the risk of lasting emotional consequences for your child.

For more information see Facts for Families:
#33: Conduct Disorder
#55: Understanding Violent Behavior in Children
#65: Children's Threats
#66: Helping Teenagers with Stress

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Facts *for* Families

Bipolar Disorder in Children and Teens

No. 38; Updated March 2015

Children and teenagers with Bipolar Disorder have manic and/or depressive symptoms. Some may have mostly depression and others a combination of manic and depressive symptoms. Highs may alternate with lows.

Manic symptoms include:

- severe changes in mood — either unusually happy or silly, or very irritable, angry, agitated, or aggressive
- unrealistic highs in self-esteem — for example, a teenager who feels all-powerful or like a superhero with special powers
- great increase in energy and the ability to go with little or no sleep for days without feeling tired
- increase in talking — the adolescent talks too much, too fast, changes topics too quickly, and cannot be interrupted
- distractibility — the teen's attention moves constantly from one thing to the next
- repeated high risk-taking behavior; such as abusing alcohol and drugs, reckless driving, or sexual promiscuity

Depressive symptoms include:

- irritability, depressed mood, persistent sadness, frequent crying
- thoughts of death or suicide
- loss of enjoyment of favorite activities
- frequent complaints of physical illnesses such as headaches or stomachaches
- low energy level, fatigue, poor concentration, complaints of boredom
- major change in eating or sleeping patterns, such as oversleeping or overeating

Some of these signs are similar to those that occur in teenagers with other problems such as drug abuse, delinquency, attention-deficit hyperactivity disorder, or even schizophrenia.

Research has improved the ability to diagnose Bipolar Disorder in children and teens. Bipolar Disorder can begin in childhood and during the teenage years, although it is usually diagnosed in adult life. The illness can affect anyone. However, if one or both parents have Bipolar Disorder, the chances are greater that their children may develop the disorder. Family history of drug or alcohol abuse also may be associated with greater risk for Bipolar Disorder.

Teenagers with Bipolar Disorder can be effectively treated. Treatment for Bipolar Disorder usually includes education of the patient and the family about the illness, mood stabilizing medications such as lithium, valproic acid, or "atypical antipsychotic," and psychotherapy. Mood stabilizing medications often reduce the number and severity of manic episodes, and also help to prevent depression. Psychotherapy helps the child understand himself or herself, adapt to stresses, rebuild self-esteem, and improve relationships.

The diagnosis of Bipolar Disorder in children and teens is complex and involves careful observation over an extended period of time. A thorough evaluation by a child and adolescent psychiatrist is needed to identify Bipolar Disorder and start treatment.

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If you need immediate assistance, please dial 911.

Suicide Prevention Program

Spanish Materials

- **Basado en el Video y/o la Evaluación, Siento Que**
  Sample Response Card for Students

- **Muestra de la Carta de Consentimiento Para los Padres:**
  - Muestra de la Carta de Consentimiento Activo
    Sample Active Parental Consent Letter
  - Muestra de la Carta de Consentimiento Pasivo para los padres
    Sample Passive Parental Consent Letter

- **Spanish Screening/Scoring Instructions for Students & Parents**

- **Muestra de Lista de Referencias Para Padres**
  Sample Referral Resource List for Parents

- **American Academy of Child & Adolescent Psychiatry: Facts for Families**
  - **El Niño Deprimido** (The Depressed Child)
  - **El Suicidio en los Adolescentes** (Teen Suicide)
  - **La Intimidación** (Bullying)
  - **Desorden Bipolar (la Enfermedad Maniaco-Depresiva) en los Adolescentes** (Bipolar Disorder in Children and Teens)

BASADO EN EL PROGRAMA SOS, SIENTO QUE:

- ☐ **<u>Necesito</u> hablar con alguien de mí o de un amigo…**
- ☐ **<u>No necesito</u> hablar con alguien de mí o de un amigo...**

NOMBRE _____

MAESTRO _____

SI DESEA HABLAR CON ALGUIEN, LE CONTACTARAN EN 24 HORAS. SI NECESITA HABLAR CON ALGUIEN ENSEGUIDA, POR FAVOR PIDA AYUDA INMMEDIATAMENTE.

BASADO EN EL PROGRAMA SOS, SIENTO QUE:

- ☐ **<u>Necesito</u> hablar con alguien de mí o de un amigo…**
- ☐ **<u>No necesito</u> hablar con alguien de mí o de un amigo...**

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BASADO EN EL PROGRAMA SOS, SIENTO QUE:

- ☐ **<u>Necesito</u> hablar con alguien de mí o de un amigo…**
- ☐ **<u>No necesito</u> hablar con alguien de mí o de un amigo...**

NOMBRE _____

MAESTRO _____

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BASADO EN EL PROGRAMA SOS, SIENTO QUE:

- ☐ **<u>Necesito</u> hablar con alguien de mí o de un amigo…**
- ☐ **<u>No necesito</u> hablar con alguien de mí o de un amigo...**

NOMBRE _____

MAESTRO _____

SI DESEA HABLAR CON ALGUIEN, LE CONTACTARAN EN 24 HORAS. SI NECESITA HABLAR CON ALGUIEN ENSEGUIDA, POR FAVOR PIDA AYUDA INMMEDIATAMENTE.

Muestra de la Carta de Consentimiento Activo (con el boletín para los padres)

Estimado padre o guardián:

El periodo de la adolescencia está marcado por un sin número de emociones, difíciles tanto para los jóvenes como para los padres y educadores. Es fácil malinterpretar la depresión como una parte normal del adolescente confundido. Sin embargo, la depresión (una de las enfermedades mentales más comunes) parece estar ocurriendo a una edad mucho más temprana. La depresión –la cual es tratable- es un factor principal de riesgo de suicidio. Además, la autolesión se ha convertido en un problema creciente en la juventud.

Para tratar estos temas, [nuestra escuela] está ofreciendo un entrenamiento para el reconocimiento y la prevención de la depresión y el suicidio a través del Programa de Prevención de Suicidio SOS (SOS Signs of Suicide® Prevention Program). Este programa ha sido exitoso en incrementar la cantidad de alumnos que solicitan ayuda al estar preocupados por sí mismos o por un amigo. Además, es el único programa de prevención de suicidios con base en una escuela listado por SAMHSA por su Registro Nacional de Prácticas y Programas Basados en Evidencia (National Registry of Evidence-Based Programs and Practices) que trata el riesgo de suicidio y la depresión, al mismo tiempo de reducir intentos de suicidio. En un estudio aleatorio controlado, el programa SOS Program for high school mostró una reducción del 40% en los intentos de suicidio auto-reportados (BMC Public Health, Julio 2007).

Nuestros objetivos al participar en este programa son directos:

- Ayudar a nuestros estudiantes a entender que la depresión es una enfermedad tratable
- Explicar que el suicidio es una tragedia prevenible que con frecuencia es resultado de un problema de depresión no tratado
- Entrenar a los estudiantes a identificar un problema serio de depresión y de posible suicidio en ellos mismos o en un amigo
- Hacer entender a los jóvenes que ellos pueden ayudarse a sí mismos o a un amigo simplemente con hablar con un adulto responsable sobre sus preocupaciones
- Ayudar a los estudiantes a saber con quién pueden hablar en la escuela para recibir ayuda si es que la necesitan

[Inserte una breve descripción de cómo su escuela intenta implementar el programa, incluyendo si los estudiantes tomarán o no la evaluación]

Estamos incluyendo una copia del boletín para los padres y la lista de recursos de referencia para que usted tenga información sobre la depresión y sus riesgos.

Por favor firme la forma de permiso para permitir que su hijo(a) participe en el programa SOS para escuelas secundarias, y devuelva esta forma a la [dirección] con atención a [el administrador escolar designado].

Si tiene alguna pregunta o preocupación sobre este programa, por favor no dude en comunicarse conmigo al [incluya su número de teléfono, correo electrónico y horario en el que está disponible]

Sinceramente,

[Nombre y puesto del administrador designado]

Muestra de la Carta de Consentimiento Pasivo (con el boletín para los padres)

Estimado padre o guardián:

El periodo de la adolescencia está marcado por un sin número de emociones, difíciles tanto para los jóvenes como para los padres y educadores. Es fácil malinterpretar la depresión como una parte normal de un trastorno de la adolescencia. Sin embargo, la depresión (una de las enfermedades mentales más comunes) parece ocurrir a una edad mucho más temprana. La depresión – la cual es tratable – es el factor principal de riesgo de suicidio. Así mismo, la autolesión se ha convertido en un problema creciente entre los jóvenes de hoy en día.

Para tratar estos temas, [nuestra escuela] está ofreciendo un entrenamiento para el reconocimiento y la prevención de la depresión y el suicidio a través del Programa de Prevención de Suicidio SOS (SOS Signs of Suicide® Prevention Program). Este programa ha sido exitoso en incrementar la cantidad de alumnos que solicitan ayuda al estar preocupados por sí mismos o por un amigo. Además, es el único programa de prevención de suicidios con base en una escuela listado por SAMHSA por su Registro Nacional de Prácticas y Programas Basados en Evidencia (National Registry of Evidence-Based Programs and Practices) que trata el riesgo de suicidio y la depresión, al mismo tiempo de reducir intentos de suicidio. En un estudio aleatorio controlado, el programa SOS Program for high school mostró una reducción del 40% en los intentos de suicidio auto-reportados (BMC Public Health, Julio 2007).

Nuestros objetivos al participar en este programa son muy directos:

- Ayudar a nuestros estudiantes a entender que la depresión es una enfermedad tratable
- Explicar que el suicidio es una tragedia prevenible que con frecuencia es resultado de un problema de depresión no tratado
- Entrenar a los estudiantes a identificar un problema serio de depresión y de posible suicidio en ellos mismos o en un amigo
- Hacer entender a los jóvenes que pueden ayudarse a sí mismos o a un amigo simplemente con hablar con un adulto responsable sobre sus preocupaciones
- Ayudar a los estudiantes a saber con quién pueden hablar en la escuela para recibir ayuda si es que la necesitan

[Inserte una breve descripción de cómo su escuela intenta implementar el programa, incluyendo si los estudiantes tomarán o no la evaluación]

Estamos incluyendo una copia del boletín para los padres y la lista de recursos de referencia de salud mental para que tenga información sobre la depresión y sus riesgos.

Si **NO** desea que su hijo(a) participe en el programa SOS para escuelas secundarias (SOS Program), por favor llene esta forma y envíela a [dirección] con atención a [administrador escolar designado]. Si no recibimos su respuesta, asumiremos que su hijo tiene permiso de participar en este programa.

Sinceramente,

[Nombre y puesto del administrador designado]

SOS Signs of Suicide® Prevention Program (Parent Spanish)

Cuestionario para los Padres

- Edad de su niño/a: _____

- Sexo de su niño/a:

☐ Femenino ☐ Masculino

☐ Transgénero

- Grado escolar de su niño/a:

☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ 11 ☐ 12 ☐ Programa GED

☐ Otros: _____

- Grupo étnico de su niño/a:

☐ Hispanic/Latino ☐ Not Hispanic/Latino

- Grupo racial del niño/a: *(Marque todas las que apliquen)*

☐ Indio Americano/Nativo de Alaska ☐ Asiático

☐ Nativo de Hawai/Pacífico Isleño ☐ Blanco

☐ Negro/Afroamericano ☐ Otros/Multiracial

- ¿Está recibiendo su niño/a tratamiento para la depresión?

☐ Sí ☐ No

Breve Prueba para la Depresión en los Adolescentes (BSAD)*

Estas preguntas son acerca de los sentimientos que las personas algunas veces tienen, y sobre cosas que le pueden haber ocurrido a su niño/a**.** La mayoría de las preguntas son acerca de las **ÚLTIMAS CUATRO SEMANAS.**

Lea cada pregunta con cuidado y marque con un círculo la respuesta correcta.

1.	En las últimas cuatro semanas ¿hubo una época en la que pareciera que nada fuera divertido para él/ella y que simplemente nada le interesaba?	**Sí No**
2.	¿Parecía que él/ella tuviera menos energía que de costumbre?	**Sí No**
3.	En las últimas cuatro semanas ¿parecía que él/ella no podía pensar tan claro o tan rápido como acostumbraba?	**Sí No**
4.	En las últimas cuatro semanas ¿habló él/ella seriamente sobre matarse?	**Sí No**
5.	¿Ha tratado él/ella de quitarse la vida ***en el último año?***	**Sí No**
6.	En las últimas cuatro semanas ¿ha tenido él/ella problemas para dormir, es decir para quedarse dormido/a, seguir durmiendo o despertarse demasiado temprano?	**Sí No**
7.	¿Ha habido un momento en que su hijo/a pareciera hacer cosas, como caminar o hablar, mucho más lento de lo que acostumbra?	**Sí No**
8.	En las últimas cuatro semanas ¿le pareció que él/ella tenia problemas para mantener la atención en la tarea escolar u otras cosas?	**Sí No**
9.	¿Ha dicho él/ella que no podía hacer nada bien o que no era tan atractivo/a o tan inteligente como otros?	**Sí No**

SOS Signs of Suicide® Prevention Program
Instrucciones de puntuación e interpretación para los padres

La Breve Prueba para la Depresión en los Adolescentes (BSAD) es una herramienta de evaluación de la depresión para jóvenes y adolescentes. En la versión para padres, le pedimos contestar las preguntas acerca de su niño/a. El BSAD **no** es un diagnóstico que indique que un niño/a o adolescente esté deprimido, pero si indica que él o ella debe ser referido a un profesional del cuidado de salud (médico, psiquiatra, psicólogo/a, enfermero/a, consejero/a o trabajador/a social) para una evaluación más detallada.

El resultado del BSAD se obtiene sumando el número de respuestas "Sí" con las 9 preguntas en la escala. Las siguientes guías son ***estimados*** de la probabilidad de que su niño/a pueda estar deprimido/a:

PUNTUACIÓN	MEANING
0-2	Puntuación de 2 o menos (dos o menos respuestas "Sí") indican que es **improbable** que él/ella este deprimido/a.
3	Puntuación de 3 (tres respuestas "Sí") indican que él/ella ***puede*** estar deprimido/a, y podría beneficiarse de una evaluación más detallada con un profesional de la salud mental.
4-9	Puntuación de 4 o más (cuatro o más respuestas "Sí") indican que es ***probable*** que él/ella esté depremido/a. Él/ella probablemente tiene algunos sintomas significativos de la depresión y se beneficiaría de hablar con un profesional de la salud mental sobre esos sentimientos.

Preguntas 4 y 5	Estas preguntas son acerca de pensamientos suicidas e intentos de suicidio. Si respondió "Sí" a cualquiera de estas preguntas, le ***recomendamos enérgicamente*** que su niño/a vea a un profesional de salud mental para una evaluación más detallada, ***independientemente de su puntuación.***

Si está preocupado por usted o por otra persona,
llame a la Línea Nacional de Prevención del Suicidio al 1-800-273-TALK (8255).

SOS Signs of Suicide® Prevention Program (Student Spanish)

Cuestionario para el Estudiante

- Edad: _____

- Sexo:

☐ Femenino ☐ Masculino

☐ Transgénero

- Grado escolar:

☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ 11 ☐ 12 ☐ Programa GED

☐ Otros: _____

- Grupo étnico:

☐ Hispanic/Latino ☐ Not Hispanic/Latino

- Grupo racial: *(Marque todas las que apliquen)*

☐ Indio Americano/Nativo de Alaska ☐ Asiático

☐ Nativo de Hawai/Pacífico Isleño ☐ Blanco

☐ Negro/Afroamericano ☐ Otros/Multiracial

- ¿Está recibiendo actualmente tratamiento para la depresión?

☐ Sí ☐ No

Breve Prueba para la Depresión en los Adolescentes (BSAD)*

Estas preguntas son acerca de los sentimientos que las personas algunas veces tienen, y sobre cosas que le pueden haber ocurrido**.** La **mayoría** de las preguntas son acerca de las ***ÚLTIMAS CUATRO SEMANAS.***

Lea cada pregunta con cuidado y marque con un círculo la respuesta correcta.

1.	En las últimas cuatro semanas ¿ha habido un momento en el que nada te divertía y simplemente no estabas interesado en nada?	**Sí No**
2.	¿Tienes menos energía de lo acostumbrado?	**Sí No**
3.	¿Sientes que no puedes hacer nada bien o que no eres tan atractivo/a o tan inteligente como la mayoría de la gente?	**Sí No**
4.	¿Has pensado seriamente en quitarte la vida?	**Sí No**
5.	¿Has intentado quitarte la vida ***en el último año?***	**Sí No**
6.	¿Te cansas demasiado al hacer cualquier cosa?	**Sí No**
7.	En las últimas cuatro semanas ¿te ha parecido que no podías pensar tan claro o rápido como acostumbrabas?	**Sí No**

Identificando a un Adulto de Confianza

Describa a un adulto de confianza con quien podría contar si necesita ayuda para usted o un amigo (ejemplo: “Mi maestro de Inglés,” “consejero,” “mi madre,” “tio,” etc.)

En la escuela _____

Fuera de la escuela _____

SOS Signs of Suicide® Prevention Program - Tu puntuación BSAD y lo que significa

BSAD (Breve Prueba para la Depresión en los Adolescentes) es un auto-estudio para que puedas evaluar por depresión y riesgo de suicidio. Tu puntuación en la encuesta BSAD te dirá si deberías ver a un profesional de salud en la escuela (psicólogo, enfermera, consejero o trabajador social) para tener una conversación acerca de tu puntuación.

Para saber tu resultado en el BSAD, suma el número de respuestas "Sí" a las preguntas 1-7. Usa la escala de abajo para averiguar qué significa tu puntuación y lo que debes hacer.

PUNTUACIÓN	SIGNIFICADO
0-2	Es ***poco probable*** que tengas depresión. Sin embargo, si a menudo te sientes triste debes hablar con un adulto de confianza (padres/tutores/personal de la escuela) para tratar de averiguar que debes hacer. A pesar de que tu puntuaje dice que no estas deprimido, puede que todavía quieras hablar con un profesional de la salud si tus sentimientos de tristeza no desaparecen.
3	Es ***posible*** que tengas depresion. ***Deberías hablar con un profesional de salud***. Dile a un adulto de confianza (padre/madre/tutor/personal de la escuela) de tus preocupaciones y pregúntale si puede conectarte con un profesional de salud mental. Si te hace sentir más cómodo/a, trae a un amigo contigo. Dile al adulto que ***puede ser*** que estés deprimido y que necesitas consultar a un profesional de la salud mental.
4-7	Es ***probable*** que tengas depresión. Probablemente tengas algunos síntomas significativos de depresión y ***deberías hablar con un profesional de salud mental*** acerca de estos sentimientos. Dile a un adulto de confianza (padre/madre/tutor/personal de la escuela) tus sentimientos y pregúntale si puede ayudarte a ver a un profesional de salud mental.

Preguntas 4 y 5	Estas dos preguntas son acerca de pensamientos y comportamiento ***suicidas***. Si contestaste "Sí" a ***cualquiera*** de las preguntas **4** o **5**, deberías ver a un profesional de salud mental inmediatamente - ***sin importar tu puntuación total en el BSAD.***

Identificando a un Adulto de Confianza

Preocupado por ti o por un amigo	Es importante saber con quién puedes contar si necesitas hablar. Si se te hizo dificil identificar a un adulto de confianza, pregunta si puedes hablar con la persona que está implementando el programa SOS. Dejale saber a alguien que necesitas ayuda estableciendo esta conexión importante. Si estas preocupado por tu amigo pero tu amigo se niega a hablar con alguien, pídele a tu adulto de confianza que te ayude a conseguirle a tu amigo la ayuda que necesita.

En Pocas Palabras: Toma estos resultados en serio y busca ayuda. Tú o tu amigo se merecen sentirse mejor, y hay ayuda y apoyo a tu disposición. **Si estas preocupado por ti o por otra persona, llama a la Línea Nacional de Prevención del Suicidio al 1-800-273-TALK (8755).**

SOS Signs of Suicide® Prevention Program (Student Spanish)

with Alcohol Use Questions Included

Cuestionario para el Estudiante

- Edad: _____

- Sexo:

☐ Femenino ☐ Masculino

☐ Transgénero

- Grado escolar:

☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ 11 ☐ 12 ☐ Programa GED

☐ Otros: _____

- Grupo étnico:

☐ Hispanic/Latino ☐ Not Hispanic/Latino

- Grupo racial: *(Marque todas las que apliquen)*

☐ Indio Americano/Nativo de Alaska

☐ Asiático

☐ Nativo de Hawai/Pacífico Isleño

☐ Blanco

☐ Negro/Afroamericano

☐ Otros/Multiracial

- ¿Está recibiendo actualmente tratamiento para la depresión?

☐ Sí ☐ No

Breve Prueba para la Depresión en los Adolescentes (BSAD)*

Estas preguntas son acerca de los sentimientos que las personas algunas veces tienen, y sobre cosas que le pueden haber ocurrido**.** La **mayoría** de las preguntas son acerca de las ***ÚLTIMAS CUATRO SEMANAS.***

Lea cada pregunta con cuidado y marque con un círculo la respuesta correcta.

1.	En las últimas cuatro semanas ¿ha habido un momento en el que nada te divertía y simplemente no estabas interesado en nada?	**Sí No**
2.	¿Tienes menos energía de lo acostumbrado?	**Sí No**
3.	¿Sientes que no puedes hacer nada bien o que no eres tan atractivo/a o tan inteligente como la mayoría de la gente?	**Sí No**
4.	¿Has pensado seriamente en quitarte la vida?	**Sí No**
5.	¿Has intentado quitarte la vida ***en el último año?***	**Sí No**
6.	¿Te cansas demasiado al hacer cualquier cosa?	**Sí No**
7.	En las últimas cuatro semanas ¿te ha parecido que no podías pensar tan claro o rápido como acostumbrabas?	**Sí No**

Uso de Alcohol

a.	En el año pasado ¿ha habido un momento en el que has consumido cinco o más bebidas alcohólicas en una sola ocasion? (Por "bebidas" nos referimos a cualquier tipo de cerveza, vino o licor)	**Sí No**
b.	En el año pasado ¿has consumido alcohol por sentirte sin energías?	**Sí No**

Identificando a un Adulto de Confianza

Describa a un adulto de confianza con quien podría contar si necesita ayuda para usted o un amigo (ejemplo: "Mi maestro de Inglés," "consejero," "mi madre," "tio," etc.) En la escuela _____ Fuera de la escuela _____

SOS Signs of Suicide® Prevention Program - Tu puntuación BSAD y lo que significa

BSAD (Breve Prueba para la Depresión en los Adolescentes) es un auto-estudio para que puedas evaluar por depresión y riesgo de suicidio. Tu puntuación en la encuesta BSAD te dirá si deberías ver a un profesional de salud en la escuela (psicólogo, enfermera, consejero o trabajador social) para tener una conversación acerca de tu puntuación.

Para saber tu resultado en el BSAD, suma el número de respuestas "Sí" a las preguntas 1-7. Usa la escala de abajo para averiguar qué significa tu puntuación y lo que debes hacer.

PUNTUACIÓN	SIGNIFICADO
0-2	Es ***poco probable*** que tengas depresión. Sin embargo, si a menudo te sientes triste debes hablar con un adulto de confianza (padres/ tutores/ personal de la escuela) para tratar de averiguar que debes hacer. A pesar de que tu puntuaje dice que no estas deprimido, puede que todavía quieras hablar con un profesional de la salud si tus sentimientos de tristeza no desaparecen.
3	Es ***posible*** que tengas depresion. ***Deberías hablar con un profesional de salud***. Dile a un adulto de confianza (padre/madre/tutor/ personal de la escuela) de tus preocupaciones y pregúntale si puede conectarte con un profesional de salud mental. Si te hace sentir más cómodo/a, trae a un amigo contigo. Dile al adulto que ***puede ser*** que estés deprimido y que necesitas consultar a un profesional de la salud mental.
4-7	Es ***probable*** que tengas depresión. Probablemente tengas algunos síntomas significativos de depresión y ***deberías hablar con un profesional de salud mental*** acerca de estos sentimientos. Dile a un adulto de confianza (padre/madre/ tutor/personal de la escuela) tus sentimientos y pregúntale si puede ayudarte a ver a un profesional de salud mental.

Preguntas 4 y 5	Estas dos preguntas son acerca de pensamientos y comportamiento ***suicidas***. Si contestaste "Sí" a ***cualquiera*** de las preguntas **4** o **5**, deberías ver a un profesional de salud mental inmediatamente - ***sin importar tu puntuación total en el BSAD.***

Preguntas sobre el uso de Alcohol

Preguntas a y b	Si respondiste "Sí" a la pregunta **a** o **b**, sobre el uso de alcohol, puedes estar usando alcohol en una manera que es perjudicial para tu salud. Recomendamos que hables con un adulto de confianza o un profesional de salud mental acerca de estos sentimientos y comportamiento.

Identificando a un Adulto de Confianza

Preocupado por ti o por un amigo	Es importante saber con quién puedes contar si necesitas hablar. Si se te hizo dificil identificar a un adulto de confianza, pregunta si puedes hablar con la persona que está implementando el programa SOS. Dejale saber a alguien que necesitas ayuda estableciendo esta conexión importante. Si estas preocupado por tu amigo pero tu amigo se niega a hablar con alguien, pídele a tu adulto de confianza que te ayude a conseguirle a tu amigo la ayuda que necesita.

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Muestra De Lista De Referencias Para Padres

Como parte del programa, entregue a los padres una lista de referencias de servicios de salud mental en su comunidad. Cuando le sea posible incluya los nombres, direcciones, calendario de tarifas, los planes de seguro médico que aceptan, servicios y horarios, ya que estos datos pueden ser útiles para dirigir a las personas a la instalación adecuada. Asegúrese de incluir instalaciones financiadas con fondos públicos y aquellas que aceptan personas que no cuentan con un seguro médico. Utilice esta forma como modelo y cópiela para incluirla en los documentos que envíe a los padres y/o para distribuirla en los eventos o reuniones para padres.

Una Llamada Puede Hacer La Diferencia

Usted puede obtener ayuda para su hijo en las siguientes instalaciones o médicos individuales. Es posible que usted tenga que llamar a varias instalaciones para poder determinar cuál es la que más le conviene según sus necesidades.

Lista de Recursos de Salud Mental en su Comunidad

- Centro(s) de salud mental
- Hospital(es) General(es) con servicios psiquiátricos
- Hospitales Psiquiátricos
- Instalaciones estatales, locales, o del condado que ofrecen tratamiento gratuito o tarifas reducidas según su ingreso
- Su Asociación Psicológica local o la oficina regional de Trabajo Social
- Centros locales de Consejería Espiritual
- Grupos de Autoayuda
- Grupos de Apoyo (Mental Health Association, National Alliance for the Mentally Ill)
- Médicos privados

American Academy of Child & Adolescent Psychiatry: Facts for Families

Facts *for* Families

El Niño Deprimido

No. 4 (Revisado 7/04)

No son sólo los adultos los que se deprimen. Los niños y los adolescentes pueden sufrir también de depresión, que es una enfermedad tratable. La depresión se define como una enfermedad cuando la condición depresiva persiste e interfiere con la habilidad de funcionar del niño o adolescente.

Aproximadamente un 5 por ciento de los niños y adolescentes de la población general padece de depresión en algún momento. Los niños que viven con mucha tensión, que han experimentado una pérdida o que tienen desórdenes de la atención, del aprendizaje, de la conducta, o de desórdenes de ansiedad corren mayor riesgo de sufrir depresión. La depresión también tiende a correr en las familias.

El comportamiento de los niños y adolescentes deprimidos puede ser diferente al comportamiento de los adultos deprimidos. Los siquiatras de niños y adolescentes le recomiendan a los padres que estén atentos a síntomas de depresión que puedan presentar sus niños.

Los padres deben de buscar ayuda si uno o más de las siguientes señales de depresión persisten:

- tristeza frecuente, lloriqueo y llanto profuso
- desesperanza
- pérdida de interés en sus actividades; o inhabilidad para disfrutar de las actividades favoritas previas
- aburrimiento persistente y falta de energía
- aislamiento social, comunicación pobre
- baja autoestima y culpabilidad
- sensibilidad extrema hacia el rechazo y el fracaso
- aumento en la irritabilidad, coraje u hostilidad
- dificultad en sus relaciones
- quejas frecuentes de enfermedades físicas, tales como dolor de cabeza o de estómago
- ausencias frecuentes de la escuela y deterioro en los estudios
- concentración pobre
- cambios notables en los patrones de comer y de dormir
- hablar de o tratar de escaparse de la casa
- pensamientos o expresiones suicidas o comportamiento autodestructivo

Un niño que jugaba a menudo con sus amigos empieza a pasarse la mayor parte del tiempo solo y pierde interés por todo. Las cosas de las que disfrutaba previamente ya no le dan placer al niño deprimido. Los niños y adolescentes deprimidos dicen a veces que quisieran estar muertos o pueden hablar del suicidio. Los niños y adolescentes deprimidos corren un mayor riesgo de cometer suicidio. Los adolescentes deprimidos pueden abusar del alcohol o de otras drogas tratando de sentirse mejor.

Los niños y adolescentes que se portan mal en la casa o en la escuela pueden estar sufriendo de depresión. Los padres y los maestros a veces no se dan cuenta de que la mala conducta es un síntoma de depresión porque el niño no siempre da la impresión de estar triste. Cuando se les pregunta directamente, los niños algunas veces admiten que están tristes o que son infelices.

El diagnóstico y tratamiento temprano de la depresión es esencial para los niños deprimidos. La depresión es una enfermedad real que requiere ayuda profesional. Un tratamiento comprensivo a menudo incluye ambas terapias, individual y de familia. Por ejemplo, la terapia de comportamiento cognositivo (CBT) y la sicoterapia interpersonal (IPT) son formas de terapia individual que han demostrado ser efectivas en el tratamiento de la depresión. El tramiento puede también incluir el uso de medicamentos antidepresivos. Para ayudarles, los padres deben pedirle a su médico de familia que los refiera a un professional de la salud mental capacitado, quien puede diagnosticar y tratar la depresión en niños y adolescentes.

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Usted puede también enviar su contribución a "Campaign for America's Kids", P.O. Box 96106, Washington, DC 20090. Por favor haga su cheque a nombre de AACAP.

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Facts *for* Families

El Suicidio en los Adolescentes

No. 10 (Revisado 7/04)

El suicidio entre los adolescentes ha tenido un aumento dramático recientemente a través de la nación. Cada año miles de adolescentes se suicidan en los Estados Unidos. El suicidio es la tercera causa de muerte más frecuente para los jóvenes de entre 15 a 24 años de edad, y la sexta causa de muerte para aquellos de entre 5 a 14 años.

Los adolescentes experimentan fuertes sentimientos de estrés, confusión, dudas de sí mismos, presión para lograr éxito, incertidumbre financiera y otros miedos mientras van creciendo. Para algunos adolescentes el divorcio, la formación de una nueva familia con padrastros y hermanastros o las mudanzas a otras nuevas comunidades pueden perturbarlos e intensificarles las dudas acerca de sí mismos. Para algunos adolescentes, el suicidio aparenta ser una solución a sus problemas y al estrés.

La depresión y las tendencias suicidas son desórdenes mentales que se pueden tratar. Hay que reconocer y diagnosticar la presencia de esas condiciones tanto en niños como en adolescentes y se debe desarrollar un plan de tratamiento apropiado. Cuando hay duda en los padres de que el niño o el joven pueda tener un problema serio, un examen siquiátrico puede ser de gran ayuda.

Muchos de los síntomas de las tendencias suicidas son similares a los de la depresión. Los padres deben de estar conscientes de las siguientes señales que pueden indicar que el adolescente está contemplando el suicidio:

- cambios en los hábitos de dormir y de comer
- retraimiento de sus amigos, de su familia o de sus actividades habituales
- actuaciones violentas, comportamiento rebelde o el escaparse de la casa
- uso de drogas o de bebidas alcohólicas
- abandono fuera de lo común en su apariencia personal
- cambios pronunciados en su personalidad
- aburrimiento persistente, dificultad para concentrarse, o deterioro en la calidad de su trabajo escolar
- quejas frecuentes de síntomas físicos, tales como: los dolores de cabeza, de estómago y fatiga, que están por lo general asociados con el estado emocional del joven
- pérdida de interés en sus pasatiempos y otras distracciones
- poca tolerancia de los elogios o los premios

Un adolescente que está contemplando el suicidio también puede:

- quejarse de ser una persona mala o de sentirse abominable
- lanzar indirectas como: no les seguiré siendo un problema, nada me importa, para qué molestarse o no te veré otra vez
- poner en orden sus asuntos, por ejemplo: regalar sus posesiones favoritas, limpiar su cuarto, botar papeles o cosas importantes, etc.
- ponerse muy contento después de un período de depresión
- tener síntomas de sicosis (alucinaciones o pensamientos extraños)

Si el niño o adolescente dice yo me quiero matar o yo me voy a suicidar, tómelo muy en serio y llévelo de inmediato a un profesional de la salud mental capacitado. La gente a menudo se siente incómoda hablando sobre la muerte. Sin embargo, puede ser muy útil el preguntarle al joven si está deprimido o pensando en el suicidio. Esto no ha de ponerle ideas en la cabeza, por el contrario, esto le indicará que hay alguien que se preocupa por él y que le da la oportunidad de hablar acerca de sus problemas.

Si el niño o adolescente dice yo me quiero matar o yo me voy a suicidar, tómelo muy en serio y llévelo de inmediato a un profesional de la salud mental capacitado. La gente a menudo se siente incómoda hablando sobre la muerte. Sin embargo, puede ser muy útil el preguntarle al joven si está deprimido o pensando en el suicidio. Esto no ha de ponerle ideas en la cabeza, por el contrario, esto le indicará que hay alguien que se preocupa por él y que le da la oportunidad de hablar acerca de sus problemas.

Si una o más de estas señales ocurre, los padres necesitan hablar con su niño acerca de su preocupación y deben de buscar ayuda profesional cuando persiste su preocupación. Con el apoyo moral de la familia y con tratamiento profesional, los niños y adolescentes con tendencias suicidas se pueden recuperar y regresar a un camino más saludable de desarrollo.

Si usted cree que Información para la Familia le ha servido de ayuda, considere enviar un donativo a la "AACAP's Campaign for America's Kids" con el cual ayudará a que la salud mental se convierta en una realidad para todos los niños. Su respaldo económico nos ayudará para a poder continuar produciendo y distribuyendo libre de cargo Información para la Familia, al igual que otra información vital sobre la salud mental.

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Facts *for* Families

La Intimidacion ("Bullying")

No. 80 (03/01)

El intimidar, forzar a otra persona a hacer algo, es una experiencia común para muchos niños y adolescentes. Las encuestas indican que hasta una mitad de los niños de edad escolar son intimidados en algún momento durante sus años escolares y por lo menos un 10% son intimidados con regularidad.

El comportamiento de intimidar a otros puede ser físico o verbal. Los varones tienden a usar la intimidación física o las amenazas, sin importarles el género de sus víctimas. La intimidación de las niñas es con mayor frecuencia verbal, usualmente siendo otra niña el objetivo. Recientemente el intimidar ha sido reportado en las salas de conversación ("chat rooms") de las computadoras y mediante la correspondencia electrónica ("e-mail").

Los niños que son intimidados experimentan un sufrimiento real que puede interferir con su desarrollo social y emocional, al igual que con su rendimiento escolar. Algunas víctimas de intimidación hasta han intentado suicidarse antes de tener que continuar tolerando tal persecución y castigo.

Los niños y adolescentes que intimidan, se engrandecen y cobran fuerzas ("thrive") al controlar o dominar a otros. Ellos muchas veces han sido las víctimas de abuso físico o de intimidación. Los intimidadores ("bullies") pueden también estar deprimidos, llenos de ira y afectados por eventos que suceden en la escuela o en el hogar. Los niños que son el blanco de los intimidadores también tienden a caer bajo un perfil particular. Los intimidadores a menudo escogen niños que son pasivos, que se intimidan con facilidad o que tienen pocos amigos. Las víctimas también pueden ser más pequeños o menores a quienes se les hace muy difícil defenderse a sí mismos.

Si usted sospecha que su hijo está intimidando a otros, es importante que busque ayuda para él o ella tan pronto como le sea posible. Sin una intervención, la intimidación puede llevar a serias dificultades académicas, sociales, emocionales y legales. Hable con el pediatra, maestro, principal, consejero escolar o médico de familia de su niño. Si la intimidación continúa, una evaluación comprensiva por un siquiatra de niños y adolescentes u otro profesional de la salud mental debe de ser planificada. La evaluación puede ayudarlos a usted y a su niño a entender cuál es la causa de la intimidación y a desarrollar un plan para ponerle fin al comportamiento destructivo.

Si usted sospecha que su niño ha sido víctima de intimidación, pídale a él o a ella que le diga lo que está pasando. Usted puede ayudar proveyéndole muchas oportunidades para que hable con usted de manera abierta y sincera.

También es importante que se responda de manera positiva y con aceptación. Hágale saber a su hijo que no es su culpa y que él o ella hizo lo correcto al decírselo a usted. Otras sugerencias específicas incluyen lo siguiente:

- Pregúntele a su niño lo que él o ella cree que se debe de hacer. ¿Qué él ha tratado ya? ¿Qué le funcionó y qué no le funcionó?
- Busque ayuda de la maestra del niño o del consejero de la escuela. La mayor parte de la intimidación ocurre en las áreas de juego, en las cafeterías, los baños, los autobuses escolares o en los pasillos donde no hay supervisión.
- Pídale a los administradores de la escuela que busquen información acerca de programas que han sido utilizados en otras escuelas y comunidades para combatir la intimidación, tales como la mediación entre los pares, la resolución de conflictos, el adiestramiento para controlar la ira y el aumento en la supervisión por adultos.
- No estimule a su niño para que se defienda peleando. En vez de ello, sugiera que él o ella trate de alejarse para evitar al intimidador, o que busque la ayuda del maestro, entrenador u otro adulto.
- Ayude a su niño a practicar a hacer valer sus derechos. El simple acto de insistir que el intimidador lo deje solo o quieto puede tener un efecto sorpresivo. Explíquele a su niño que la meta del intimidador es lograr una respuesta.
- Ayude a su hijo a practicar qué decirle al intimidador de manera que esté preparado para la próxima vez.
- Estimule a su niño para que esté con sus amigos cuando viaja hacia la escuela y de regreso, durante los viajes para hacer compras, o en otras salidas. Los intimidadores tienden a no molestar al niño que está en un grupo.

Si su niño se torna retraído, deprimido o si se resiste a asistir a la escuela, o si usted se da cuenta de un deterioro en el comportamiento escolar, puede necesitarse una consulta o intervención adicional. Un siquiatra de niños y adolescentes u otro profesional de la salud mental puede ayudar al niño, a la familia y a la escuela a desarrollar una estrategia para tratar con la intimidación. Busque a tiempo la ayuda profesional para así evitar el riesgo de consecuencias emocionales duraderas para su niño.

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Facts *for* Families

Desorden Bipolar (la Enfermedad Maniaco-Depresiva) en los Adolescentes

No. 38 (Revisado 7/2004)

Los niños y adolescentes con un Desorden Bipolar tienen síntomas maníacos y/o depresivos. Algunos pueden tener mayormente depresión y otros una combinación de síntomas maníacos y depresivos. Las altas pueden alternar con las bajas.

Las investigaciones han mejorado la habilidad para diagnosticar el Desorden Bipolar en niños y adolescentes. El Desorden Bipolar puede comenzar en la niñez y durante los años de la adolescencia, aunque usualmente se dianostica en la vida adulta. Esta enfermedad puede afectar a cualquiera. Sin embargo, si uno o ambos padres tienen un Desorden Bipolar, hay mayor probabilidad de que los hijos desarrollen el desorden. La historia familiar de abuso de drogas o del alcohol puede también estar asociada con un mayor riesgo para desarrollar el Desorden Bipolar.

Los síntomas maníacos incluyen:

- cambios de humor severos: usualmente se siente demasiado contento o tonto, o demasiado irritable, enfadado, agitado o agresivo
- altas poco realistas en la autoestima: por ejemplo, el adolescente que se siente todopoderoso o como un super héroe con poderes especiales
- aumento de energía desmedido y la habilidad de poder seguir durante días sin dormir y sin sentirse cansado
- hablar excesivamente: el adolescente no deja de hablar, habla muy rápido, cambia de tema constantemente y no permite que lo interrumpan
- distracción: la atención del adolescente se mueve de una cosa a otra constantemente
- comportamiento arriesgado repetitivo: tal como el abuso del alcohol y las drogas, el guiar temerario y descuidado o la promiscuidad sexual.

Los síntomas depresivos incluyen:

- irritabilidad, depresión, tristeza persistente, llanto frecuente
- pensamientos acerca de la muerte o el suicidio
- disminución en la capacidad para disfrutar de sus actividades preferidas
- quejas frecuentes de malestares físicos, tales como el dolor de cabeza y de estómago
- nivel bajo de energía, fatiga, mala concentración y se queja de sentirse aburrido
- cambio notable en los patrones de comer o de dormir, tales como comer o dormir en exceso

Algunos de estos síntomas se parecen a otros que ocurren en el adolescente con otros problemas, tales como el abuso de drogas, la delincuencia, el Desorden de Deficiencia de Atención debido a Hiperactividad ("ADHD – Attention Deficit Hyperactivity Disorder"), o inclusive la esquizofrenia.

Los adolescentes con un Desorden Bipolar pueden ser tratados efectivamente. El tratamiento para el Desorden Bipolar incluye por lo general la educación e información al paciente y a su familia acerca de la enfermedad, el uso de medicamentos estabilizadores del humor tales como el litio, el ácido valpórico y la sicoterapia. Los medicamentos estabilizadores del humor a menudo reducen el número y la severidad de los episodios maníacos y ayudan también a prevenir la depresión. La sicoterapia ayuda al niño/adolescente a comprenderse a sí mismo, a adaptarse al estrés, a rehacer su autoestima y a mejorar sus relaciones.

El diagnóstico de Desorden Bipolar en los niños y adolescentes es complejo y conlleva la observación cuidadosa durante un largo período de tiempo. Una evaluación minuciosa por un siquiatra de niños y adolescentes puede identificar el Desorden Bipolar y comenzar el tratamiento.

Si usted cree que Información para la Familia le ha servido de ayuda, considere enviar un donativo a la "AACAP's Campaign for America's Kids" con el cual ayudará a que la salud mental se convierta en una realidad para todos los niños. Su respaldo económico nos ayudará para a poder continuar produciendo y distribuyendo libre de cargo Información para la Familia, al igual que otra información vital sobre la salud mental.

Usted puede también enviar su contribución a "Campaign for America's Kids", P.O. Box 96106, Washington, DC 20090. Por favor haga su cheque a nombre de AACAP.

La "American Academy of Child and Adolescent Psychiatry (AACAP)" representa a más de 7,150 siquiatras de niños y adolescentes quienes son doctores egresados de una escuela de medicina, con por lo menos cinco años adicionales de entrenamiento en siquiatría general (adultos) y siquiatría de niños y adolescentes.

Section 7: Additional Materials

Turn Them Around: 10 Steps to Teacher Buy-In

By Cynthia R. Knowles

You've got a great new idea for programming. You've done your data collection and found a science-based program that meets the identified needs of your population. You know this is going to be the program that makes the difference, the one that turns things around. The trouble is no one wants to try it.

That's not completely true. Some of your school staff will welcome the new materials, see their value and appreciate the research behind them. However, others will resist you. Some might actively fight against changes to the current program. How can you get everyone on your side so that this new program has a better chance for success?

Faithful classroom implementation of a new program is critical to getting positive results in student behaviors. Unfortunately, faithful implementation won't happen without staff buy-in. Buy-in might be the most critical factor predicting your success or failure with a new program.

Without teacher buy-in, you will have incomplete program implementation, and poor program results.

The following ten steps offer you a way of increasing cooperation and minimizing your dissension. See if some of these ideas fit your situation:

1. Involve teachers from the start
It's important that the teachers who will be using these new programs be included in the process that precedes the selection of the materials. No teacher likes to be surprised with curriculum add-ons, or told what to do and how to do it without having some say of her/his own. By involving teachers in the initial data review and the writing of program goals and objectives, they will have a much better understanding of what current student risk behaviors are, what needs to change, and how the school plans to do this.

They can also be involved in selecting the new curriculum or program. They will have a better picture of what their role is and the importance of that role. They will know what format will work best for their teaching style and student population and what works best within the school structure.

Once materials are selected, teachers can help schedule intensive teacher training as necessary. If you do not provide for teacher involvement from the very beginning, then you are compromising the effectiveness and completeness of program implementation.

2. Growth is required
Change requires growth. Growth means shifting our beliefs and expanding our knowledge base. In this case, that means having a clear understanding of current alcohol, drug, and violence types and rates in the population to be served by this program, thorough training in the new materials, and a crystal clear and irrefutable reason why everyone is doing this.

It's a good idea to have key staff involved with data collection and review from the very beginning. Let everyone discover the problems that exist together and be part of the decision-making about program changes.

3. Don't rush the change
Change is a process – it takes time. Your staff won't swing over and embrace your ideas after a 30-minute meeting. Rather than get angry at how slow the process can be, anticipate it. Start the process six months earlier than you think you need to.

4. Speak to teacher needs
If you want teacher buy-in, then you need to meet staff needs rather than expect them to meet yours. Is there an advantage for teachers in doing things the new way? How will teachers benefit? Make sure everyone can see that advantage. Also make sure that teachers know that there is a reason for the change, that there will be compensation or support for them if they have to change their routine, and that there will be adequate training provided for them in the new materials or techniques. Ask them what would make things easier, how you can help, and then follow through with what is agreed upon. Listen carefully when they talk, and especially when they complain.

5. Speak their language
Keep your information relevant to your audience. When talking to teachers explain the educational impact of this change or program. You may want to have a teacher give the actual presentation or "pitch" the program.

6. Keep change small and simple
When new programming comes to schools, staff members are pulled out of their comfort zones and are expected to change personal habits, reschedule their days and sometimes their entire curriculum. Your proposed changes need to be small. Present this as something that is similar to what is already being done. The closer the change is to current behavior or practice, the easier it will be to accept.

7. Everyone is different
People will accept change at different speeds. While some will jump right on the bandwagon, some will be slow to agree or will agree with conditions. Some will require support through the change process, and a few will resist until the bitter end and may even act as saboteurs. Remember to listen and maintain an honest dialogue. Open and honest communication is your best defense against the naysayers.

8. Change is reversible
All changes are ultimately reversible. You can always go back to the old way if the new way doesn't work. Remind all involved parties that you will monitor key data to make sure that these program changes are worth all the trouble. If they're not, they won't last.

9. Maintaining change
Maintaining change takes constant effort until it becomes habit. During this initial period of implementation; the staff must be supported and motivated to continue moving in the new direction. Without support there may be a relapse to older and easier ways.

10. Minimize the risks
Who exactly is responsible if this program fails? Who will be held accountable and what will be the impact on the school and community? The lower the personal risk, the more likely people will be to accept change. To minimize risk, specifically outline who is accountable for program selection, materials acquisition, program scheduling, and implementation and evaluation of program effectiveness.

Also outline the costs (energy, time, money) if this fails and show that it is worth the risk. Explain the track record and reputation of the selected program.

Not all of these steps will pertain to the situation at your school, but some of them are sure to. The process of change can be tricky, but following these 10 steps will assure you of better results.

Student Mental Health Screening: A Risk Management Perspective

By Constance Neary
Vice President for Risk Management, United Educators Insurance

"As a firm that provides liability insurance to schools and colleges, United Educators actively encourages schools to provide a safe environment for students and reduce the institution's liability. I believe that the SOS Suicide Prevention program can serve as an important risk management tool for schools.

A record of prevention programs is important. Many causes of serious student injury and death relate to mental health concerns. Screening efforts and counseling services help show that the school takes student mental health issues seriously. Programs, like SOS, that have proven effective in bringing troubled students to the attention of school professionals, can help save lives and prevent problems. When a tragedy does occur, they can also help in court. Consider the SOS Program as part of your institution's risk management efforts."

Note from Screening for Mental Health:

It is important to convey to students and parents that the screenings being conducted in your school are informational, not diagnostic. Diagnoses, treatment recommendations, and second opinions should not be given.

Faculty, staff, parents, and students should be informed that the program is primarily for educational purposes and is not a substitute for a diagnostic examination. Program team members will recommend that students seek complete evaluations if their symptoms are consistent with depression and/or suicidality.

Essential suicide prevention components that every school should have in place are:

- Protocols for helping students at possible risk of suicide.
- Protocols for responding to a suicide death (postvention plan).
- Prompt disclosure of a suicide threat to a parent is authorized by law and prudent.
- It is essential to document each step in the process when a student is identified as possibly being at risk for suicide and assessed for suicide risk.
- Student information needs to be kept confidential for both ethical and legal reasons.
- Protocol for responding to a suicide attempt in the school or on the school grounds.

Where Schools Can Call for Additional Help

Contact the following organizations for referrals, for assistance in implementing your program, and/or to order additional educational materials on depression and suicide prevention.

American Academy of Child and Adolescent Psychiatry (800) 333-7636
Call or visit www.aacap.org for referrals or information, including Facts for Families, a series of fact sheets that include information on depression, teen suicide, health insurance, how to seek help, and other topics.

American Association of Suicidology (202) 237-2280
Call for written material on suicide and suicide prevention or visit www.suicidology.org

American Foundation for Suicide Prevention (888) 333-AFSP (2377)
For more information on suicide prevention, call toll free or visit www.afsp.org

American Psychiatric Association (703) 907-7300
Contact the national office for information on depression or visit www.psych.org

American Psychological Association (800) 964-2000
Call for a local referral to a psychologist. For additional materials about depression, visit the APA Help Center at www.helping.apa.org

Depression and Bipolar Support Alliance (800) 826-3632
Call the national organization for local chapters and written information on depression or visit www.dbsalliance.org

Mental Health America (800) 969-NMHA (6642)
Call for local referral and written information on depression or visit www.nmha.org

National Alliance on Mental Illness (800) 950-NAMI (6264)
Call Help Line for local support groups and/or additional materials on depression, or visit www.nami.org

National Association of Social Workers (202) 408-8600
Contact your local chapter or visit www.socialworkers.org. To find a social worker or for educational materials for consumers, go to: http://www.helpstartshere.org

National Institute of Mental Health (866) 615-6464
Public domain materials are available in multiple formats. For browsing online, downloading in PDF, and ordering brochures through the mail, visit www.nimh.nih.gov

National Suicide Prevention Lifeline (800) 273-TALK (8255)
Provides immediate assistance to individuals in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider www.suicidepreventionlifeline.org

Suicide Prevention Resource Center (SPRC) (877) GET-SPRC (438-7772)
Provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies, and to advance the National Strategy for Suicide Prevention. Includes materials for students, parents, school staff, and others. Includes state suicide data on state pages www.sprc.org

Substance Abuse and Mental Health Services Administration (SAMHSA) (800) 729-6686
Provides the largest federal source of public domain information about mental health research, treatment, and prevention, available to the public at www.samhsa.gov. Visit SAMHSA's Center for Mental Health Services Locator https://findtreatment.samhsa.gov. This locator provides comprehensive information about mental health services and resources near the location you specify and is useful for professionals, consumers, families, and the public.

Trevor Project (866) 4-U-TREVOR (488-7386)
The Trevor Project is the leading national organization focused on crisis and suicide prevention efforts among lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. http://www.thetrevorproject.org

Useful Resources

School Suicide Prevention

Preventing Suicide, A Resource for Teachers and Other School Staff, World Health Organization,
www.who.int/mental_health/media/en/62.pdf

Safeguarding our Children: An Action Guide. Dwyer, K. and Osher, D. 2000.
www.ed.gov/admins/lead/safety/actguide/action_guide.pdf

Center for Mental Health in Schools at UCLA (866) 846-4843
A wide range of educational and training materials available at http://smhp.psych.ucla.edu

The Youth Suicide Prevention School-Based Guide, NOVA
Provides resources and information that school administrators can use to enhance or add to their existing suicide prevention program http://theguide.fmhi.usf.edu/

Treatment

Practice Parameter for the Assessment and Treatment of Children and Adolescents With Suicidal Behavior, Shaffer, Pfeffer, et al. J. Am. Acad. Child Adolesc. Psychiatry, 40:7 Supplement, July, 2001. See: https://www.aacap.org/App_Themes/AACAP/docs/practice_parameters/depressive_disorders_practice_parameter.pdf

Treating Self-Injury : A Practical Guide Barent Walsh, PhD. "Treating Self-Injury: A Practical Guide" © 2005 by Barent Walsh, all rights reserved, published by Guilford Press, New York, NY. Order the book at your local bookstore, online at www.guilford.com or www.amazon.com, or call 800-365-7006. Email: barryw@thebridgecm.org Phone: 508.755.0333

Fundraising

Ask and You and Will Receive: A Fundraising Guide for Suicide Prevention Advocates A 14-page document that presents new ways to think about generating support for your suicide prevention efforts. Suicide Prevention Resource Center (SPRC) and SPAN USA (Suicide Prevention Action Network) http://library.sprc.org/item.php?id=118842, 2005.

Centers for Disease Control, Youth Risk Behavior Survey Includes state data reports, online comprehensive results, slide set, http://www.cdc.gov/HealthyYouth/yrbs/index.htm

"Case Study: Nebraska School District Responds in Aftermath of Suicide Cluster", Poland & Lieberman, NewsLink, a publication of the American Association of Suicidology, 2004.

International Suicide Data World Health Organization,
http://www.who.int/mental_health/prevention/suicide/suicideprevent/en

Postvention Resources

Postvention Standards Manual: A Guide for a School's Response in the Aftermath of Sudden Death, Services for Teens at Risk (STAR Center) http://www.starcenter.pitt.edu/Files/PDF/Manuals/Postvention.pdf

Project SERV (School Emergency Response to Violence)
http://www.ed.gov/programs/dvppserv/index.html
Project SERV provides education-related services to school districts where the learning environment has been disrupted due to a violent or traumatic crisis. Funds may be used to assist schools facing an undue financial hardship in providing extraordinary services due to an event that has had a traumatic affect on the learning environment. This program offers short-term and long-term assistance to local education agencies (LEAs) to recover from a violent or traumatic event in which the learning environment has been disrupted. Immediate services assistance covers up to 60 days from the date of the incident. Extended services assistance covers up to one year from the incident.

Responding to Crisis at a School Center for Mental Health in Schools at UCLA. (2005). A resource aid packet on responding to a crisis at a school. Los Angeles, CA: Author. Revised November 2005. Copies may be downloaded from: http://smhp.psych.ucla.edu

Suicide Prevention Resource Center After a Suicide: A Toolkit for Schools
Developed by the American Foundation for Suicide Prevention (AFSP) and the Suicide Prevention Resource Center (SPRC), in consultation with a diverse group of national experts, including school-based personnel, clinicians, researchers, and crisis response professionals, After a Suicide: A Toolkit for Schools is an online resource for schools facing the suicide death of a student or other member of the school community. The Toolkit incorporates relevant existing material and research findings as well as references, templates, and links to additional information and assistance.
http://www.sprc.org/sites/sprc.org/files/library/AfteraSuicideToolkitforSchools.pdf?sid=45232

The U.S. Department of Education Emergency Planning
http://www.ed.gov/admins/lead/safety/emergencyplan/index.html
DOE has unveiled this new website designed to be a one-stop shop that provides school leaders with information they need to plan for any emergency, including natural disasters, violent incidents, and terrorist acts.

Suicide Prevention Program

Self-Injury Packet

Introduction

We are providing materials about self-injury as part of the SOS Middle School program to address the increased prevalence of this phenomenon among youth in middle schools. We have povided these materials to help raise awareness about the signs of self-injury and to establish action steps for teachers, parents, and school-based clinicians. We encourage you to reproduce and distribute the materials designed for teachers, parents of students who self-injure, and school-based clinicians as part of your self-injury prevention efforts. Schools who wish to raise awareness among students about the signs of self-injury can teach them that the action steps are the same for any individual who encounters or experiences the signs of depression and suicide:
ACT: **A**cknowledge your friend has a problem, show the person you **C**are, and **T**ell a trusted adult.

Acknowledgements
We are grateful to Barent Walsh, PhD, Richard Lieberman, PhD, and Kathy Cowan for their guidance in developing these materials. We would like to thank Susan Bowman and Kaye Randall, authors of the book, S*ee My Pain! Creative Strategies and Activities for Helping Young People who Self-Injure* for their permission to provide schools with the materials for teachers and family members.

Facts about Self-Injury: Self-injury is one of the least understood risky behaviors of adolescence and it presents a significant challenge to parents, mental health professionals, and school personnel. It appears to be growing at an alarming rate, is fairly high on the spectrum of harmful behaviors, and although not usually an attempt at suicide, is a clear indication of a troubled youth. School personnel can help students who self-injure by recognizing those at-risk and providing appropriate support.

- Self-injury is a maladaptive behavior that troubled teens use to deal with extreme and painful emotions
- Behaviors include cutting, burning, hitting, poking, picking, hair pulling, and head banging; the most common form is cutting
- Those who self-injure are typically not attempting suicide. By expressing their inner pain through injury, they may be keeping themselves from suicide; however, those who self-injure can become suicidal or accidentally kill themselves
- Between 150,000 and 360,000 adolescents in the United States self-injure
- It is estimated that 60% or more of those who self-injure are girls
- Youth who self-injure have low self-esteem and difficulty regulating their emotions
- Those who self-injure can have underlying personality or mood disorders and depression
- Self-injury appears to have a contagious effect among peer groups
- Although the individual who self-injures may not be driven by suicidal intention during the act, he or she may, at some point, consider suicide or try to harm themselves more seriously
- Self-injury is generally separate and distinct from body modification such as tattoos and body piercings from professionals

Signs of Self-Injury: Detecting students who self-injure is difficult because of the secretive nature of the behavior. Adults can look for certain signs of self-injury, however, that may also indicate other risk factors such as depression or abuse:

- Frequent or unexplained scars, cuts, bruises, and burns, (often on the arms, thighs, abdomen) and broken bones (fingers, hands, wrists, toes)
- Consistent, inappropriate use of clothing designed to cover scars
- Secretive behavior, spending unusual amounts of time in the bathroom or other isolated areas
- General signs of depression
- Social and emotional isolation and disconnectedness
- Substance use
- Possession of sharp implements (razor blades, thumb tacks)
- Indications of extreme anger, sadness, or pain or images of physical harm in class work, creative work, etc.
- Extreme risk-taking behaviors that could result in injuries

Intervention Recommendations: The best role for schools is to identify students who self-injure. Refer them to and coordinate with community mental health resources; and offer safe, caring, and nonjudgmental support. Interventions should be conducted individually, never in a group, to avoid contagious behavior.

Incorporate Self-Injury Training Into Your Crisis Team Responsibilities: Include the school psychologist, counselor, social worker, the school nurse, and the appropriate administrator. The crisis team should address medical needs, assess the suicide risk, determine appropriate support resources, notify parents (or, if necessary, child protective services), and coordinate with relevant community resources. Students should always be dealt with individually and supervised until deemed safe or put in the care of their parents.

Provide Information to All Adults on How to Recognize Signs of Self-Injury: Parents and certain school personnel, especially coaches and PE teachers, are often in the best position to detect the physical evidence of self-injury.

Train All Staff Members to Respond Appropriately

- Staff members should not further alienate or isolate students who self-injure
- Staff members should not react with criticism or horror
- The responding staff member must let the student know that he or she is required to inform a parent or guardian, not as a punishment, but to help the student get help
- Clearly differentiate the roles and responsibilities of crisis team personnel (risk assessment and ongoing support) and other school staff members (identification and initial intervention)

Use Caution When Educating Students

- Keep information about self-injury very general and within the context of seeking help from a trusted adult. The action steps are the same for students: ACT: Acknowledge, Care, Tell
- With students, focus on self-injury as a mental health problem that can be treated, the signs of emotional stress and risk behaviors, alternative coping strategies, and identification of adults within the school who are trained to help students
- Descriptions of why or how students hurt themselves should be avoided because of their potentially suggestive effect

Notify and Involve Parents

- When a student is at risk for harm through self-injury, the school is responsible for warning parents and providing resources to help the student
- Call parents while the student is present so everyone hears what is said
- If there is danger or a history of abuse in the family, the school's duty to warn parents is satisfied through contact with the local children's protective services agency

Collaborate With the Student's Parents and Psychologist

- The school mental health professional should coordinate with the student's private clinician and parents to reinforce alternative coping mechanisms and implement appropriate interventions
- Students should know at least one adult in the building to whom they can go if they feel the impulse to hurt themselves. Usually this would be the school psychologist, nurse, social worker, or counselor

Limit Contagion

- Limit activities that detail or focus on self-injuring behaviors
- The best approach is one that is low key and individually focused to prevent imitative behaviors
- Refrain from assemblies dedicated to the topic
- To the extent possible, monitor movies (such as *Thirteen*), television programs, and websites/social media that address self-injury because these can also trigger self-injuring behavior in at-risk students

Responding to a Student Who Self-Injures

No matter how unnerving their behavior, it is critical not to alienate a self-injuring teen, but rather to build trust. Teachers can offer reassurance and support, but should always refer the student to school mental health personnel. Students should be supervised at all times until they have been assessed as safe or handed into the care of their parents.

- Notify parents
- Address medical needs first, as necessary
- Do not react in horror or discomfort
- Encourage connectedness without invading their space. Don't be directive or judgmental. Reassure them that there is nothing to be ashamed of

- Acknowledge their feelings. Offer to listen
- Empathize but do not pretend to "know" how they feel
- Emphasize hope
- Emphasize that self-injury is a mental health problem that is treatable
- Take them to the crisis team member but reassure them that they are not in trouble

Source: Richard Lieberman. Richard Lieberman is a school psychologist who leads the Los Angeles Unified School District's Suicide Prevention Unit and co-chair of the National Emergency Assistance Team of the National Association of School Psychologists (NASP). This fact sheet was created for the SOS Program in cooperation with NASP. Adapted with permission from "Understanding and Responding to Students Who Self-Mutilate" in Principal Leadership, 2004 National Association of Secondary School Principals. The complete article can be accessed at www.naspcenter.org/principals.

Reaching and Helping Youth Who Self-Injure (SI)
Suggestions for School Counselors/Social Workers/Psychologists

- Self-injury is generally separate and distinct from suicide. Self-injury is when people deliberately harm their bodies, usually without suicidal intent, in order to reduce psychological distress. However, since self-injury can be a risk factor for future suicides, referral to a professional with expertise in the area of self-injury is indicated for any student who self-injures.
- Avoid being effusively sympathetic or judgmentally condemning when learning that someone is self-injuring. Excessive sympathy may inadvertently reinforce the behavior. Condemning the behavior may make an already distressed person feel worse.
- Responding initially to the behavior with a "respectful curiosity" can be helpful and reassuring to someone who is self- injuring. An appropriate, respectfully curious question is, "What does self-injury do for you?"
- Attempting to "contract for safety" is contraindicated. Asking youth to give up self-injury when it is their best emotion regulation technique is unrealistic. Expecting or demanding that youth quickly give up self-injury can result in their lying or becoming evasive.
- Work with the individual's therapist to support specific agreed-to alternatives to self-injury while in school. Identify a designated adult for the student to contact if he or she feels the impulse to self-injure while in school. Likewise, the school should clearly communicate to parents and the student how the school is required to respond (Lieberman, 2004).
- Most forms of self-injury can be helped in outpatient counseling. Exceptions that should be referred for emergency psychiatric evaluation include self-injury that causes extensive tissue damage (e.g. wounds that require suturing) or that involves face, eyes, breasts in females, and genitals.
- Self-injury can be contagious. Evaluate whether the student has friends who self-injure. If so, they may be reinforcing the behavior in each other. Ask that these students stop communicating with each other about self-injury, indicating that they may be inadvertently "hurting their friends." Also, determine if the student is spending time on websites or social media devoted to self-injury. These activities can also be triggering.
- Self-injury is a complex bio-psychosocial phenomenon. Biological, psychological, and environmental factors combine to produce the behavior and must be addressed to eliminate the behavior.
- Counseling for self-injury often proves effective. Effective counseling focuses on reducing the environmental factors that trigger self-injury (e.g. conflicts with parents, peer isolation, dating problems, academic or athletic perfectionism). Counseling also teaches replacement skills that enable youth to deal with emotional distress using healthier, more effective strategies (e.g. breathing techniques, visualization, journaling, communicating with adults, physical exercise, artistic expression, etc.).
- Psychological treatment, often combined with medication, has been successful in treating self-injury.

Source: Barent Walsh, PhD. Barent Walsh is the Executive Director of The Bridge of Central Massachusetts, Inc. in Worcester, Massachusetts. Adapted from "Treating Self-Injury: A Practical Guide" Order the book at your local bookstore, online at www.guilford.com or www.amazon.com, or call 800-365-7006.Email: barryw@thebridgecm.org Phone: 508.755.0333

Reaching and Helping Youth Who Self-Injure (SI) Suggestions for Teachers

Teachers have many more responsibilities today than they did years ago. If you are a teacher I'm sure you would agree that it wasn't the same ten years ago when schools could focus more on teaching and not dealing with all the other problems that are in today's classroom. It is virtually impossible for teachers to discern which students have psychological problems, know the red flags of a student with hidden rage, or know which students are on medication and the side effects. In addition, some teachers are expected to know how to handle tragedies such as a terrorist attack, school shooting, or suicide. Faced with many of these concerns, teachers are still receiving limited training in how to effectively handle these challenges. SI is now another growing problem to add to that list. Many teachers have not been trained in SI and do not know how they should handle a student who shows signs of this behavior. Often students will come to a teacher that he/she trusts and either tell the teacher about the SI behavior, or show where on their body he/she self-injured.

It is important for teachers to know the Do's and Don'ts of how to handle such situations. Teachers need to know that in following these suggestions, they cannot stop the SI and they need to refer any student who they suspect of this behavior to the school guidance counselor, school social worker, or the school nurse. The following Do's and Don'ts are suggestions for helping teachers respond to any student they think may be involved in self-injurious behavior.

Do

- Try to approach the student in a calm and caring way
- Accept him/her even though you do not accept the behavior
- Let the student know how much you care about him/her and believe in his/her potential
- Understand that this is his/her way of coping with the pain that he/she feels inside
- Refer that student to your school's counselor, social worker, and/or nurse
- Offer to go with that student to see the professional helper
- Listen! Allow the student to talk to you. Be available
- Discover what the student's personal strengths are and encourage him/her to use those strengths
- Help him/her get involved in some area of interest, a club, sport, peer program, outreach project, e.g., volunteer at a local animal shelter or wildlife sanctuary, help an older person at a nursing home, tutor a young child after school, or mentor a child with low self-esteem

Don't

- Say or do anything to cause the student to feel guilt or shame (e.g., "What did you do to yourself?", "Why did you do that?")
- Act shocked or appalled by his/her behavior
- Talk about their SI in front of the class or around his/her peers
- Try to teach him/her what you think he/she should do
- Judge the student even if you do not agree with him/her
- Tell the student that you won't tell anyone if he/she shares self-harming behaviors with you
- Use punishment or negative consequences if a student does SI
- Make deals in an effort to get the student to stop SI
- Make promises to the student that you can't keep

Websites Related to Self-Injury

There are scores of websites that focus on self-injury. They fall into two main categories: 1) websites designed by professionals to assist self-injurers, and 2) websites created by self-injurers intended to offer peer support. This list is meant to be representative, not exhaustive.

The Cornell Research Program on Self-Injury and Recovery was launched in 2003 to understand what was then widely believed to be a new and emerging behavior among youth and adults. Since that time CRPSIR have conducted multiple studies on a wide variety of topics and have begun the process of translating what they and others have learned into user friendly materials for individuals who injure as well as those who live with, care about, and work with them. CRPSIR provides a clearinghouse of resources, helpful websites, books and assessment tools. http://www.selfinjury.bctr.cornell.edu/index.html

LifeSIGNS (Self-Injury Guidance & Network Support) is an online, user-led volunteer organization, founded in 2002 to create understanding about self-injury and provide information and support to people of all ages affected by self-injury. LifeSIGNS recognizes self-injury and self-harm as a way of coping with distressing experiences and difficult emotions, and they encourage people to reflect on the issues behind their self-injury, and to develop and explore alternative coping mechanisms. http://www.lifesigns.org.uk

SAFE Alternatives® (Self-Abuse Finally Ends) (1-800-366-8288) is a nationally recognized treatment approach, professional network and educational resource base, which is committed to helping achieve an end to self-injurious behavior. S.A.F.E. Focus Group is a self-injury support group based off of the S.A.F.E. Alternatives Program. S.A.F.E. Alternatives also provides information on how to find a therapist to treat self-injury. https://www.selfinjury.com

Additional Resources

Bowman, Susan, & Randall, Kaye. *See My Pain! Creative Strategies and Activities for Helping Young People Who Self-Injure.* Chapin, SC: YouthLight, Inc., 2005. To order go to www.youthlightbooks.com.

Lieberman, Richard (2004). Understanding and Responding to Students Who Self-Mutilate. Principal Leadership.4(7). National Association of Secondary School Principals. This complete article can be accessed at http://naspcenter.org/principals/nassp_cutting.html

Walsh, Barent. *Treating Self-Injury: A Practical Guide.* New York, NY: Guilford Press, 2005.

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References

Section 1: Overview

Centers for Disease Control and Prevention. (2012). Suicide: Facts at a Glance. Atlanta, Georgia: U.S. Department of Health and Human Services Centers for Disease Control and Prevention.

Office of Applied Studies. (2006). Results from the 2005 National Survey on Drug Use and Health: National findings (DHHS Publication No. SMA 06-4194, NSDUH Series H-30). Rockville, MD: Substance Abuse and Mental Health Services Administration.

U.S. Department of Health and Human Services. (1999). Mental Health: A Report of the Surgeon General-Chapter 3, children and mental health. Rockville, MD: Author, Center for Mental Health Service, National Institutes of Health, National Institute of Mental Health.

Section 2: Planning

UCLA Center for Mental Health in Schools. School Community Partnerships: a guide. Retrieved from http://smhp.psych.ucla.edu/pdfdocs/guides/schoolcomm.pdf

Section 3: Educating Staff and Parents

Doan, J., Roggenbaum, S., & Lazear, K. (2012). Youth Suicide Prevention School-based Guide—Issue brief 3a: Risk Factors: Risk and protective factors, and warning signs.Tampa, FL: Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Series Publication #218-3a)

Gould, M., et al. (2003). Youth Suicide Risk and Preventive Interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42 (4), 386-405.

Grossman, D., et al. (2005). Gun Storage Practices and the Risk of Youth Suicide and Unintentional Firearm Injuries. *Journal of the American Medical Association*, 293 (6), 707-714.

Kataoka, S. Zhang, L. Wells, K. (2002). Unmet Need for Mental Health Care Among U.S. Children: Variation by ethnicity and insurance status. American Journal of Psychiatry, 159 (9), 1548-1555.

National Adolescent Health Information Center. (2006). Fact Sheet on Suicide: adolescents and Young Adults. San Francisco, CA: Author, University of California, San Francisco.

National Institute of Mental Health. (2009) Suicide in the U.S., Statistics and Prevention. Retrieved June 15, 2009, from http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml

Shenassa, E., Rogers, M., Spalding, K. (2004). Safer Storage of Firearms at Home and Risk of Suicide: a study of protective factors in a nationally representative sample. *Journal of Epidemiology and Community Health*, 58, 841-848.

Suicide Prevention Resource Center (SPRC). (2014). Teens page. Retrieved May 8, 2015, from http://www.sprc.org/sites/sprc.org/files/Teens.pdf

World Health Organization. (2000). Preventing Suicide: A resource for teachers and other school staff. Geneva, Switzerland: Mental and Behavioral Disorders, Department of Mental Health.

Section 4: Lesbian, Gay, Bisexual, Transgender & Questioning Resource Guide

D'Augelli, A. R. (2002). Mental Health Problems Among Lesbian, Gay, and Bisexual Youths Ages 14 to 21. *Clinical Child Psychology and Psychiatry* (7), 439-462.

Gender Spectrum. (2014). Understanding Gender. Retrieved from http://www.genderspectrum.org/child-family/understanding-gender

Kosciw, J.G., Greytak, E.A., Diaz, E.M., Bartkiewicz, M.J. (2010). 2009 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual and Transgender Youth in Our Nation's Schools. New York: Gay, Lesbian Straight Education Network.

Massachusetts Department of Education. (2006). Suicidality and Self-inflicted Injury. In Massachusetts Department of Education, 2005 Massachusetts Youth Risk Behavior Survey results. Malden, MA: Retrieved May 8,2015, from http://www.doe.mass.edu/cnp/hprograms/yrbs/05/ch6.doc

Ryan, C., et al. (2010). Family Acceptance in Adolescence and the Health of LGBT Young Adults. *Journal of Child and Adolescent Psychiatric Nursing*, 4 (23), 205-213.

Ryan, C. (2009). Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual & Transgender Children.

Suicide Prevention Resource Center. (2008). Suicide Risk and Prevention for Lesbian, Gay, Bisexual, and Transgender Youth. Newton, MA: Educational Development Center, Inc.

Section 5: Lesson Plans

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed., Text Revision). Washington, D.C.: Author.

Center for Disease Control and Prevention. (2008). Web-based Injury Statistics Query and Reporting System (WISQARS). Retrieved June 11, 2009, from http://www.cdc.gov/injury/wisqars/index.html

Kalafat, J., Ryerson, D., and Underwood, M. Lifelines ASAP - Lifelines Adolescent Suicide Awareness and Response Program. Piscataway, NJ: Rutgers University.

Kerr, M. Suicide Prevention in Schools: Best Practices and Questionable Practices (2009). Retrieved from STAR-Center Online Website: http://www.wpic.pitt.edu/oerp/webcast/A034webcast.htm

Section 6: Materials for Reproduction

National Alliance of Mental Illness (NAMI). (2009). Depression in Children and Adolescents. Retrieved on June 16, 2009 from http://www2.nami.org/Content/NavigationMenu/Mental_Illnesses/Depression/children_and_adolescents.pdf

Aseltine, R., et al. (2007). Evaluating the SOS Suicide Prevention Program: A replication and extension. *BMC Public Health* 7(161).

Anderman, C., Cheadle, A., Curry, S., Diehr, P. Shultz, L., Wagner, E. (1995). Selection Bias Related to Parental Consent in School-Based Survey Research. Evaluation Review, 19(6), 663-674.

Esbensen, F. A., & Deschenes, E. P. (1996). Active Parental Consent in School-based Research: An examination of ethical and methodological issues. Evaluation Review, 20(6), 737-753.

Fletcher, A. C., & Hunter, A. G. (2003). Strategies for Obtaining Parental Consent to Participate in Research. Family Relations, 52, 216-221.

Ji, P. Y., Pokorny, S. B., & Jason, L. A. (2004). Factors Influencing Middle and High Schools' Active Parental Consent Return Rates. Evaluation Review, 28(6), 578-591.

Knowlton, J., Bryant, D., Rockwell, E., Moore, M., Straub, B. W., Cummings, P., Wilson, C. (1999). Obtaining Active Parental Consent for Evaluation Research: A case study. *American Journal of Evaluation*, 20(2), 239-249.

Leakey, T., Lunde, K. B., Koga, K., & Glanz, K. (2004). Written Parental Consent and Use of Incentives in a Youth Smoking Prevention Trial: A case study from Project SPLASH. *American Journal of Evaluation*, 25(4), 509-523.

McMorris, B.J., Clements, J., Evans-Whipp, T., Gangnes, D., Bond, L., Toumbourou, J.W., Catalano, R. (2004). A Comparison of Methods to Obtain Active Parental Consent for an International Student Survey. *Evaluation Review*, 28(1), 64-83.

Noll, R. B., Zeller, M. H., & Vannatta, K. (1997). Potential Bias in Classroom Research: Comparison of children with permission and those who do not receive permission to participate. *Journal of Clinical Child Psychology*, 26(1), 36-42.

O'Donnell, L. N., Duran, R. H., San Doval, A., Breslink, M. J., Juhn, G. M., Stueve, A. (1997). Obtaining Written Parent Permission for School-based Health Surveys of Urban Young Adolescents. *Journal of Adolescent Health*, 21, 376-383.

Pokorny, S. B., Jason, L. A., Schoeny, M. E., Townsend, S. M., Curie, C. J. (2001). Do Participation Rates Change when Active Consent Procedures Replace Passive Consent? *Evaluation Review*, 25(5), 567-580.

Ross, J. G., Sundberg, E. C., & Flint, K. H. (1999). Informed Consent in School Health Research: Why, how, and making it easy. *Journal of School Health*, 69(5), 171-176.

Tigges, B. B. (2003). Parental Consent and Adolescent Risk Behavior Research. *Journal of Nursing Scholarship*, 35(3), 283-289.

Unger, J. B., Gallaher, P., Palmer, P. H., Baezconde-Garbanati, L., Trinidad, D. R. Cen, S., Johnson, C. A. (2004). No News is Bad News: Characteristics of adolescents who provide neither parental consent nor refusal for participation in school-based survey research. *Evaluation Review*, 28(1), 52-63.

Section 7: Additional Resources

Bjorklun, E. (1996). School Liability for Student Suicides. *West's Education Law Reporter*, 5 (2), 339-350.

Cafaro, C. (2000). Student Suicides and School System Liability. *University of North Carolina School of Government School Law Bulletin*, 31(2),17-28.

Knowles, C. (2001). Prevention that Works! Thousand Oaks, CA: Corwin Press.

Litts, D. (August 2, 2004). USAF Suicide Prevention Program: Lessons for Public Health Prevention in Non-military Communities. Retrived June 2, 2009 from http://www.sprc.org/training-institute/r2p-webinars/usaf-suicide-prevention-program-lessons-public-health-prevention-n-0

Simpson, M. (1999). Student Suicide: Who's Liable? Retrieved from: https://hems.nea.org/neatoday/9902/rights.html

Washington State Youth Suicide Prevention Program. (July 28, 2004). Evaluation of Community Networks in Eight Washington Counties. Retrieved June 2, 2009 from http://yspp.org/downloads/about_yspp/YSPP_CommunityReport_2004.pdf

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One Washington Street, Suite 304
Wellesley Hills, MA 02481
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www.MentalHealthScreening.org