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Utah Mental Health Professionals' Recommendations for  
Working with Youth at Risk for Suicide

Amy Paskett Stillman

A thesis submitted to the faculty of  
Brigham Young University  
in partial fulfillment of the requirements for the degree of  
Educational Specialist

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## ABSTRACT

### Utah Mental Health Professionals' Recommendations for Working with Youth at Risk for Suicide

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Suicide has immediate and long-term negative effects on surviving family members and adverse effects in the school and community. Suicide rates for children and adolescents have increased in the United States since 2009. As part of suicide prevention efforts, information about risk factors and warning signs are typically addressed in schools, private organizations, and communities. In addition to academic literature for professional audiences, various therapeutic resources are available to assist those who grieve the suicide of a loved one. In particular, practical and easy-to-implement interventions are needed by those who offer support to suicidal individuals and survivors of suicide. Practical resources are needed to address suicide prevention, intervention, and postvention needs.

This study is based on a questionnaire that was given to 250 registered individuals at an annual state suicide prevention training conference. Of those attending, 60 (24%) completed the questionnaire. Participants who did not have experience working with suicidal youth did not participate, so the actual participation rate was influenced by this factor. Questions explored the recommendations of mental health professionals ( $N=60$ ) who worked with (a) suicidal youth, (b) siblings of youth who completed suicide, and/or (c) youth whose parent completed suicide. More specifically this study investigated specific strategies and resources for working with these three specific groups of survivors. Findings from this study indicated that mental health professionals recommend a variety of suicide prevention resources and strategies such as implementing evidenced-based prevention programs, accessing community resources, offering individual and group counseling for survivors, involving or creating support systems, and listening to the affected youth. Also, recommended therapeutic approaches should include an action plan where students are able to receive appropriate mental health services. Based on this study, mental health professionals may be more effective as they acquaint themselves with available resources such as counselors, school psychologists, and community services to comprehensively care for struggling individuals. Mental health professionals, educators, and staff members should obtain relevant information and utilize effective intervention models in order to better address the prevention, intervention, and postvention needs of surviving individuals.

Recommendations are made for future research in identifying the combination of resources that are most helpful. Recommendations are also made regarding specific content and training strategies to more effectively prepare and equip professionals to engage more fully in effective and supportive suicide prevention efforts.

Keywords: youth suicide, suicidal ideation, suicide survivors, suicide prevention, suicide intervention, suicide postvention, parent suicide, sibling suicide

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## DESCRIPTION OF THESIS STRUCTURE

This thesis, *Utah Mental Health Professionals' Recommendations for Working with Youth at Risk for Suicide*, is written in a hybrid format. The hybrid format combines typical thesis requirements with a journal-ready publication format.

The initial pages of the thesis fulfill requirements for university submission. Following these initial pages, the thesis report is presented as a journal-ready article and conforms to formatting and style presented in the latest American Psychological Association publication manual (6th ed., 2010).

This thesis format includes two reference lists. The first reference list contains references cited in the journal-ready article. The second reference list is located at the end of Appendix A, "Review of the Literature." This second reference list includes all citations that are included in the literature review.

## Introduction

Although suicide is considered a preventable occurrence, the Centers for Disease Control and Prevention (CDC) reports that someone dies by suicide every 15 minutes (2013). Suicide rates for children and adolescents have been increasing in the United States since 2009. In addition to the tragic loss of an individual's life, each suicide siphons emotional energy and deflates personal fortitude and hope from surviving peers, family members, schools, and communities. The overall amount of suicide ideation for youth prior to the age of 18, according to a national youth risk behavior survey, is the highest among high school students. Of those surveyed, 15.8% reported seriously considering suicide, 12.8% of those students reported making a plan to commit suicide, and 8% reported attempting suicide one or more times during the 12 months before the survey was administered (CDC, 2011). Of the youth who attempt suicide, each year approximately 157,000 youths between the ages of 10 and 24 receive medical care for self-inflicted injuries at medical centers across the United States (CDC, 2013).

Other research indicates that about one in nine children attempt suicide prior to graduation from high school, with some children attempting suicide during elementary school (Mazza, Catalano, Abbott, & Haggerty, 2011). One longitudinal study surveyed 883 young adults, ages 18 to 19-years-old, about previous suicide attempts (Mazza et al., 2011). Of these young adults, 78 (9%) reported previously attempting suicide. Of the 39 teens who reported multiple attempts of suicide, initial attempts were made in elementary school, some as young as 9-years-old. Almost 40% of high school students who attempted suicide reported prior attempts in elementary and/or middle school.

## **Suicide Prevention**

The task of suicide prevention is challenging and includes understanding the core risks that contribute to suicide and an awareness that risk of suicide is not limited to any specific demographic (Roggenbaum, 2008). The ultimate goal of suicide prevention programs is to minimize risk factors; promote resilience; encourage the identification of typical risk factors; and then to address these critical issues in schools, communities, families, and private organizations (Roggenbaum, 2008; US Department of Health and Human Services [DHHS], Office of the Surgeon General, 2012).

The 2012 *National Strategy for Suicide Prevention* recommends that the “thousands of first responders, crisis line volunteers, law enforcement professionals, clergy, teachers, school counselors, individuals working in the justice system and/or in law enforcement, and others who are on the frontlines of suicide prevention” are the ones that should be “trained on suicide prevention” (US DHHS, Office of the Surgeon General, 2012, p. 46). Those closest to the individual such as family members, including siblings, are in a position to notice the signs of suicidal ideation and may be the first responders to a suicide attempt (Gould, Greenberg, Velting, & Shaffer, 2003).

Because suicide is a growing and pervasive problem, understanding both prevention and postvention strategies including dealing with the aftermath of a completed suicide is of paramount importance. Each suicide alters the lives of surviving family members, friends, teachers, and community members. Survivors feel their grief is disenfranchised; often have trouble reaching out to others for support; and have difficulty healing, moving forward, and adaptively coping with grief (Balk, Zaengle, & Corr, 2011). Dealing with grief in the aftermath of suicide is a highly complex process due to the necessity of coping with both grief and the

trauma that occurs due to the “preoccupation” of how the person died (Jordan & McIntosh, 2011). For youth whose sibling or parent completed suicide, grief reactions often include depression and anxiety (Dyregrov & Dyregrov, 2005). For youth whose parent completed suicide, grief reactions may be multiplied because of his or her dependency on the deceased parent and the immediate loss of the parent as a role model and caregiver (Webb, 2011).

Services and strategies to support grieving youth, siblings, and children of parents who complete suicide should occur in schools and communities (American Foundation for Suicide Prevention [AFSP] & Suicide Prevention Resource Center [SPRC], (2011). According to Andriessen (2009), listening to survivors and exploring their needs and experiences should be the first step in establishing effective postvention services. Listening and establishing support is considered a contributing factor toward effective suicide prevention for those bereaved by suicide (Andriessen, 2009). Supports should be well-planned and occur in a timely manner. Because bereaved family members are profoundly affected by the loss, adjusting to life with the absence of a loved one should be underpinned by timely support with a specific postvention plan (Lindqvist, Johansson, & Karlsson, 2008).

There are evidence-based resources, such as Question Persuade Refer (QPR), Positive Behavior Intervention and Supports (PBIS), and Cognitive Behavior Therapy (CBT), that can address the needs of individuals with suicidal ideation or the needs of youth whose sibling or parent has completed suicide. The application goal of evidence-based practices is turning carefully controlled clinical research discoveries into improved and timely care for an individual (Kazdin, 2004). A fundamental problem is that evidenced-based practices and the direct application of those practices may miss the pressing need of the survivor because the evidence-based practice may not generalize across populations and to non-controlled settings (Kazdin,

2004). In an effort to expand the focus beyond identifying evidence-based treatments effective in clinical settings, the purpose of this study was to gather recommendations from practitioners on how to best work with at-risk youth with prevention and intervention needs as well as with youth with postvention needs of dealing with the aftermath of a sibling or parent who completed suicide. Furthermore, the purpose of this study is to identify the recommended therapeutic approaches that are beneficial in helping to create an action plan to help at-risk youth receive appropriate mental health services.

### **Statement of the Problem**

Community members and professionals can be trained to identify and respond to individuals with suicidal ideation. Many studies show the effectiveness of suicide prevention programs that address at-risk students and educate teachers, counselors, and mental health professionals who work with those youth (Browne, Gafni, Roberts, Byrne, & Majumdar, 2004; Dahlberg & Butchart, 2005; Katz et al., 2013). Research should be used to identify effective resources that address suicide prevention training, intervention, and postvention strategies. Other resources should be included that will increase the safety net for students at risk, effectively intervene with suicidal youth, support siblings of youth who complete suicide and support children of a parent who completed suicide.

There is a shortage of research in relation to identifying resources recommended by professionals in relation to suicide. Ascertaining the prevention, intervention, and postvention programs recommended and used by mental health and school professionals regarding suicide may benefit teachers, paraeducators, families, and communities and may produce greater levels of effectiveness in the programs used (Browne et al., 2004). The intention of this study is to

gather information regarding resources and strategies utilized to address suicide prevention, intervention, and postvention needs.

Administrators, counselors, and teachers are an integral part of the school system and have a critical role in the education of students. School personnel may be approached by students with suicidal behaviors and may be key in noticing and referring struggling students who need help. School personnel can fill an important gatekeeper role in suicide prevention (Cannon, 2014).

Trained mental health professionals, including school psychologists, school social workers, and school counselors are an integral part of the community mental health system. Because of their frequent contact with youth, school-based mental health professionals play a critical role in suicide prevention, intervention, and postvention. Individuals in these mental health and educational roles may identify practitioner recommended resources that help address the needs of at-risk youth.

The purpose of this study was to gather information from respondents who were mental health professionals who have worked closely with at-risk youth in prevention and intervention and with youth whose sibling or parent completed suicide to ascertain perceived methods and practices of effective prevention and postvention strategies.

### **Research Questions**

In regard to youth suicide prevention efforts, this research attempted to identify practitioners' endorsed resources and strategies that address the needs of suicidal youth; survivors of a sibling's suicide; and child survivors of a parent's suicide. More specifically, this study focused on the following three questions:

1. What strategies and resources are recommended by mental health professionals who work with suicidal youth?
2. What strategies and resources are recommended by mental health professionals who work with youth whose sibling completed suicide?
3. What strategies and resources are recommended by mental health professionals who work with youth whose parent completed suicide?

### **Method**

Utah's statewide Conference on Youth Suicide Prevention was held on December 3, 2014 in Provo, Utah. This one-day conference provided suicide prevention training geared toward school and community professionals who work with school-aged youth. This conference included 250 registered attendees. A one-page, paper-pencil questionnaire was included in each attendee's conference packet. This questionnaire is included in Appendix B.

During the conference's opening session's introduction, attendees were encouraged to complete the paper questionnaire. Prior to leaving the conference, participants were directed to return completed questionnaires to the conference registration desk volunteers.

In advance of the conference, the paper-pencil questionnaire was prepared by three members of the Hope4Utah Suicide Prevention Conference Planning Committee (a social worker, a psychologist, and a school district student service worker). The questionnaire was intended to gather information from those who work closely with youth. More specifically, the questionnaire was intended to gather recommendations regarding helpful resources and strategies to support three specific groups of youth (18-years-old and younger): (a) suicidal youth, (b) youth who experienced a sibling's suicide, and (c) youth who were coping with their parent's suicide.

Subsequent to the conference, Brigham Young University's Institutional Review Board (BYU IRB) Committee granted approval for the primary researcher to use the existing conference data set (data from the questionnaires). Approval from both BYU IRB and Hope4Utah were obtained prior to analyzing the participants' responses.

### **Questionnaire**

The study's questionnaire was constructed to gather information from attendees of Utah's annual suicide prevention conference. The brief questionnaire consisted of 10 questions that were organized in the following manner: (a) four questions were fill-in-the-blank questions related to the demographic characteristics of the participant; (b) three questions required a *yes* or *no* response. These questions referred to whether or not participants had experience working with suicidal youth, siblings of youth who completed suicide, and children of parents who completed suicide; and (c) three questions were open-ended, requesting the participant's helpful strategies or resources they would recommend for those working with suicidal youth, siblings of youth who completed suicide, and children whose parent completed suicide. The time required to complete the survey was approximately 10 minutes.

Participation in completing the questionnaire was optional and participants did not include their name on their questionnaire. Those who conveyed interest in participating were encouraged to complete the questionnaire and return it to the conference registration desk prior to the leaving the conference. No names were written on the questionnaires. Confidentiality was maintained and no identifying data were matched with participant responses. Participants' handwritten responses were typed into an Excel spreadsheet. Although data are summarized as group data, specific comments are also reported to show representative comments and also to highlight unique individual comments that demonstrate the range of recommended strategies and

resources. Responses were coded and broken down into a first level category that delineated whether the response was either a strategy or a recommended resource. On the next tier, the responses were broken down into individual basic units to be able to analyze each one to find common themes in both strategies and resources suggested. A second coder analyzed the data independently to verify the common themes.

Participants' input was summarized and shared with the conference sponsor, Hope4Utah. This organization planned to use this information to assist with future suicide prevention training and informational handouts.

This study included results from each section of the questionnaire. For the demographic portion, participants were asked to either select from a provided list of optional responses (circling selected responses) or write a short response (i.e., fill-in-the-blank questions). Participants wrote in their age, their job title, and circled response options in the following demographic descriptors. These included the following: (a) participant's age (participant filled in the blank by writing in their age); (b) participant's job title (participants wrote in their job title); (c) number of years working with children or youth (participants filled in the blank by writing in the number of years); (d) participants indicated if they worked in a school setting (participant circled *yes* or *no*); and (e) participants indicated if they had previously worked with a suicidal youth (participant circled *yes* or *no*); if they had previously worked with youth whose sibling completed suicide (participant circled *yes* or *no*); and if they had previously worked with youth whose parent completed suicide (participant circled *yes* or *no*).

Participants' responses to six questions contained in the questionnaire's subsequent sections were the main focus of this study. Short response options were provided for the following short response (*yes* or *no* answers) and open-ended questions, which included: (a)

experience working with a youth with suicidal ideation (*yes or no*); (b) respondent's recommended strategies and resources for addressing needs of youth with suicide ideation (*fill-in-the-blank*); (c) experience working with siblings of a youth who completed suicide (*yes or no*); (d) respondent's recommended strategies of resources for addressing needs of siblings of youth who completed suicide (*fill-in-the blank*); (e) experience working with a youth who had a parent who completed suicide (*yes or no*); and (f) respondent's recommended strategies and resources for addressing needs of children of a parent who completed suicide (*fill-in-the-blank*).

Table 1 describes the seven questions, response options associated with each question, and how each question relates to the research questions. Three of seven questions required participants to either circle or check printed response options.

### **Participants**

Of the 250 registered attendees of Utah's Annual Suicide Prevention Conference, 60 participants voluntarily completed conference questionnaires (24% participation rate). Of the completed questionnaires, 20 were completed by school counselors, 21 were completed by counselors (including 2 Juvenile Justice Counselors, 1 Youth Corrections Counselor, 1 CTE/Counseling Director, 1 Counselor I, 1 Counselor II), 2 Therapists, 2 School Psychologists, 2 School Social Workers, 2 Social Workers, 2 Special Education Teachers, and 1 of each of the following: School Guidance Counselor, Truancy Officer, Case Worker, Principal, Professor, High School teacher, and Prevention Specialist. Data from these questionnaires were analyzed and all completed questionnaires were included in the data summary.

Each questionnaire was completed by individuals who reported prior experience working with youth ( $n=58$ ) or siblings of youth who completed suicide ( $n=33$ ). All respondents had worked with youth survivors who had a parent who had completed suicide ( $n=60$ ).

The ages of participants ranged from 25 to 71 years ( $M = 32$ ;  $SD = 6$ ). Two respondents did not list an age. Participants' missing data were not excluded list wise, but were included when possible (pairwise deletion).

Of the 60 participants, the majority worked in school settings: 47 reported working in school settings (78.3%); 8 reported not working in a school setting (13.3%); and 5 did not respond (8.3%). Job titles are categorized and listed in Table 2.

The majority of participants disclosed that they had previously worked with suicidal youth (96%). Of the 60 participants, 58 reported working with youth with suicidal ideation (96%); 33 reported working with siblings of youth who had completed suicide (55%); 60 reported working with children of parents who had completed suicide (100%); and 2 participants (4%) did not respond and left the response blank regarding working with youth with suicidal ideation.

### **Setting**

Utah's statewide Conference on Youth Suicide Prevention was held on December 3, 2014. The conference was held in a Brigham Young University's Conference Center located in Provo, UT. This one-day conference provided suicide prevention training aimed at professionals who work with school-aged youth. Each registered participant was given a folder with printed resources, scratch paper, and a questionnaire. The participants who completed questionnaires returned them to volunteers at the conference registration desk. The training included speakers from the Hope4Utah organization, law enforcement agencies, therapists, and specialists in suicide prevention. The sole purpose of the conference was to provide suicide prevention training. A short introduction of the questionnaire preceded the training to encourage participation in the study and to encourage completion of the survey.

## **Research Design**

The research design was a mixed methods design. Random selection of participants was not used as the study involved a convenience sample from attendees at the Annual Suicide Prevention Conference. The data from the survey instrument was quantitative and qualitative with four yes/no options and five fill-in-the-blank options. Open-ended responses were analyzed for related themes. The narrative phrases were analyzed to determine the recommendations of professionals in the post-test qualitative data.

The study used a questionnaire created to evaluate the recommended resources or strategies used for suicide prevention training and for dealing with the aftermath of a completed suicide. The generalizability of the findings will be maximized if the demographic characteristics of the participants in the study are similar to what is found with professionals in other locations.

## **Data Analysis**

Responses from the completed surveys were entered into a computer Excel spreadsheet. Descriptive statistics were used to summarize the demographic data (means and standard deviations). Data from the open-ended questions were examined to describe and summarize emerging recommendations and suggested strategies and resources. Responses were analyzed and coded by two independent coders.

## **Results**

The purpose of this study was to ascertain mental health professionals', including school psychologists and school counselors, recommendations for suicide prevention, intervention, and postvention resources. The questions presented to conference attendees included inquiries regarding recommended strategies and resources by those who work with suicidal youth, recommended strategies and resources by those who work with youth whose sibling completed

suicide, and recommended strategies and resources by those who work with youth whose parent completed suicide.

Data from these questionnaires were analyzed for this study. Each of the questionnaires were completed by individuals who reported prior experience working with youth or survivors. No surveys were excluded.

Of the 250 registered attendees at the 2014 Suicide Prevention Conference, 60 completed the questionnaire (24% participation rate). Of the 60 participants, 47 (78.3%) reported working in school settings; 8 (13.3%) reported not working in a school setting, and 5 (8.4%) left the response blank. Each of the 60 participants reported a job title. These included the categorized titles listed in Table 2. Of the completed questionnaires, 47 (78.33%) were completed by professionals who worked directly with youth mental health issues. These individuals included school-based and community-based mental health counselors who worked with youth in schools, mental health agencies, school and community crisis response efforts, and/or youth served in alternative education settings.

Of the 60 attendees who completed the survey, all reported recommendations for strategies or resources in at least one of the three open-ended response areas. Of the 60 participants, 58 (96.6%) participants disclosed that they had previously worked with suicidal youth and two participants left this response blank; 33 (55%) reported working with siblings of youth who had completed suicide; 60 (100%) reported working with children whose parent had completed suicide.

### **Recommendations for Working with Suicidal Youth**

Attendees at the conference shared several strategies along with recommended resources for working with suicidal youth. Information presented in this section is based on responses from

58 (96.6%) of the 60 participants who reported working with youth with suicidal ideation. Those who left the responses blank for working with youth with suicidal ideation nonetheless offered suggestions for resources or strategies. Of the 58 who reported working with youth who were struggling with suicidal ideation, 53 participants offered recommendations for resources or strategies. Therefore, the responses summarized in Table 3 are based on input from 53 participants who reported working with suicidal youth and two participants who did not indicate previous experience working with suicidal youth.

Participants were asked if they had worked with youth who had suicidal ideation and were then given the opportunity to respond to the following open-ended question: “What strategies and resources did you find helpful?” Responses were categorized into the following themes: listening/teaching/talking and counseling strategies, utilizing school or community-based resources, training in evidenced-based programs, and collaboration with parents/teachers/therapists. These themes are summarized in Table 3.

**Listening/teaching/talking and counseling strategies.** The questionnaire asked for recommended resources and strategies designed to support youth in coping with suicidal thoughts. The most frequent response was counseling ( $n=14$ ). Some examples of other effective individual counseling strategies included listening ( $n=6$ ); Cognitive Behavioral Therapy (CBT,  $n=2$ ), which is short-term therapy based on understanding the connection and interrelationship between thoughts, feelings, and behavior; Rational Emotive Behavior Therapy (REBT,  $n=1$ ), a directive therapy focusing on resolving emotional and behavioral problems and turmoil; Dialectical Behavior Therapy (DBT,  $n=1$ ), a therapy designed to help change patterns of unhelpful behavior such as self-harming, suicidal ideation, or substance abuse; and using “mindfulness” ( $n=2$ ), which is training to use active, open attention to focus on the present,

reduce stress, and increase overall wellness. Two additional respondents included “working with cognitive distortions” and “Support Therapy” as effective counseling methods/strategies.

Participants’ comments regarding effective counseling strategies included applicable pointers such as “helping youth gain self-awareness and skills” by teaching about “triggers;” enhancing “communication and coping skills” ( $n=2$ ); teaching “coping strategies for handling stress;” working with students on “meeting their own needs—socially, emotionally, and spiritually;” and finally “work(ing) on positive self-therapy” while additionally underscoring the importance of “letting students know they are not alone.”

In relation to listening ( $n=9$ ), teaching, and talking with the individuals concerned, respondents included suggestions such as, “Let students voice their worries and concerns;” “Listen first: let them say what they want to say with little interruption;” “actively listening;” use “Reflective Listening” “listen” but also “engage” with them; use “honest open dialogue;” “validate...experiences” and “validate feelings (pain, hurt, sadness, etc.);” discuss “agency;” and also “talk through the crisis.” One respondent specifically advised having “open conversation” which allows “the individual to talk openly about feelings and thoughts without judgment. Not always but sometimes by having the open dialogue allowed the student to problem-solve and find their own hope that things can get better.”

Other suggestions made in relation to talking effectively with students included, “express(ing) love/caring for the student;” “building a level of comfort;” “build(ing) self-worth;” “listening, engaging, reinforcing goals and upcoming events;” “talking to them, pointing out their good qualities;” “sympathizing and establishing a relationship;” and finally “helping them feel they are valuable and loved.” Some additional statements included, “I hope they felt someone cared before they left;” “personal connections with the child are important to be built

and/or repaired;” and “complete care for student [should be] expressed.” Additionally, “motivational interviewing,” an interview process which includes asking questions and making suggestions specifically targeted toward helping the youth take active steps toward involvement, wholeness, and wellbeing, was recommended.

Another strategy suggested by a participant who worked with grieving youth was the use of “figurative comparisons” such as the “rollercoaster” and “sea glass” metaphors. Regarding the rollercoaster ride, the participant suggested that “life is sometimes up and down” and that an individual can expect “highs and lows in life.” As pertaining to the “sea glass” metaphor, the participant expressed the idea that the smooth edges of sea glass are created by the process of salt water and sand continuously smoothing the edges of broken glass, which then becomes physically weathered—i.e., it becomes the glass often found on beaches where the weathering process has produced smooth edges and naturally-frosted glass. Similarly, grief and pain are likened to initially sharp-edged glass that is exposed to the sea. In this case, the “sea” is the continual support of others that can “soften” the pain of the trauma. Over time, the initially sharp pain becomes smoother by knowing others are there to offer unceasing support.

As another important part of the counseling process, one participant emphasized asking questions designed to target and address the students’ needs and to gain an “education about ways to interview the suicidal youth,” learning “what” to ask and “how to” ask questions. Some specific questions which were offered as recommendations were: “Ask the student if they were thinking about hurting themselves” and “Ask (the) student after talking if they want to call a parent or if they want me (the mental health professional) to call (the parent).” Specific tools or forms to ask targeted questions and to assess the risk of suicide were suggested and included “administering a Suicide Probability Scale (SPS)” ( $n=2$ ) and the “suicide risk assessment

training/forms” ( $n=1$ ). These were to be used along with a “safety plan” ( $n=3$ ), a plan put in place which includes writing down “actions to take” and “people to contact” in order to have a course of action to follow when suicidal feelings are present. The plan is designed “to start at step one and continue through the steps until the individual feels safe.” These types of plans are available on phone or computer apps and can be linked to contact information such as trusted adults and suicide prevention hotlines. “Carey Guides Safety Plans” was mentioned by name as being an effective tool for this. These are “commercially available manuals used by corrections professionals” to understand and address risk factors, triggers, and other conditions that are often present during times of crisis.

Another respondent emphasized that “many, many, many meetings and phone calls of support and continued open and honest conversation” are needed in counseling at-risk youth. A suggestion to follow the protocols outlined in the school district’s crisis plan ( $n=2$ ) was recommended as a guide in how to do this. Another respondent said that “offering counseling specifically focusing on struggling students’ family members” was recommended, including “family therapy” ( $n=2$ ) and “referring” family members “to clinicians” ( $n=1$ ).

**Utilizing school or community-based resources.** Participants strongly suggested gaining knowledge of “community resources” and becoming familiar with outside organizations, such as “community mental health centers” ( $n=4$ ) and district “family centers” ( $n=1$ ) to effectively deal with suicide prevention. Other suggestions included specific referrals to mental health organizations such as Primary Children's Hospital at Wasatch Canyons ( $n=1$ ), a facility located in Salt Lake City, UT that provides 24-hour care for children and adolescents ages 5-18 who have depression, anxiety, bipolar, anger management, or other psychiatric and behavioral issues; Bear River Mental Health ( $n=2$ ) and Wasatch Mental Health ( $n=3$ ), two non-profit

organizations that provide mental health services for several counties in Utah; Hope Squad ( $n=2$ ), a school-based organization comprised of peers' representatives who are trained to watch for at-risk students in order to provide friendship, identify any warning signs for suicide risk and then properly seek help from adults when signs are present; and finally, the Jordan Family Ed Center ( $n=1$ ), a center that offers family counseling and support groups specifically for adolescents and adults who are having issues or struggles within their families. The Jordan Family Ed Center is free to families who are in the Jordan School District (UT).

Other suggested resources included Suicide Prevention Hotlines like the Suicide Hotline sponsored by National Suicide Prevention Lifeline (1-800-273-8255 or 1-800-273-TALK) and the University Neuropsychiatric Institute (UNI) Crisis hotline (801-587-3000) a 24-hour, seven-days-a-week service staffed by mental health professionals who answer crisis calls. One additional suggestion included a referral to the Mobile Crisis Outreach Team (MCOT), an interdisciplinary team that provides "crisis resolution services for anyone experiencing or at risk of a mental health crisis."

**Training or implementing evidenced-based programs.** Participants' responses relating to training or implementing evidenced-based programs included recommendations to participate in "education" ( $n=2$ ), including training from conferences or lectures ( $n=1$ ). These trainings included the "Utah Suicide Prevention Training," an annual state-wide event sponsored by Hope4Utah ( $n=1$ ). Trainings were also mentioned that specifically targeted suicide prevention through school districts ( $n=5$ ). Those who mentioned these school-based trainings specifically mentioned training from Gary Leu, a Davis School District school psychologist who teaches about "comprehensive and effective suicide risk assessment." Another online training that was mentioned was Columbia training, a Columbia University-based training available on YouTube

[[https://www.youtube.com/watch?v=Xfddz\\_Yfnc4](https://www.youtube.com/watch?v=Xfddz_Yfnc4)]. This training uses the *Columbia Suicide Severity Rating Scale* to assess suicide risk.

Another training that was mentioned was conducted by the Department of Child & Family Services (DCFS), a government organization that supports preventive services and education for families in order to assist them in “protecting children” [<http://dcfs.utah.gov/services/prevention>]. Crisis Intervention Training or CIT trainings, which are training programs developed in certain states that help police officers react appropriately to circumstances involving individuals with mental illness or developmental disability; and finally QPR training ( $n=6$ ), training which teaches participants to see the warning signs of a possible suicide and how to respond to that by following their three basic steps: (a) Q: Questioning the individual's desire or intent; (b) P: Persuading the person to seek and accept help; and then (c) R: Referring the person to appropriate resources (Quinnett, 2013).

Suggested in tandem with training were pointers to “share information learned with other staff members” ( $n=2$ ) and to have “crisis thinking training,” i.e., pre-planning and thinking about a crisis and learning how to react *before* a crisis actually occurs. Another participant who had attended the Utah Suicide Prevention trainings also suggested “having classroom presentation(s)” and sharing with students and staff the new things individuals are learning in their suicide prevention trainings. This *sharing* allows information to be passed down through members of the entire school.

**Collaboration with parents/teachers/therapists.** Collaborating with parents, teachers and therapists was highly recommended as an effective way of enhancing suicide prevention. One participant said that collaborating with parents or guardian ( $n=13$ ) and providing “immediate contact with parents” ( $n=3$ ) was key. “Offering community resource listings” ( $n=2$ )

was touted as the first step to doing this along with “collaboration with mental health providers” ( $n=1$ ) once there has been contact, then using social workers ( $n=1$ ), school counselors ( $n=3$ ) or a qualified mental health professional (QMHP) to come up “with a specific plan for contact and follow-through sessions for the subject.” Collaboration also includes involving the student ( $n=2$ ). Afterward “open communication between student, school, family, and the counselor would “include involving the district and administration” ( $n=1$ ), teachers ( $n=1$ ), and caseworker ( $n=1$ ) who share information consistently and freely. This is the kind of “complete community focus” another participant recommended as a necessary piece to support youth struggling with suicidal ideation.

### **Recommendations for Working with Youth Whose Siblings Completed Suicide**

Participants were asked if they had worked with youth whose sibling completed suicide and were given the opportunity to respond to the following open-ended question: “What strategies or resources did you find helpful?” Responses were categorized into the following themes: listening/teaching/talking with the individual, utilizing school or community-based resources, books and curriculum, professional resources, community and school based resources, and collaboration with school personnel and families and were summarized in Table 4. For those resources that were described in the previous section, the following two sections—recommendations for working with youth whose siblings completed suicide and recommendations for working with youth whose parent completed suicide—do not contain full descriptions of recommendations that were previously described and are also described in Tables 3, 4, and 5.

**Listening/teaching/talking strategies.** The questionnaire asked for recommended resources and strategies designed to support youth in coping with the repercussions of a sibling

who completed suicide. The most frequently recommended strategy was individual counseling ( $n=9$ ). *Some* examples of statements regarding effective individual counseling strategies included listening ( $n=3$ ), Cognitive Behavioral Therapy (CBT;  $n=1$ ), Eye Movement Desensitization and Reprocessing (EMDR;  $n=1$ ), and instruction on relaxation breathing techniques ( $n=1$ ).

Participants' comments regarding counseling strategies included pointers such as helping children recognize the importance of "open communication about anger and sadness;" "talking openly and sharing common experiences" including "process interviews (open and honest communication)" during sessions; encouraging the subject to "share happy memories of their sibling" and letting the subject "talk about their sibling" while prompting him or her with "more questions of what they loved, funny stories about them, etc." Other recommendations included "following up;" "being available;" "personalizing support;" "building relationships that show trust and caring;" and finally "checking back in" with the surviving siblings.

Offering counseling groups specifically focusing on students' grief was also recommended as an effective strategy. This included youth group grief sessions ( $n=5$ ), family therapy ( $n=1$ ), and family support groups ( $n=2$ ). The purpose of these groups was reportedly to help support the youth directly and to help parents and others learn how to be supportive of the affected youth. One participant recommended that counselors use a "grief support group curriculum" specific to children's needs.

**Books and curriculum.** Another recommendation included bibliotherapy ( $n=2$ ). One of the books suggested was entitled *Tear Soup* (DeKlyen & Schwiebert, 2007), which was described as a picture book that offers youth and families a "recipe for healing after loss."

Other suggestions of helpful resources included specific references to curriculum that included: *Mourning Child Grief Support Group Curriculum* (Lehmann, Jimerson, & Gaasch, 2001), a 10-session lesson plan with activities to enable young children to manage sensitive and painful topics. Another participant listed “SOS,” which would either be Signs of Suicide (SOS; [<http://www.sprc.org/bpr/section-I/sos-signs-suicide>]), a school-based curriculum and screening program for adolescents; or Survivors of Suicide (SOS; [<http://www.survivorsofsuicide.com>]), an independently owned and operated website for survivors to share their grief and communicate with others who have faced similar loss. The participant did not list which particular website was intended under the SOS banner.

**Professional resources.** Another participant mentioned the works of Dr. Alan Wolfelt (Ft. Collins, CO). Wolfelt sponsors a website, Center for Loss & Life Transition [<http://www.centerforloss.com/>]. He has authored numerous books on grief, with a few of his books being specific to grief that is associated with suicide. These books include *Understanding Your Suicide Grief: Ten Essential Touchstones for Finding Hope and Healing Your Heart* (2009) and the companion publication, *Understanding your Suicide Grief Journal* (2009); *Healing Your Traumatized Heart: 100 Practical Ideas after Someone You Love Dies a Sudden, Violent Death* (2002); and *The Wilderness of Suicide Grief: Finding Your Way* (Wolfelt, 2010).

Another author that was mentioned, Karen Johnson, is a grief counselor from Riverton, UT. Her name was recommended as a potential resource for training and support. Johnson sponsors a website [<http://www.everydaygrief.com>]. On this website she lists her publications which include details regarding training and grief-related curriculum development for educational settings.

**Utilizing school or community-based resources.** Other suggestions of helpful resources included specific referrals to mental health organizations which included: Signs of Suicide (SOS; <http://www.sprc.org/bpr/section-I/sos-signs-suicide>); The Sharing Place, a grief support center in Salt Lake City, UT that is specifically geared to support grieving children, teens, and families; Bear River Mental Health, a non-profit organization servicing mental health needs for several counties in Utah; Reach4Hope, a non-profit group located in southern Utah dedicated to suicide prevention and survivor support with a website at [www.reach4hopeutah.org](http://www.reach4hopeutah.org); Hope Squad, comprised of students who are trained to watch for at-risk students in order to provide friendship, identify any warning signs, and properly seek help from adults; University Neuropsychiatric Institute (UNI) Crisis hotline (801-587-3000 or 800-273-TALK), a 24-hour, seven-days-a-week service staffed by mental health professionals; National Alliance of Mental Illness (NAMI), a national resource center that offers a Family-to-Family class designed as an evidence-based program by a Federal agency (The Substance Abuse and Mental Health Services Administration or SAMHSA) to better understand mental illness and increase coping skills; Survivors of Suicide (SOS) support groups with national ties and training available from American Association of Suicidality; and a school district's Family Center that offers grief support for parents and children.

**Programs and community support groups.** The support groups listed by name were Canary Support Group, mentioned in the previous section, and Compassionate Friends Support Group, a national organization that supports family and friends following the death of a child. The Compassionate Friends Support Group can be reached by phone (877-969-0010) or email [[nationaloffice@compassionatefriends.org](mailto:nationaloffice@compassionatefriends.org)]. This group also has a website, [[https://www.compassionatefriends.org/Find\\_Support/Chapters/Chapter\\_Locator.aspx](https://www.compassionatefriends.org/Find_Support/Chapters/Chapter_Locator.aspx)].

**Collaboration with school personnel and families.** Another strategy suggested includes collaborating with parents, social workers and counselors to come up with a specific plan for contact and follow-through sessions for the subject ( $n=2$ ) and to refer the student and family to the school social worker ( $n=1$ ). It was strongly urged that mental health workers involved with affected youth receive continuing training and education. A participant offered a specific suggestion for training which included Question, Persuade, Refer training (QPR; Quinnett, 2013), described in the previous section.

Other strategies involved memorializing special memories about a sibling and providing a grief journal or feelings/grief notebook for youth to record their thoughts and insights. Keeping the youth “involved in something” (e.g., outside activities) was also recommended. A suggestion of timing for continuous involvement of youth included one year after the completed suicide for a surviving sibling in programs aimed at suicide prevention.

### **Recommendations for Working with Youth Whose Parent Completed Suicide**

Participants were asked if they had worked with youth whose parent had completed suicide. They were given the opportunity to respond to the following open-ended question: “What strategies or resources did you find helpful?” Responses were categorized into the following themes: listening/teaching/talking with the individual, group counseling, utilizing school or community resources, books or website resources, professional resources, and finally collaboration with school personnel and families and summarized in Table 5.

**Listening/teaching/talking strategies.** The questionnaire asked for recommended resources and strategies designed to support youth in coping with the aftermath of a parent who had completed suicide. The most frequent recommended strategy was individual counseling ( $n=10$ ). Some examples of statements regarding effective individual counseling strategies

included Rational Emotive Behavior Therapy (REBT;  $n=1$ ), described in a previous section; using “mindfulness” ( $n=2$ ), helping youth be “continuously present” in dealing with day-to-day activities and challenges; Dialectical Behavior Therapy (DBT;  $n=1$ ), therapy designed to help change patterns of unhelpful behavior such as self-harming, suicidal ideation, or substance abuse; Cognitive Behavioral Therapy (CBT;  $n=1$ ), described in a previous section; and Eye Movement Desensitization and Reprocessing therapy (EMDR;  $n=1$ ) designed to alleviate the distress related to traumatic memories, including instruction on relaxation methods and breathing techniques designed to induce relaxation.

Participants’ comments regarding counseling strategies included suggestions such as listening ( $n=8$ ), normalizing feelings ( $n=2$ ), and conducting consistent, regular sessions for processing through the loss ( $n=1$ ). Another recommendation included creating the counseling environment to be a “safe place to express feelings” ( $n=2$ ) without “judgment” ( $n=1$ ). Other counseling strategies included the suggestion to teach coping strategies ( $n=1$ ) and to teach the stages of grief ( $n=1$ ), which include the stages of denial, bargaining, depression, anger, and acceptance. One specific coping strategy suggested by a participant who worked with grieving youth was using the “sea glass” metaphor, described in a previous section.

Participants’ comments regarding effective counseling strategies included helping children by “allowing them a place to express themselves” freely and to “listen to the student.” Specific comments under this theme also included “talking to youth about their feelings associated with their parent’s death;” “reflective listening;” “care;” the “personalization of support;” (i.e., looking at exact individual needs and addressing those needs specifically instead of trying to generalize emotions and fit the student into specific patterns of healing); “communication/talking with youth;” “open communication;” and “be(ing) available over time

to listen and validate” the feelings the children will experience. Participants also cautioned that outside appearances of wellness aren’t always reliable, that “each student is different and one cannot assume all is well by outside appearances.” Often deeper probing is suggested to truly understand the survivor’s depth of grief and the degree of emotional wellness.

Also, as a part of “listening,” participants suggested encouraging youth affected by grief to “reinforce goals of being involved in upcoming events” and encouraging the youth to “identify positive aspects in their lives.” After these positive aspects are identified, it is then suggested to encourage the students to “find ways to keep them (the parent that was lost)” as “a part of their lives.” Another idea stressed the importance of emphasizing to the youth that “you are *not* alone” and that help will be continuously available.

Another social worker, who had dealt with a young person who had lost a parent to suicide, suggested that a young person in a post-suicide usually takes “more time.” They are generally “more difficult” to talk to and it is “harder to get them to open up.” In order to deal with this, it was stressed by this participant that these types of youth “need much more time” in order to “develop a trusting relationship for them to share. Listening is...key.”

Additional strategies suggested for use during counseling sessions included implementing safety plans ( $n=1$ ) as needed, to set up intervention plans ( $n=1$ ) and to use “motivational interviewing,” an interview process which includes asking questions and making suggestions specifically targeted toward helping the youth take active steps toward involvement, wholeness and wellbeing. A specific safety plan that was mentioned by name as a recommended program is called “Carey Guides Safety Plans” (Sharos, 2012), previously described. Another strategy involved providing a feelings/grief notebook for youth to record their thoughts and insights in order to help them navigate through their feelings and emotions.

For students who are receiving community-based counseling and support, participants indicated the importance of supplemental school-based strategies to support students, including “providing a safe place if they needed somewhere to go during the school day.” Another recommendation included continuing to assess youth at school “to make sure they are making good choices and depression level stays up.” A further recommendation included keeping “a watch list of students that are struggling” and systematically “keep(ing) in contact with them.”

Offering counseling groups specifically focused on students’ grief was recommended as a further effective strategy. These recommendations included group grief sessions ( $n=3$ ), family therapy ( $n=1$ ), support therapy ( $n=1$ ), and support groups ( $n=3$ ). A specific curriculum named included “Mourning Child Grief Support Group Curriculum” from Ann Gaasch and Linda Lehmann. The purpose of these groups is to offer support to affected youth directly and then to help parents and others learn how to be supportive in their respective roles, as well.

**Utilizing school or community-based resources.** Recommendations of helpful resources to support affected youth included: specific referrals to mental health organizations, one which was “Signs of Suicide” (SOS; [<http://www.sprc.org/bpr/section-I/sos-signs-suicide>]). Signs of Suicide conducts courses for school staff or other organizational members who are “looking to deepen their understanding of youth mental health, and considering implementing an evidence-based suicide prevention program.” It “teaches participants to recognize and respond to the warning signs of depression and suicide.”

The Sharing Place was listed as a good community-based resource. It is a grief support center located in Salt Lake City, UT, that is specifically geared to support grieving children, teens, and families going through difficulties. Survivors of Suicide (SOS) support groups with national ties and training available from American Association of Suicidality was also

recommended. There are also other mental health organizations that were listed, such as Bear River Mental Health and Wasatch Mental Health, which are non-profit organizations that provide mental health services for several counties in Utah. Additional suggestions included referrals to Mobile Crisis Outreach Team (MCOT), an interdisciplinary team providing crisis resolution services for anyone experiencing or at risk of a mental health crisis; the Department of Children & Family Services (DCFS), a government entity that provides preventive services and education to families to assist them in protecting and helping children; the Suicide Hotline sponsored by National Suicide Prevention Lifeline (1-800-273-8255 or 1-800-273-TALK); the University Neuropsychiatric Institute (UNI) Crisis Hotline (801-587-3000), a 24-hour, seven-days-a-week service staffed by mental health professionals who are willing to respond to applicable questions; and finally generic “drug treatment programs” and “district family centers” ( $n=2$ ).

Care needs to be taken when referring students and their family to community-based resources, making sure to “do your homework” in checking out these resources and making sure that the agency or group will meet the unique needs of the specific student and family. It should be noted here that although the Department of Children & Family Services (DCFS) was recommended as a “helpful resource” by one participant, another participant reported that DCFS was the “least helpful” resource.

**Books and website resources.** Bibliotherapy was offered as a recommended resource ( $n=1$ ) including any “grief counseling activity booklet.” One recommended book, that was also previously suggested as helpful, is entitled *Tear Soup* (DeKlyen & Schwiebert, 2007). This is a picture book that offers youth and families a “recipe for healing after loss.” One participant found this book to be beneficial because the book offers the surviving parent information to help

guide and support the affected child/children. Additionally the participant recommended that in addition to sharing the book the surviving parent should also be referred to the Hope4Utah Suicide Prevention website.

**Professional resources.** Another participant mentioned Dr. Alan Wolfelt (Ft. Collins, CO) as a highly recommended resource. Wolfelt sponsors a website called “Center for Loss & Life Transition” [<http://www.centerforloss.com/>]. He has also authored numerous books on grief with a few of his books being specifically targeted toward the grief that is associated with suicide. These books (previously mentioned) include *Understanding Your Suicide Grief: Ten Essential Touchstones for Finding Hope and Healing Your Heart* (2009) and the companion publication, *Understanding your Suicide Grief Journal* (2009); *Healing Your Traumatized Heart: 100 Practical Ideas after Someone You Love Dies a Sudden, Violent Death* (2002); and *The Wilderness of Suicide Grief: Finding Your Way* (Wolfelt, 2010). According to this participant, Dr. Wolfelt conducts week-long trainings in Ft. Collins and also speaks at conferences that help train others in suicide recovery.

Another participant mentioned two local experts, Kent Bills and Troy Humphries, who are counselors at Lehi High School (Utah). According to this participant, these two individuals have established effective counseling methods and insights surrounding suicide prevention and healing post suicide.

**Collaboration with school personnel and family.** Another strategy suggested by participants included collaborating with surviving parents or guardians, teachers, social workers, counselors, doctors, and therapists to provide and “find” support for the youth and the family after a crisis. One participant suggested that a critical key toward healing included “keep(ing) the surviving parent strong so they can support the (affected) child/youth.” Additional collaboration

strategies encompassed “inform(ing) teachers” and referring students to “school counselors,” to bring up their names “in team meetings” and to notify social workers about concerns and progress; to work in tandem with “teachers, other counselors, and parent and family;” to involve “peer support” as much as possible; to help youth “work on relationships with their family members,” including “communication with grandparents;” and also “referring (youth) to a therapist” or “mental health counseling” as needed. Other various suggestions that were listed as helpful collaboration included “attend(ing) the viewing” of the relative; sending a “card;” “giving a book on grief;” and finally, “keeping the youth involved in something” (e.g., recreational or other activities).

It was strongly advised that mental health workers involved with affected youth receive continuing training, practice, and education. A participant offered a specific suggestion for training which included Question, Persuade, Refer (QPR) training. The participant described QPR training as a “one-hour course which trains the gatekeepers” to recognize early warning signs of a suicide crisis. This training helps individuals learn how to question, persuade, and refer someone to help.

Another participant listed the importance of selecting training programs that were “evidence- based practice” (EBP;  $n=1$ ). This means that training must include interventions that have been proven in research and also in applied settings.

For those in law enforcement, one recommendation included CIT trainings. This training was described as a training program developed in certain states which is designed to help police officers react appropriately to circumstances involving individuals with mental illness or developmental disabilities in crisis situations. With a better understanding of mental health

issues, police officers will be better equipped to help with life and death situations involving those with mental illness/

Participants offered recommendations such as counseling techniques, listening techniques, training programs, group and family therapy, utilizing school or community resources, books or website resources, professional resources, and benefits of collaboration with school personnel and families. It was strongly advised that mental health workers involved with affected youth receive continuing training, practice, and education in order to benefit youth with prevention, intervention and postvention support.

### **Discussion**

This study examined the recommendations for suicide prevention, intervention, and postvention resources by professionals who had worked with struggling youth or with youth who had lost a sibling or parent to suicide. The central purpose of the study was to identify different professional's suggestions and compare those recommendations to current research to determine if they aligned with evidence-based strategies and resources (refer to Table 5). Setting forth the strategies and resources that have been identified through research and experience, which can result in higher levels of self-efficacy in dealing with at-risk youth, may aid in finding and implementing best practices that help ensure the highest level of effective care and success.

The research questions addressed the following issues: Are the strategies and resources recommended by mental health professionals who work with youth with suicidal ideation consistent with evidence-based strategies and resources; were the strategies and resources recommended by mental health professionals who work with youth whose sibling completed suicide consistent with evidence-based strategies and resources; and were the strategies and resources recommended by mental health professionals who work with youth whose sibling

completed suicide consistent with evidence-based strategies and resources.

The majority of strategies and resources recommended by the mental health professionals who worked with suicidal youth were consistent with current research (refer to Table 6)—that is, the practices were directly correlated to evidence-based information. Existing research shows preventative programs such as QPR and Hope4Utah programs increase gatekeepers' awareness of warning signs and teach them the importance of the need for referrals to mental health providers to support at-risk youth. Existing research is similar in regard to counseling theory applications such as in Cognitive Behavior Therapy (CBT), which shows a reduction in depression and reducing suicide attempts in at-risk populations; Rational Emotive Behavior Therapy (REBT), which shows a decrease in self-destructive behaviors including suicide; Dialectical Behavior Therapy (DBT), which demonstrates efficacy in reducing suicide risk among younger adults; and Eye Movement Desensitization and Reprocessing (EMDR), which has been shown to be effective for overcoming anxiety, stress, and trauma in survivors of suicide.

Previous research supports the recommendation for encouraging students to access help with suicide crisis hotlines and crisis centers. Suicide crisis hotlines were shown to have significant decreases in suicidal ideation during the course of the phone session with the level of intent to die at the end of the call as the highest predictor of a possible subsequent suicide completion (Kalafat, Gould, Munfakh, & Kleinman, 2007). The availability, proximity, and awareness of community crisis services was also shown to decrease the level of hospitalizations for self-injury from suicide in communities where such centers are present.

Existing research in the area of “listening” supports the effectiveness of listening as part of suicide prevention training. One study delineated “active listening” as a specific skill helpful

in suicide prevention. An additional study showed that training in key areas, including strengthening empathy and active listening skills, increased the school counselor's knowledge and confidence regarding suicide prevention and intervention (King & Smith, 2000). However, existing research is dissimilar in the area of "caring" or helping youth feel "valued and loved" in that emotional support given to a struggling individual was not the focus of available research—although one study listed the effectiveness of active listening as an "emotional responsiveness and reflection of feelings with concern, care, and nonverbal communication" (Cross, 2007). Substance Abuse and Mental Health Association (SAMSHA) website updated October 29, 2015 also lists "listen without judging and show you care" as a suggestions for individuals to incorporate in suicide prevention.

The recommendation for collaboration with mental health professionals, families and school personnel to help at-risk youth is consistent with research that shows collaboration is extremely effective for helping those with suicidal ideation. Also recommended by current research is peer collaboration and support training, in connection with school prevention training, to move key players toward a common language, goals and efforts toward at-risk youth. Consistent collaboration of those key players who develop specific intervention plans for students have been shown to have positive outcomes in decreasing suicide attempts (Wyman et al., 2010).

Findings from this study relate directly to the current research that shows that effective suicide prevention, intervention, and postvention is based on access to services and the increased knowledge that comes from ongoing training, the kind of training which teaches an awareness of the signs of suicidal ideation, the implementation of helpful interventions including accessing community resources and therapy and then follow up over time to provide consistent support.

## **Implications for Practitioners**

It is presupposed that all the strategies and tools listed are not to be used exclusively as single solutions to the problem of suicide prevention, intervention, and postvention but they are to be used collectively and comprehensively, in order to integrate the best practices and resources to give the most effective care to those affected by this serious problem. Practitioners may benefit from the results of this study by confirming which strategies and resources utilized in practice are evidence-based. Further, the expectation that youth's needs should be effectively addressed, according to evidenced-based strategies, is strengthened by the corroboration that practicing mental health professionals are recommending and applying verifiable strategies such as preventative programs, accessing community resources, engaging in individual and group counseling, involving support systems, and listening to the youth. This research provided recommendations and strategies that were given a "stamp of approval" by experienced mental health practitioners and adds to the knowledge base of those who did not feel like experts. It thus may instill a level of confidence for new practitioners who may apply and implement the recommendations.

## **Limitations**

This study was limited in its scope due to the fact that the sample group was taken from a convenience sample of attendees at a Utah Suicide Prevention Conference. Hence, the results from this convenience sample of mental health professionals may not generalize to other groups of mental health professionals across the nation or around the world. Various locations will definitely have other local resources and community-based groups to support youth struggling with suicidal ideation or coping with grief associate with suicide. Many available resources will be unique to the specific school district or city.

Limitations existed in the questionnaire in that it lacked specific questions specifying the demographics of the participants, such as ethnicity, race, and education level. In retrospect, adding racial, ethnic, and educational background to the demographics section might have improved the generalizability of the results. The questionnaire also should have requested that recommendations were listed according to a participant's perceived hierarchical order of importance, which it did not. Having participants list the recommended resources or strategies in ranking order as so their importance and effectiveness would have better identified the leading recommended resources and strategies that could be set forth. Additionally, responses may have been different if options of specific strategies or recommendations were provided rather than the open-ended or fill-in-the-blank format that was used.

There were also other limitations due to various participants' answers. For example, one respondent stated for an answer, "Mostly the same answers as above." Because of that, the reviewers could not determine the intended response and all potential responses of this participant were removed for that response section. Another respondent's answers were removed from the data due to illegible writing. One response to the first question for dealing with youth who had suicidal ideation read, "Treatment professional - monitor, [illegible], caring" and was removed. In another question which asked for recommendations for how to deal with children whose parents completed suicide, the respondent's answer was "Great staff." This seemed too vague to categorize it as a recommended resource or strategy. One respondent also listed "SWBC" as an acronym for a recommended resource for siblings of youth who had completed suicide. The acronym's meaning was not written out and the reviewers could not determine the intended resource or strategy.

An additional limitation of this study existed in the self-reported data of the respondents in that the recommendations they suggested cannot be independently verified as to whether these mental health professionals actually used those recommendations or if they adopted their recommendations based on research or through other means. It was assumed in the study that the recommended resources and strategies were in fact used by the participants and found to be helpful. It is good to note that either way, most of the self-reported data from participants is congruent with data from other sources and research. However, it would have added efficacy to the study if participants were asked if they had actually put their recommendations into practice.

The participation rate in completion of the questionnaire may also have been affected by an attendee's lack of involvement in working with youth with prevention, intervention, or postvention needs. We suspect many did not participate because they did not feel like an expert who could offer suggestions.

Limitations of this study may also exist depending upon the level of consistency with other mental health professionals in other states with similar professions, years of experience, comparable number of students enrolled in school, population numbers, and geographic region. Since Utah's suicide rates for teenagers and adults consistently rate in the Top 10 for states nationwide (CDC, 2013), other mental health professionals in states with similar levels of suicide and demographic composites may have comparable results as to the effectiveness of resources and strategies recommended.

### **Implications for Future Research**

Rather than drawing upon a convenience sample, future studies should poll randomly selected participants from various locations and should gather information from a variety of mental health professionals (e.g., therapists, school counselors, school psychologists, social

workers). Future questionnaires should include more comprehensive demographic data and should include a variety of recommendations, asking whether each of the specific recommendations is used by the participating professional. Additionally, the questionnaire may include specific questions about whether or not participants are aware of and are using evidence-based recommendations.

To improve upon this study, participation rate could be increased by offering an incentive to participants. Additionally the utility of information gathered could be improved upon by asking participants questions that focus on the quality of the resources. Participants could also be asked to report the effectiveness of those resources in supporting youth who are suicidal or whose loved one died by suicide.

## **Conclusions**

Based on this study's findings, practitioners used and were willing to recommend a variety of resources and strategies to address the needs of youth who contemplated suicide, who experienced a peer's suicide, or who experienced the suicide of a parent. To address the unique needs of these individuals dealing with suicide-related challenges, practitioners need effective strategies and interventions. Also, prevention and intervention procedures should include an action plan where students can receive appropriate mental health services. Action plans created should include best-practice recommendations and evidence-based practices to support youth in need. These plans should provide supports that occur in a timely manner. When immediate assistance is needed, mental health professionals must have reliable and effective strategies. Based on this study, experienced mental health professionals recommended support from a wide variety of sources, including professionals with expertise in suicide prevention, intervention, and postvention. Participants in this study also recommended specific strategies and resources, many

of which are associated with local groups and professionals.

Regarding the needs of youth who are affected by a loved one's suicide, those who work with youth should consult with school-based and community-based mental health professionals about intervention strategies and resources specific to suicide-related needs. In order to comprehensively care for youth who are contemplating suicide or who are struggling with the aftermath of a loved one's suicide, mental health professionals—whether working in schools or in the community—should familiarize themselves with local resources and should also consult with professionals who have experience in this specific area of mental health. Mental health professionals, educators, and staff members need relevant information and an intervention model with proven strategies to address youth suicide prevention, intervention, and postvention needs.

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Table 1

*Description of Questionnaire: Questions and Response Options*

Demographic questions	Type of response		
1. Age	Fill-in-the-blank		
2. Job Title	Fill-in-the-blank		
3. Do you work in the school setting?	Yes/No		
4. Number of years worked with children or youth?	Fill-in-the-blank		
Question	Type of response	Follow up question	Type of response
5. Have you worked with suicidal youth?	Yes/No	If yes, what resources or strategies were helpful?	Open ended response
6. Have you worked with youth whose sibling completed suicide?	Yes/No	If yes, what resources or strategies were helpful?	Open ended response
7. Have you worked with youth whose parent completed suicide?	Yes/No	If yes, what resources or strategies were helpful?	Open ended response

Table 2

*Description of Participants and Workplace*

Type of worker/profession	<i>n</i>	%
Community-based mental health workers	19	31.67
Counselor	15	25.00
Therapist	2	3.33
Psychologist	1	1.67
Social Worker	1	1.67
School-based mental health workers	29	48.33
School Counselor	24	40.00
School Psychologist	2	3.33
School Social Worker	3	5.00
School-based personnel	6	10.00
Special Education Teacher	2	3.33
Administrator	1	1.67
Truancy Officer	1	1.67
CTE/Counseling Director	1	1.67
High School Teacher	1	1.67
Justice System personnel	3	5.00
Youth Corrections Counselor	1	1.67
Juvenile Justice System Counselors	2	3.33
Other professionals	3	5.00
Case Worker	1	1.67
Professor	1	1.67
Prevention Specialist	1	1.67

Table 3

*Summary of Mental Health Professionals' Recommendations for Resources to Support Youth Who Struggle with Suicidal Ideation*

Category	Strategy or Resource	Description
Internet websites and national suicide prevention training	QPR	QPR is a training introducing the warning signs of a possible suicide and how to respond to that by following three basic steps: (a) <u>Q</u> : Question the individual's desire or intent; (b) <u>P</u> : Persuade the person to seek and accept help; and (c) <u>R</u> : Refer the person to appropriate resources [www.qprinstitute.com]
	Hope4Utah	UT-based organization that provides prevention training and emphasizes peer-to-peer support, school-based Hope Squad [http://hope4utah.com/]
	Crisis Intervention Training or CIT trainings	Training programs developed in certain states to help police officers react appropriately to circumstances involving individuals with mental illness or developmental disability [http://www.citinternational.org]
	Columbia training	Columbia University based training available on YouTube with emphasis on the use of <i>Columbia Suicide Severity Rating Scale</i> [http://www.cssrs.columbia.edu/]
Suicide prevention hotlines	National Hotline	1-800-273-8255 or 1-800-273-TALK 24-hour, seven-days-a-week service staffed by mental health professionals
	UNI- Hotline (UT)	1-801-587-3000 24-hour, seven-days-a-week service staffed by mental health professionals
Local community support groups	Canary Support Group	Orem, UT service that offers free grief support groups for children and youth 801-960-2684
	The Sharing Place	Salt Lake City, UT grief support center geared to support grieving children, teens, and families 801-466-6730
	Bear River Mental Health	Non-profit organization that provides mental health services for several counties in Utah [http://brmh.com/pages/contactus.html]
	Wasatch Mental Health	Non-profit organization that provides mental health services for several counties in Utah. Utah County 801-373-4760; Wasatch County 435-654-3003
	Mobile Crisis Outreach Team (MCOT)	Salt Lake County, UT interdisciplinary team providing 24-hour, seven-days-a-week crisis resolution services for anyone experiencing or at risk of a mental health crisis 801-587-3000; also takes calls before crisis level, "warm line" 801 587-1055

Table 3

*Summary of Mental Health Professionals' Recommendations for Resources to Support Youth Who Struggle with Suicidal Ideation*

Category	Strategy or Resource	Description
School support services	Jordan School District (UT) Family Education Center	Support services and classes for families and students in Jordan School District (UT); addresses a wide variety of student needs 801-565-7442
	Hope Squad (HOPE4UTAH)	Student peer representatives are trained to watch for at-risk students in order to provide friendship; identify suicide warning signs; and when needed, properly seek help from adults
Community resources	Department of Child & Family Services (DCFS)	Government organization that supports preventive services and education to families to assist them in protecting children
	Primary Children's Hospital at Wasatch Canyons	24-hour care for children and adolescents ages 5-18 with depression, anxiety, bipolar, anger management, other psychiatric and behavioral issues
Counseling	Cognitive Behavior Therapy (CBT)	Short-term therapy based on the connection and interrelationship between thoughts, feelings, and behavior
	Rational Emotive Behavior Therapy (REBT)	Directive therapy focusing on resolving emotional and behavioral problems and turmoil
	Dialectical Behavior Therapy (DBT)	Therapy designed to help change patterns of unhelpful behavior such as self-harming, suicidal ideation, or substance abuse
	Mindfulness	A state of active, open attention on the present intended for stress management and overall wellness; living in the present moment
	Group therapy	Therapy with a group of individuals that meet to describe and discuss their problems under the supervision of a therapist
	Family therapy	Therapy that helps family members improve communication and process conflicts
Tools	Suicide Probability Scale (SPS)	Specific tools or forms to ask targeted questions and to assess the risk of suicide.
	Safety plans	Assist student to write down actions to take and people to contact in order to feel safe from suicide. Carey Guides Safety plans available for corrections professionals
	District crisis plan or protocols	School district approved step-by-step plan for school staff (including teachers) to refer and follow for crisis management

Table 3

*Summary of Mental Health Professionals' Recommendations for Resources to Support Youth Who Struggle with Suicidal Ideation*

Category	Strategy or Resource	Description
Skills to teach to the student	Managing triggers	Noticing and counteracting the antecedents or events that result in physical and emotional responses and reactions
	Communication skills	Ability to self-advocate and express needs and wants; capacity to recognize and understand one's own emotions
	Coping strategies	Methods or systemized routine a person uses to deal with stress; deep and controlled breathing; muscle relaxation; meditation; yoga; mindfulness
Counseling and mental health skills	Listening	Taking time; giving full attention, attentiveness, open mindedness without interruptions or judgment
	Continued education and training	Process of receiving systematic instruction in suicide prevention and intervention practices
	Collaboration	Working jointly with others (individual, family, school personnel, mental health workers) in a cooperative way to produce a better result

Table 4

*Summary of Mental Health Professionals' Recommendations for Resources to Support Siblings of Youth Who Completed Suicide*

Category	Strategy or Resource	Description
National suicide prevention training	QPR	QPR is a training introducing the warning signs of a possible suicide and how to respond to that by following three basic steps: (1) <u>Q</u> : Question the individual's desire or intent; (2) <u>P</u> : Persuade the person to seek and accept help; and (3) <u>R</u> : Refer the person to appropriate resources [www.qprinstitute.com]
	Signs of Suicide (SOS)	School-based curriculum and screening program for adolescents [https://mentalhealthscreening.org/programs/youth]
Suicide prevention hotlines	National Hotline	1-800-273-8255 or 1-800-273-TALK 24-hour, seven-days-a-week service staffed by mental health professionals
	UNI-Hotline (UT)	1-801-587-3000 24-hour, seven-days-a-week service staffed by mental health professionals
Local community support groups	Family support groups	Support groups involving parents and children of different ages
	Canary Support Group	Orem, UT service that offers free grief support groups for children and youth 801-960-2684
	Compassionate Friends Support Group	National organization that supports family and friends following the death of a child 877-969-0010
	The Sharing Place	Salt Lake City, UT grief support center geared to support grieving children, teens, and families 801-466-6730
	Bear River Mental Health	Non-profit organization that provides mental health services for several counties in Utah [http://brmh.com/pages/contactus.html]
	Reach4Hope	Non-profit group located in southern Utah dedicated to suicide prevention and survivor support [http://www.reach4hopeutah.org]
	National Alliance of Mental Illness (NAMI)	National resource center that offers a Family-to-Family class designed as an evidence-based program by a Federal agency; aligned with Substance Abuse and Mental Health Services Administration or SAMHSA; aims to help individuals and families to better understand mental illness and increase coping skills [https://www.nami.org]
	Survivors of Suicide (SOS)	Local grief support group for survivors; has national chapters; group facilitation training provided by American Association of Suicidality [http://www.survivorsofsuicide.com]

Table 4

*Summary of Mental Health Professionals' Recommendations for Resources to Support Siblings of Youth Who Completed Suicide*

Category	Strategy or Resource	Description
School support services	Jordan School District Family Center	Support services and classes for families and students in Jordan School District (UT); addresses a wide variety of student needs 801-565-7442
Counseling	Cognitive Behavior Therapy (CBT)	Short-term therapy based on the connection and interrelationship between thoughts, feelings, and behavior
	Eye Movement Desensitization and Reprocessing (EMDR)	Therapy designed to alleviate the distress related to traumatic memories, includes relaxation breathing techniques
	Group therapy	Therapy with a group of individuals that meet to describe and discuss their problems under the supervision of a therapist.
	Family therapy	Therapy that helps family members improve communication and process conflicts
Therapeutic tools/activities	Bibliotherapy	Adjunct to therapy; involves reading (or being read to) specific texts for the purpose of learning and healing. An example— <i>Tear Soup</i> (DeKlyen & Schwiebert, 2007)
	Grief or feelings journal	Journal to write and record thoughts and feelings
Skills to teach to the student	Get involved in outside activities	Encourage involvement in extracurricular activities
	Open communication about anger and sadness	Assist the student in sharing anger, sadness, as well as happy memories of the sibling
Mental health worker skills to develop	Listening	Giving full attention, attentiveness, open-mindedness without judgment and non-interruption of speaker
	Continued education and training	Process of receiving systematic instruction in suicide prevention and intervention practices
	Collaboration	Working jointly with others (individual, family, school personnel, mental health workers) in a cooperative way to produce a better result
Professional resources	Dr. Alan Wolfelt Center for Loss & Life Transition	Authored numerous books on grief and sponsors a website [ <a href="http://www.centerforloss.com/">http://www.centerforloss.com/</a> ]
	Karen Johnson	Sponsors a website for training and grief related curriculum for educational settings [ <a href="http://www.everydaygrief.com">http://www.everydaygrief.com</a> ]

Table 5

*Summary of Mental Health Professionals' Recommendations for Resources to Support Youth Whose Parent Completed Suicide*

Category	Strategy or Resource	Description
National suicide prevention training	QPR	QPR is a training introducing the warning signs of a possible suicide and how to respond to that by following three basic steps: (1) <b>Q</b> : Question the individual's desire or intent; (2) <b>P</b> : Persuade the person to seek and accept help; and (3) <b>R</b> : Refer the person to appropriate resources [www.qprinstitute.com]
	Signs of Suicide (SOS)	School-based curriculum and screening program for adolescents [https://mentalhealthscreening.org/programs/youth]
	Crisis Intervention (CIT) Training	Training programs developed in certain states to help police officers react appropriately to circumstances involving individuals with mental illness or developmental disability [http://www.namiut.org/families-caregivers/police-intervention-cit]
Suicide prevention hotlines	National Hotline	1-800-273-8255 or 1-800-273-TALK 24-hour, seven-days-a-week service staffed by mental health professionals
	UNI-Hotline (UT)	1-801-587-3000 24-hour, seven-days-a-week service staffed by mental health professionals
Local Community Support Groups and Websites	Family Support Groups	Support groups involving parents and children of different ages
	Canary Support Group	Orem, UT service that offers free grief support groups for children and youth 801-960-2684
	Compassionate Friends Support group	National organization that supports family and friends following the death of a child 877-969-0010
	The Sharing Place	Salt Lake City, UT grief support center geared to support grieving children, teens, and families 801-466-6730
	Survivors of Suicide (SOS)	Local grief support group for survivors; has national chapters; group facilitation training provided by American Association of Suicidality [http://www.survivorsofsuicide.com]
	Wasatch Mental Health	Non-profit organization that provide mental health services for several counties in Utah. Utah County 801-373-4760; Wasatch County 435-654-3003
	Hope4Utah	UT-based organization that provides prevention training and emphasizes peer-to-peer support, school- based Hope Squad [http://hope4utah.com/]
School Support Services	Department of Child & Family Services (DCFS)	Government organization that supports preventive services and education to families to assist them in protecting children
	District Family Center	Support services and classes for families and students in a school district

Table 5

*Summary of Mental Health Professionals' Recommendations for Resources to Support Youth Whose Parent Completed Suicide*

Category	Strategy or Resource	Description
Counseling	Cognitive Behavior Therapy (CBT)	Short-term therapy based on the connection and interrelationship between thoughts, feelings, and behavior
	Rational Emotive Behavior Therapy (REBT)	Directive therapy focusing on resolving emotional and behavioral problems and turmoil
	Mindfulness	A state of active, open attention on the present intended for stress management and overall wellness; living in the present moment
	Dialectical Behavior Therapy (DBT)	Therapy designed to help change patterns of unhelpful behavior such as self-harming, suicidal ideation, or substance abuse
	Eye Movement Desensitization and Reprocessing (EMDR)	Therapy designed to alleviate the distress related to traumatic memories, includes relaxation breathing techniques
	Group Therapy	Therapy with a group of individuals that meet to describe and discuss their problems under the supervision of a therapist.
	Family Therapy	Therapy that helps family members improve communication and process conflicts
Tools	Bibliotherapy	Adjunct to therapy; involves reading (or being read to) specific texts for the purpose of learning and healing. An example— <i>Tear Soup</i> (DeKlyen & Schwiebert, 2007)
	Grief or feelings journal	Journal to write and record thoughts and feelings
	Safety plan	Assist student to write down actions to take and people to contact in order to feel safe from suicide. Carey Guides Safety plans available for corrections professionals
Skills to Teach to the Student	Coping Strategies	Methods or systemized routine a person uses to deal with stress; deep and controlled breathing; muscle relaxation; meditation; yoga; mindfulness
	Stages of grief	Stages of denial, bargaining, depression, anger, and acceptance
	Share metaphors and examples	“Sea glass” and “roller coaster” metaphors about life and loss
	Normalizing feelings	Feelings surrounding the loss are normal and typical responses to grief

Table 5

*Summary of Mental Health Professionals' Recommendations for Resources to Support Youth Whose Parent Completed Suicide*

Category	Strategy or Resource	Description
Mental Health Worker Skills to Develop	Listening	Taking time; giving full attention, attentiveness, open mindedness without interruptions or judgment
	Continued education and training	Process of receiving systematic instruction in suicide prevention and intervention practices
	Collaboration	Working jointly with others (individual, family, school personnel, mental health workers) in a cooperative way to produce a better result
Professional Resources	Dr. Alan Wolfelt Center for Loss & Life Transition	Authored numerous books on grief and sponsors a website [ <a href="http://www.centerforloss.com/">http://www.centerforloss.com/</a> ]
	Karen Johnson	Sponsors a website for training and grief related curriculum for educational settings [ <a href="http://www.everydaygrief.com">http://www.everydaygrief.com</a> ]

## APPENDIX A: REVIEW OF LITERATURE

The Centers for Disease Control and Prevention (CDC) reports that someone dies by suicide every 15 minutes and that suicide is a serious problem that can have a lasting impact on individuals, families, and communities (2013). Suicide rates for children and adolescents have been increasing in the United States since 2009. The overall amount of suicide ideation, according to a national youth risk behavior survey, is the highest among high school students. Of those surveyed, 15.8% reported seriously considering suicide, 12.8% of those students reported making a plan to commit suicide, and 8% reported attempting suicide one or more times during the 12 months before the survey was administered (CDC, 2011). Of the youth who attempt suicide, each year approximately 157,000 youths between the ages of 10 and 24 receive medical care for self-inflicted injuries at medical centers across the United States (CDC, 2013). In Utah, according to the 2015 Student Health and Risk Prevention Survey, during the past 12 months before the survey, 14.4 % of youth grades 6-12 report seriously considering suicide, 6.7% of Utah youth grades 6-12 students attempted suicide one or more times, and 13.9% of these students report harming themselves without the intention of dying.

A suicide attempt may occur at a young age. One longitudinal study surveyed 883 adults between 18 and 19 years of age about previous suicide attempts (Mazza, Catalano, Abbott, & Haggerty, 2011). Of these young adults, 78 (9%) reported previously attempting suicide. Of the 39 teens who reported multiple attempts of suicide, initial attempts were made in elementary school, some as young as 9-years-old. Almost 40% of students attempting suicide previously attempted it in elementary or middle school, suggesting that children are considering suicide long before previously supposed. In fact, recent numbers indicate that about 1 in 9 children have

attempted suicide before graduation with some reports showing children making plans as early as elementary school (Mazza et al., 2011).

Several core risks of suicide have been studied. Main factors that contribute to increased suicide rates include mental disorders, alcohol or drug abuse, traumatic events, bully-related issues, ethnicity, and previous suicide attempts. The task of suicide prevention is challenging. Risk factors that might contribute to suicide prevention, according to the Florida Suicide Prevention Implementation Guide (2008), should be communicated to schools, communities, and private organizations. Suicide prevention is complex for many reasons, including the problem that suicide is pervasive and not limited to a specific demographic (Roggenbaum, 2008). The goal of suicide prevention programs is to minimize risk factors, promote resilience, and encourage the identification of typical risk factors. Suicide prevention programs characteristically possess the objective of reducing factors that may increase risk and increasing factors that support resilience (CDC, 2013).

Addressing suicide prevention for the at-risk age group of 10 to 17 years old can occur in the family and in the school system. School settings are a part of the structure for children and adolescents. Training for individuals, staff members, and students may be beneficial in decreasing suicide risk. Although there are evidence-based practices used to inhibit suicide, there is not a particular established model at the practice level (Roggenbaum, 2008). Training school personnel is an important step in suicide prevention (Heath & Ashbaker, 2004). Personnel trained in following effective practices of suicide prevention help result in at-risk students receiving appropriate services and interventions. Therefore, training personnel in suicide prevention and identifying evidenced-based materials or resources is pertinent to the welfare of students.

## **Suicide Risk Factors**

Families and school personnel may benefit from an awareness of a number of core underlying risk factors that may lead to increased rates of suicide. Factors such as mental disorders, alcohol or drug abuse, perceived body weight, sexual orientation, ethnicity, gender, learning disorders, bully-related issues, and traumatic life events contribute to suicidal tendencies. Individuals in schools, communities, and private organizations can be educated and trained to detect the risk factors of suicide in order to contribute to suicide prevention.

**Mental disorders.** Statistics show that 71% - 95% of older adults who kill themselves have a diagnosable mental disorder. Most of these disorders include either a depressive disorder or a substance abuse disorder (Conwell, Duberstein, & Caine, 2002). Family history of depression disorders may also contribute to risk factors for suicide.

**Alcohol or drug abuse.** Another factor that increases the likelihood that a person will take his or her own life is substance abuse. Alcohol and drug abuse are second only to depression and other mental disorders as the most recurrent risk factors of suicidal behavior. A data brief summarizing suicide deaths due to poisoning by alcohol or drugs, taken from reports from 16 states in the National Violent Death Reporting System (NVDRS), shows that in 2007, alcohol was a factor in one-third of suicides with 62% of these individuals with a blood alcohol content (BAC) of greater than .08 at the time of death. The majority of substance overdose suicides (79%) are related to prescription drug overdoses and the second leading cause (10%) is due to overdoses of over-the-counter drugs such as acetaminophen (NVDRS, 2007).

**Overweight or underweight body image perceptions.** The perception of body image may be more of a factor than actual weight in terms of the increased likeliness of suicidal tendencies. Regardless of body mass index, extreme perceptions of weight appear to be

significant risk factors that contribute to suicidal behaviors that vary according to race and ethnicity (Eaton, Lowry, Brener, Galuska, & Crosby, 2005). A meta-analysis also showed a significant association between unhealthy eating behaviors, or eating disorders, and suicide ideation, especially in females (Evans, Hawton, & Rodham, 2004).

**Sexual orientation.** A study conducted in Quebec, Canada, showed that heterosexual youth without same-sex behavior were at less risk of suicidality compared with adolescents with LGB identities (Zhao, Montoro, Igartua, & Thombs, 2010).

**Traumatic life events.** Evans and colleagues (2004) gathered evidence that suggests a strong association between sexual abuse, parental divorce or other difficult life events and risks of suicide. Individuals who reported an abuse history were more likely to have made a suicide attempt compared to those who did not report a history of abuse. One of the most traumatic life events that contribute to suicide ideation is when suicide has occurred in family members, particularly a parent or a sibling. When that occurs, some individuals are more likely to view suicide as an alternative (Brodsky et al., 2001). Brent, Melhem, and Donohoe (2009) concluded that children of parents who died by suicide had higher rates of “current and incident depression up to 21 months after the death than the non-bereaved than the children of parents who died by sudden natural death.” Those children also had a higher rate of substance abuse including alcohol (Brent et al., 2009). Dyregrov and Dyregrov (2005) reported that siblings of suicide casualties experienced “depression, anxiety, post-traumatic and grief reactions.” In 2008, one research team intended to identify the needs of suicide survivors and stated that “the aftermath of suicide led to difficulties related to disruption of family relations and routine, functional impairment in daily activities, difficulties with social relationships, financial and juridical problems” (McMenamy, Jordan, & Mitchell, 2008).

**Previous suicide attempts.** A longitudinal study of fifty-four adolescents who attempted suicide were identified from a group of 1,729 high school students. The students reported details on their suicide attempts and were then interviewed over the phone 4 to 6 years later. One-third of the 54 teens reported an additional suicide attempt during that time (Miranda, De Jaegere, Restifo, & Shaffer, 2014).

**Ethnicity and gender.** In the United States, the highest adolescent suicide rates are among the Native American and Inuit populations (NIMH, 2009). The lowest rate of suicide is represented by the Asian and Pacific Islander populations (NIMH, 2009). The suicide rates among non-Hispanic white males account for most suicide deaths (SAMHSA, 2007).

**Bullying and cyberbullying.** Bullying may be motivated by a pursuit for status and power in a peer group (Juvonen & Graham, 2014). Cyberbullying is the use of technology, cell phones, or the internet to threaten, harass, or humiliate a minor youth. Individuals affected by bullying or perpetrators of bullying behaviors have an increased risk of suicidal ideation (Kowalski & Limber, 2013). Students with disabilities are even more at risk than non-disabled peers to bully or to become victims of bullying (Carter & Spencer, 2006).

**Learning disabilities.** Lower academic achievement, reduced performance, and failures in school can have an effect on elevated risk factors that may lead to suicide. Students in special education and students with disabilities have been shown to have increased suicidal ideation (Wachter & Bouck, 2008).

**At-risk students.** At-risk youth include those who have a history of mental disorders, alcohol or drug abuse, those who have gone through traumatic life events, or those who have made previous suicide attempts. In one study, 1 of every 10 newly-detained or adjudicated youth had a history of attempted suicide (Hayes, 2009). Because past suicide attempts are a strong

predictor of future suicide attempts, detained youth are often at greater suicide risk than youth in the general population (Foley et al., 2006, Hayes, 2009). In 2009, The Office of Juvenile Justice and Delinquency Prevention sponsored a national survey that examined juvenile suicide rates among incarcerated youth. Incarcerated youth, according to the national data collection of 110 juveniles completing suicide between 1995 and 1999, included individuals with a history of physical abuse (20-27%), a history of sexual abuse (28%), a history of emotional abuse (44%), a history of substance abuse (73%), a history of mental illness (66%), and a history of previous suicide attempts (46%). The demographics and social history data suggest that there is a greater risk of suicide for incarcerated youth (Hayes, 2009). According to Gallagher and Dobrin (2006), incarcerated youth die by suicide at a rate two times higher than that of youth in the general population.

Identification of factors associated with suicide phenomena play an important role in the development of school setting or community-based prevention or intervention plans (Evans et al., 2004). Awareness of risk factors and warning signs should be one element of effective suicide prevention programs.

### **Mental Health Professionals Identify Effective Prevention Programs and Practices**

Experts have identified evidence-based prevention and postvention elements, strategies, and resources that help individuals, community members, and mental health professionals increase awareness of suicide risk factors and the implement effective prevention strategies.

**Recognition of factors that influence an individual.** Many prevention programs utilize the four-level social-ecological model to augment the effects of possible prevention strategies (Dahlberg & Butchart, 2005). The four-level model attempts to demonstrate the complex interplay between individual, relationship, community, and societal factors. The model illustrates

the relationship between an individual and his or her environment so that prevention programs may be put in place that address the various factors that put people at risk of experiencing suicide.

**Explicit instruction that targets specific behaviors.** Programs with the strongest evidence of effectiveness target specific behaviors instead of engaging in general activities. For example, Research and Training Center for Children's Mental Health (2011) stated addressing and changing specific behaviors and skills associated with a targeted problem (e.g., depression or behavioral problems) are more effective than interventions that included only general activities (e.g., field trips) which did not target specific problem areas. The general activities did not enhance the suicide prevention program (Doan, LeBlanc, Roggenbaum, & Lazear, 2012).

**Common factors in evidenced-based programs.** Rones and Hoagwood (2000) and Ringeisen, Henderson, and Hoagwood (2003) summarized several factors that contribute to the effectiveness of prevention programs. The top three factors that affect the success of suicide prevention programs, according to the meta-analysis, include: 1) having prevention programs that are implemented with consistency and maintained on a long-term basis; 2) the use of multi-component programs that address the needs of the whole child; and 3) the use of programs that target not only the student but parents, teachers, and peers in the intervention (Ringeisen et al., 2003). Empirical studies suggest the effectiveness of prevention programs is increased when a combination of individuals is involved in the implementation.

**Common factors in evidenced-based programs for schools.** Browne, Gafni, Roberts, Byrne, and Majumdar (2004) analyzed 23 reviews to glean the most effective elements of prevention strategies implemented in schools. The reviews represent hundreds of studies that

were published during the years of 1984 and 2000. The authors condensed the effective common factors into the following:

1. Programs aimed at developing protective factors, such as teaching preventative or resiliency skills, have shown greater positive results than programs aimed at reducing pre-existing negative behaviors, although these can vary by age, gender, and ethnicity of the children.
2. Younger children usually show greater positive results than older children do; however, some programs are more effective for older children.
3. Programs directed to address a specific problem have a greater effect than broad, unfocused interventions.
4. Programs that have multiple features involving the family, school, and the community are more likely to be successful over efforts aimed solely at a single person.
5. Strategies were enhanced when based on sound theoretical foundations.
6. Fear-inducing tactics and delivering information in only a didactic format were generally less effective.
7. Long-term strategies are more effective than short-term strategies when they have the continued presence of an appropriate adult staff or mentor (Browne et al., 2004).

Long-term prevention programs involving multiple individuals, each with a differing role in a student's success, showed much higher levels of effectiveness. Suggestions for school personnel included having them develop partnerships with families to help enable parents and others to recognize warning signs that might be key factors in preventing youth suicide. Suggested prevention programs included online training, commercial training programs, or training at conferences conducted by suicide prevention organizations.

## **Effective Mental Health Programs for Individuals, Schools, and Communities**

Mental health professionals have developed and researched effective programs in suicide prevention. Several examples of effective evidenced-based programs include Question Persuade Refer (QPR), Creating Suicide Safety in Schools (CSSS), and Signs of Suicide (SOS).

**Question, Persuade, Refer (QPR) training program.** One training program utilizing the best-practice recommendation is the Question, Persuade, Refer (QPR). The QPR Gatekeeper Training for Suicide Prevention is a program designed to teach gatekeepers, “those who are strategically positioned to recognize and refer someone at risk of suicide (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, police officers)” (Quinnett, 2013). The training introduces the warning signs of a possible suicide and how to respond to that by following three basic steps: (a) **Q**: Question the individual's desire or intent; (b) **P**: Persuade the person to seek and accept help; and (c) **R**: Refer the person to appropriate resources (Quinnett, 2013). In a study conducted by Wyman and colleagues (2008), 32 middle and high schools were randomly assigned to a group that received QPR gatekeeper training or to the control group, those who did not receive the training. A random sample of staff from each school (including support staff) was identified and followed for an average of 1 year after training. At the 1-year follow-up, school staff who received QPR gatekeeper training had higher declarative knowledge scores and higher perceived knowledge scores than control group staff from the other schools (Wyman et al., 2008). The school staff's declarative knowledge was evidence of the desired outcome of gatekeeper training. Other evidenced-based training programs show similar outcomes.

**Creating Suicide Safety in Schools (CSSS) training program.** A suicide prevention program that focuses on adult awareness in the educational setting is called Creating Suicide Safety in Schools (CSSS) and was created by Suicide Prevention Center of New York (2012).

CSSS provides a workshop for educational teams that helps the teams establish short-term plans for prevention. Participants plan and problem-solve detailed action plans necessary for schools to create a suicide-safe environment. Plans created include best-practice recommendations and evidence-based practices, such as including role play practice for trainees. CSSS incorporates best-practice recommendations by addressing key facets of the social-ecological prevention model, public health perspectives, and best practice recommendations for school-based suicide prevention (Berman, Jobes, & Silverman, 2006). According to the training program (CSSS, 2012), “The workshop explores six broad categories of school-based suicide safety: (1) policies, procedures, and standardized protocols; (2) staff training; (3) promotion of student protective factors; (4) identification and reduction of student risk factors; (5) ‘postvention’ planning; and (6) engagement of family and community.” Training programs that incorporate investigated components and evidence-based strategies achieve higher positive outcomes in suicide prevention.

**Sources of Strength (SOS) suicide prevention program.** A suicide prevention program that focuses on peer awareness in the educational setting is called Sources of Strength (SOS) suicide prevention program and was created in North Dakota. The goal is to provide evidence-based prevention for suicide by training, supporting, and empowering peer leaders to gain awareness of warning signs and to intervene and refer to the appropriate adults and mental health professionals and the results have been positive (Wyman et al., 2010). Overall, the peer leader trained program provided students the opportunity to influence at-risk peers and increased the perception that adults can be a helpful resource (Katz, Bolton, Katz, Isaak, Tilston-Jones, & Sareen, 2013). A similar program is available in Utah and was created by the Hope4Utah organization. Hope4Utah helps schools, school districts, and community organizations obtain

training encompassing prevention, intervention, and postvention needs. Hope4Utah encourages the creation of “Hope Squads” comprised of peers who are trained to recognize risk factors of suicide and report concerning changes in a peer’s behavior to an adult. The goal of Hope4Utah is to train individuals to speak a common “prevention” language, have a common understanding of warning signs and risk factors, and create common knowledge by training adults and peers to address suicide prevention in a collaborative way.

**Signs of Suicide training program (SOS).** SOS program includes suicide awareness, education, and screening strategies. The program utilizes video and guided classroom discussions to help students learn to acknowledge and take seriously the “SOS” or warning signs displayed by others, to let their peers know that they care, and to tell an adult. A systematic review of the empirical literature on school-based suicide prevention programs gave evidence that the SOS program reduced suicide attempts (Katz et al., 2013).

**Goal of Prevention Training.** The overall goal of prevention programs is consistent—to reduce the factors that lead to suicide and increase resiliency factors that help prevent suicide. Programs with the strongest evidence of impact target specific behaviors instead of engaging in general activities. Prevention programs may come in various formats including online training modules, commercially available training programs, or training at conferences sponsored by suicide prevention organizations. They also involve the family, school, and community (Browne et al., 2004). In the school setting, faculty and staff are part of the community that can be trained to facilitate school-based suicide safety (Berman et al., 2006). School personnel involved with youth may benefit from training which delineates the risks and warning signs associated with suicide ideation.

## **The Role of Teachers and School Teams in Suicide Prevention**

Because prevention programs involving multiple individuals in various roles in a student's association had higher levels of effectiveness, involving and training teachers, family, professional mental health workers, and community members is likely to produce greater levels of effectiveness in suicide prevention programs (Browne et al., 2004). Teachers can play a critical role in identification of students who are at risk for suicide. Laws requiring teacher training in suicide prevention are growing in the United States.

**State laws regarding training for educators.** Many states have implemented laws in the public school system to address the issue of suicide. There are four states (Alaska, Kentucky, Louisiana, and Tennessee) that require an annual 2-hour suicide prevention training for school personnel. There are ten states (Arkansas, Connecticut, Illinois, Indiana, Mississippi, New Jersey, Ohio, South Carolina, Utah, and West Virginia) that mandate training in suicide prevention for school personnel but do not require annual training. There are fifteen states (Alabama, California, Colorado, Florida, Georgia, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New York, Texas, Virginia, and Wisconsin) with laws that encourage suicide prevention training for school personnel, but training is not mandatory (U.S. Department of Health and Human Services, 2013). Suicide prevention training and intervention in the public school system include various issues and strategies that fulfill the legal requirements of differing states. Many state governments have enacted laws to require or encourage training in suicide prevention and awareness (HHS, 2013). If teachers and educators have this training, they are more likely to recognize the warning signs and take steps toward prevention.

In Utah beginning in 2013, the Utah State Code requires all educators to complete two hours of Youth Suicide Prevention training during their license cycle. Federal laws encourage suicide prevention training for school personnel. The U.S. Dept. of Health and Human Services & Action Alliance (2012) makes the following recommendation:

Teachers and other school personnel must not only be well-equipped to identify and communicate with their students about suicidal behaviors, but they must also be able to accurately discuss these issues with each other. While school staff and faculty should not be expected to make clinical diagnoses, they should be able to recognize developing signs and symptoms associated with suicide risk, mental disorders, and substance abuse.

Providing these professionals with the skills, vocabulary, and techniques to be comfortable with these issues through specific training could enhance these providers' ability to provide support to individuals at risk and make appropriate referrals.

Several state government agencies support training for teachers and federal agencies recommend specific training for school staff and faculty.

Research has measured the effect of direct training in various settings and shows positive effects on the skills, attitudes, and knowledge of people who undertake the training. Gatekeeper training is seen as an extremely promising strategy to prevent suicide (Isaac et al., 2009).

According to a gatekeeper prevention implementation study conducted by Johnson & Parsons (2008), a "variety of faculty and staff without a medical or psychology background come into contact with suicidal students in the school setting. These staff members have regular interactions with students and many know the students well, and these relationships enable them to note or observe changes in student behavior." School personnel who are trained to know what

to look for in relation to suicidal tendencies can become effective gatekeepers in the school environment (Schepp & Biocca, 1991).

**Importance of suicide training for teachers and school personnel.** According to an article authored by Heath & Ashbaker (2004), more effort should be put forth in crisis prevention and intervention training for school staff who work directly with the students. The article suggested guidelines to follow to assist in effective interventions with both teachers and school personnel. These guidelines included the following points: (a) Clearly define leadership roles and the lines of authority which need to be followed; (b) Clearly define the duties of every person involved; (c) Clearly describe situations when school personnel and teachers need to refer students to other professionals, including in relation to suicide ideation; (d) Provide ways to keep track of and report student needs; (e) Team up any paraprofessional with a teacher or other staff member; (f) Schedule frequent, brief practice sessions to train and refine skills, including role-playing to practice desired behaviors; (g) After a crisis situation, schedule a time for the school staff to review what happened, express emotions, and express concerns; and (h) Provide opportunities for teachers and school personnel to give suggestions for making improvements in the crisis plan. Involvement and input of teachers and school personnel may be a logical step in crisis prevention when each adult in the school can contribute to the support and welfare of the students (Heath & Ashbaker, 2004).

**Impact of training on teachers and school personnel.** After training, teachers and school personnel reported being more confident in their abilities to identify students' needs. Prevention program implementation and training for teachers and school personnel can be effective in increasing gatekeeping skills and in increasing the number of students approached and referred to support services for suicide prevention (Albright, Goldman, Shockley, &

Spiegler, 2013). A longitudinal study among 216 high school teachers and personnel in 82 schools in five states found that all measured variables showed statistically significant increases from pre- to post-training of staff. The increases remained significant when follow-up occurred at the three-month point. The average increase was 55% (Albright et al., 2013). Training has been shown to increase teachers' and school personnel' levels of self-efficacy in dealing with suicide prevention.

**Summary of teachers and school personnel's roles in suicide prevention.** Key gatekeepers, those people who regularly come into contact with individuals or families, must be trained to distinguish behavioral patterns and other elements that put individuals at risk of suicide and then be equipped to effectively intervene before the behaviors and early signs of risk continue to evolve (HHS, 2012). The outcome for training in suicide prevention and awareness should be an increased ability to recognize and refer students displaying warning signs, the increased likelihood in approaching struggling students, and the increased referral of those students to necessary resources where they can get the help and assistance needed. The warning signs school personnel and peers should be trained to look for include thoughts of suicide or self-harm; someone talking or writing about death, dying, or suicide; someone looking for ways to kill themselves; dramatic changes in mood; hopelessness; increased alcohol or drug use; withdrawing from friends or family; or changes in sleeping patterns (Rudd et al., 2006).

A common recommendation for effective programs is the involvement of multiple personnel and individuals in the implementation of the programs. The involvement of others such as school personnel may help increase effective implementation of the programs (Heath & Ashbaker, 2004). The involvement of other key players in a youth's environment such as peers,

family members, school counselors, administrators, and mental health professions may positively impact prevention programs effectiveness.

### **Involvement in Suicide Prevention**

Because prevention programs involving multiple individuals in various roles in a student's association had higher levels of effectiveness, involving peers, family, professional mental health workers, and community members is likely to produce greater levels of effectiveness in suicide prevention programs (Browne et al., 2004).

**Involvement of peers.** In a systematic review of 16 suicide prevention programs, two programs showed a decrease in suicide attempts. The authors proposed that the key difference in the was the involvement of peers in recognizing and referring at risk students (Katz et al., 2013). Training peers in recognizing warning signs improved their connectedness to adults, improved school engagement, increased perceptions of adult support, and increased the likelihood of referring a suicidal peer to an adult (Wyman et al., 2010). Parents should be taught to be aware of these kinds of warning signs or changes in their students, as well.

**Involvement of parents.** Research has been conducted which shows the effectiveness of collaborative efforts, including parents, in school-wide implementation of any academic or social program. School-wide implementation of the three-tiered Response to Intervention, according to Giangreco (2002), had several key elements. First, school leaders would need to build shared consensus of the why's and how's of improving system-wide procedures. The second step involved identification of resources, both human and capital, that could be put forward to maintain the infrastructure of systems needed for the long-term implementation of the program. The third step included gathering support from the school community, including parents, who would participate in the data-driven decision-making about which programs and policies to

incorporate. Finally, teachers would be prepared, through ongoing professional development instruction, on how to use best practices and give necessary instruction that would best benefit the students in need (Giangreco, 2002). Suicide prevention programs that train adults in the school setting should maintain simple guidelines that can be easily implemented and include parental participation and parental training along with it. These elements should be applied to suicide prevention programs and the implementation of those programs. Professionals, teachers, administrators, and parents are critical participants in this.

**Involvement of mental health professionals.** Prevention efforts that include peers, parents, teachers, may include the active involvement of mental health professionals in assisting at-risk student to access mental health resources and in building relationships with those struggling individuals. Five months after gatekeeper suicide prevention training in a Los Angeles Unified School District school, the district followed up with parents to assess the effects of the training. More than two-thirds of randomly sampled parents reported the prevention training had an effect on parental involvement and on the student accessing school or community mental health services (Kataoka, Stein, Nadeem, & Wong, 2007). Prevention training may increased awareness of student's needs and how to address student's needs with accessing the services of mental health professionals.

### **Identification, Prevention, and Intervention in Mental Health and School Settings**

Prevention programs and assessment instruments may be helpful in identifying individuals who struggle and facilitating the organization of resources to address the needs of those individuals. Once a struggling student is identified, classes, trainings, support groups, and access to private, community, school, or government resources should assist in outlining steps for individuals and school personnel to take during and after a suicide crisis.

**Assessments to determine risk.** School-wide screenings, conducted by school counselors or school psychologists, may identify students who show concerning symptoms. In community settings, mental health professionals should conduct screenings as part of the intake information. Information gained from screenings may be used to develop a continuum of interventions and prevention strategies. One instrument of assessment that is research-based and shown to be effective is The Columbia Severity Rating Scale (C-SSRS) (Levin, 2009). Often school districts create their own version of similar assessment tools to gauge the level of at-risk behaviors for suicide.

Clinical preventative services like suicide assessments and preventative screening “are crucial to assessing suicide risk and connecting individuals at risk for suicide to available clinic services and other sources of care.” A report from the U.S. Surgeon General and The National Strategy for Suicide Prevention (NSSP) recommended that screening efforts “should ideally include related training, education or outreach before or concurrently with screening campaigns, in order to improve and establish a more robust network of support for youth at elevated risk for suicide” (SAMHSA, 2012). Further, a group of authors cautioned that when using assessment scales, they may be used as aids to suicide assessment but should not result in “therapeutic tunnel vision”. Assessment scales should not be used as substitutes for a thorough clinical evaluation nor for failing to have awareness of the bigger assessment picture that can best serve clients and the overall intervention process (Granello, 2010).

**Supportive relationships effect on intervention.** After a youth has been identified, a variety of interventions may be helpful in supporting the at-risk student. Maintaining and building relationships with struggling individuals may have an effect on blocking the progression from ideation to attempt and may increase the likelihood of participation in treatment options

(Klonsky, May, & Saffer, 2016). Building relationships can include active listening, spending time, and caring. One article shows suicide attempts may depend on the perceived levels of social connectedness. Klonsky et al. (2016) make the following conclusion regarding the different levels of attempted suicides based on levels of connectedness:

The presence of socially oriented motivations signifies a continued connection to people, a desire to maintain these relationships, and thus a continued investment in living. This connection to people may counterbalance a desire to die, whereas the absence of communication motivations may signify less connection and thus less ambiguity about the desire to die. In addition, individuals who attempt suicide with communication motivations, particularly help-seeking, may be more interested and engaged in the treatment options that are often offered post attempt. (p. 8)

Relationship building can include offering suggestions for additional support. Additionally, another part of effective services for youth identified with suicidal ideation is awareness of available community resources to share with the youth.

**Suicide prevention hotlines.** Community resources are available to intervene for those youth who display higher levels of risk for suicide. Some of these resources include accessing suicide prevention hotlines. One study conducted to assess the effectiveness of suicide prevention hotlines included 1,085 suicide callers and measured significant decreases in suicidality during the course of the telephone session with “continued decreases in hopelessness and psychological pain during the following week” (Kalafat, Gould, Munfakh, & Kleinman, 2007). Other resources include community mental health facilities that offer counseling and assessments for individuals in need, including those individuals affected by the loss due to the completed suicide of a family member.

## **Postvention Help after a Completed Suicide**

Suicide alters the lives of surviving family members, friends, teachers, schools, and communities. Family members, including siblings, are in a position to notice the signs of suicidal ideation and may be the first responders to a suicide attempt (Gould, Greenberg, Velting, & Shaffer, 2003). The majority of adolescent suicides occur away from the school, with 71.7% of Utah adolescent suicides taking place in the home (Utah Department of Health, 2011). Survivors have difficulties in healing, moving forward, and dealing with grief (Balk, Zaengle, & Corr, 2011). For youth whose sibling completed suicide, many grief reactions include depression and anxiety as well as difficulty in obtaining targeted help (Dyregrov & Dyregrov, 2005).

Supporting grieving youth, siblings, and children of parents who complete suicide should occur in schools and communities. Supports should be well-planned and occur in a timely manner. Although bereaved family members are profoundly affected by the loss, adjusting to the life with the absence of a loved one, should be underpinned by sufficient and timely support in a specified plan (Lindqvist, Johansson, & Karlsson, 2008). For youth whose parent completed suicide, grief reactions may be multiplied because of his or her dependency on the deceased parent and the immediate loss of the parent as a role model and caregiver (Webb, 2011).

Working through the grief is a complex process, due to the necessity to deal with both grief and trauma that occurs due to the preoccupation of how the person died (Jordan & McIntosh, 2011). According to Andriessen (2009), listening to survivors to exploring their needs and experiences should be the first step in establishing effective postvention services. Listening and establishing support can be considered as contributing toward suicide prevention for those for those bereaved by suicide (Andriessen, 2009). Support can include access to school-based resources.

**School strategies.** In school districts throughout the country, including Utah school districts, a crisis team or mental health worker may respond to a suicide completion by meeting with students and staff most affected by the suicide and meeting with the parents of the individual. The overall effort is in helping the school to return to normality (Moskos & Halbern, 2007). School districts may offer family or individual support such as bereavement counseling and grief classes through a district mental health organizations staffed by district mental health professionals. The school district may choose to identify and recommend community resources, including groups, counseling, and crisis hotlines, that will aid in overall intervention and postvention efforts.

**Family strategies.** Support groups for families are available to help families dealing with a loss to be able to access community resources and support. Additional resources include support groups conducted by mental health professionals, educators, and clergy. Other community-based resources include the National Alliance on Mental Illness (NAMI). This is an information line for individuals who want to talk about mental health issues. Volunteers are trained to listen and process through mental health needs while keeping information confidential. Other local offices provide ongoing help via classes and other support groups.

**Group counseling strategies.** Families may also benefit from group support and counseling. An Australian study in 2014, evaluated the effectiveness of a suicide bereavement support group. Participants were assessed on “quality of life, psychological distress, suicidality and productivity.” Results suggest that by using bereavement groups “there was a trend to higher quality of life and lower psychological distress and levels of suicidality” (Visser, Comans, & Scuffham, 2014). In one qualitative study of 11 “suicide bereaved individuals,” demonstrated the

importance of support groups by the participants as an effective postvention strategy (Gall, Henneberry, & Eyre, 2014). Individual family members may benefit from one-on-one strategies.

**Individual therapy.** In supporting an individual with prevention, intervention, and postvention needs, counselors and therapists may be helpful. Counselors and therapists have differing approaches and philosophies in dealing with suicide intervention and postvention. Some examples of approaches include Cognitive Behavioral Therapy (CBT), Rational Emotive Behavior Therapy (REBT), Dialectical Behavior Therapy (DBT), and Eye Movement Desensitization and Reprocessing (EMDR). Cognitive Behavioral Therapy (CBT) is a short-term therapy based on the connection and interrelationship between thoughts, feelings, and behavior. In a randomized control trial study, individuals involved in CBT showed a reduction in depression including a reduction in depression for individuals with previous suicide attempts (Brown, Ten Have, Henriques, Xie, Hollander, & Beck, 2005). Rational Emotive Behavior Therapy (REBT) was shown to have similar effects. Rational Emotive Behavior Therapy (REBT) is directive therapy focusing on resolving emotional and behavioral problems and turmoil. Individuals involved in REBT show a decrease in self-destructive behaviors including suicide (Szentagotai, Lupu, & Cosman, 2008). Finally, Dialectical Behavior Therapy (DBT) is a therapy designed to help change patterns of unhelpful behavior such as self-harming, suicidal ideation, or substance abuse and demonstrates efficacy in reducing suicide risk among younger adults (Linehan et al., 2006). Lastly, Eye Movement Desensitization and Reprocessing (EMDR) is a therapy which has been shown to be effective for overcoming anxiety, stress, and trauma in survivors of suicide (Jordan & McMenemy, 2004). Many individual approaches are available to assist struggling youth in suicide prevention and in dealing with the loss of a loved one due to suicide.

## **Conclusion**

Suicide is a problem that affects individuals, families, and communities. Several core risks and warning signs of suicide have been identified (Rudd et al., 2006). The main factors that contribute to increased suicide rates are mental disorders including depression, a family history of suicide or mental illness, learning disorders, alcohol or drug abuse, bully-related issues, sexual abuse, parental divorce, perception of weight, traumatic life events, sexual orientation, incarceration, and previous suicide attempts. Awareness of the risk factors should be addressed in schools, communities, and private organizations (Florida Suicide Prevention Implementation Guide, 2008) to help others become aware of warning signs and be able to connect students with appropriate help, resources, and in building relationships with struggling youth.

The task of suicide prevention is challenging. Addressing suicide prevention for the at-risk age group of 10 to 17-years-old should occur in the school system since school settings are a part of the community structure for children and adolescents. Interventions should be implemented by community organizations, mental health professionals, and school-based mental health practitioners.

Supporting grieving youth, siblings, and children of parents who complete suicide should occur in schools and communities. Survivors have difficulties in healing, moving forward, and dealing with grief (Balk, Zaengle, & Corr, 2011). According to Andriessen (2009), listening to survivors to exploring their needs and experiences should be the first step in establishing effective postvention services. Postvention resources to address survivors' grief and loss should be identified and shared by the community professionals and school personnel, as well.

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## APPENDIX B: INSTRUMENT

This is an optional questionnaire. Information gathered may be organized to identify recommendations for suicide prevention and intervention.

1. Age: \_\_\_\_\_

2. Job Title: \_\_\_\_\_

3. Do you work in a SCHOOL setting? YES NO

4. Number of years worked with children or youth? \_\_\_\_\_

5. Have you worked with a **suicidal youth**? YES NO

If YES, what strategies or resources did you find helpful?

6. Have you worked with a **youth whose sibling completed suicide**? YES NO

If YES, what strategies or resources did you find helpful?

7. Have you worked a **youth whose parent completed suicide**? YES NO

If YES, what strategies or resources did you find helpful?