Self-Harm and Suicide Awareness and Prevention in Childhood and Early Adolescence:

A Resource for Elementary School Educators and School-Based Professionals

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INTRODUCTION

When children talk about death, communicate a wish to die, or hurt themselves—when they engage in suicidal thoughts and behaviors (hereafter referred to as "STBs")—school adults may feel stunned and disoriented. In addition to the urgent need to protect and care for their students, school adults may feel they don't have adequate training to guide their response. Consequently, educators may react in ineffective or even harmful ways, such as minimizing or ignoring the child's support needs. Rates of reported STBs in children are rising (Burstein et al., 2019), elevating the need for up-to-date information meant to ensure educators are prepared to respond in the best possible way.

This resource is designed to provide elementary school personnel, including school leaders, classroom teachers, and trained school-based mental health staff with critical knowledge and resources to help them recognize and assess the warning signs of STBs, and to respond in such a way that harm may be reduced, and children are kept safe.

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PART: **1**

Talking About Suicidal Thoughts And Behaviors: What Language Are We Using And Why?

Elementary school educators and professionals must plan their self-harm and suicide prevention and intervention efforts with careful consideration for the risks and opportunities at the different grade levels and stages of youth development represented in their schools. When we use the term **'childhood,'** we are referring to the stage of life before puberty. This stage typically corresponds to kindergarten through fourth grade. When we use the term **'early adolescence,'** we are referring to the stage of life during which children experience puberty, a phase of human development characterized by major changes in the body, brain, cognition, and emotion (Mendle et al., 2019). This age group is also sometimes referred to as 'preteen.' Current estimates suggest that, on average, both boys and girls in the United States enter puberty at approximately age 10 (Mendle et al., 2019). The early adolescent stage typically corresponds to fifth or sixth grade.

Many terms are used when describing STBs (Cash & Bridge, 2009; HHS, 2022; NIMH, 2022a):

Suicide. A death caused by self-directed injurious behavior with intent to die, either expressed explicitly or inferred.

Suicide Attempt. A non-fatal, self-directed, potentially injurious behavior with intent to die. A suicide attempt may not result in injury.

Suicidal Ideation. Thinking about, considering, or planning death by suicide[1]. Suicidal ideation comprises suicidal thoughts.

Non-Suicidal Self-Injury. Injuries inflicted to the body without suicidal intent (e.g., cutting, scratching, burning self; pulling one's hair out; hitting self).

Self-Harm. Sometimes used synonymously with non-suicidal self-injury, refers to the purposeful inflicting of pain or damage to one's body.

Social Contagion. Exposure to suicide or suicidal behaviors within one's family, one's peer group, or through media reports of suicide and can result in an increase in suicide and suicidal behaviors in persons at risk for suicide, especially in adolescents and young adults.

One of the primary ways that educators and school professionals can develop confidence in preventing and responding to STBs among children is to build awareness and comfort around the language we use to talk about these experiences. By familiarizing ourselves with terminology, we grow our ability to name challenges in front of us and contribute to a culture of prevention and intervention in our schools.

[1] The phrase 'death by suicide' is used to communicate a neutral and non-judgmental stance. Other phrases, such as "committed suicide" or "completed suicide" may reinforce stigma and misunderstandings associated with suicide, such as suicide as a sin or crime or suicide as an achievement (CAMH, 2023).

PART: **2**

Common Myths And Facts About Suicidal Thoughts And Behaviors Among Children And Early Adolescents

MYTH: Children are too immature to understand suicide, let alone engage in suicidal behavior.

FACT: Children as young as 4 and 5 years old can understand death and, although it is extremely rare, young children have died by suicide (NIMH, 2022a). Some children can understand the permanence of death, while others may make impulsive decisions without fully understanding the consequences.

MYTH: Only a small number of children die by suicide, so it's not a serious concern.

FACT: Suicidal ideation in childhood is a serious signal for later suicide attempts. We know that children who attempt suicide in childhood are six times more likely to attempt suicide in adolescence (NIMH, 2022b). Most adolescents who have died by suicide made a suicidal statement in the past (NIMH, 2022b).

MYTH: Children who make comments about suicide are just looking for attention.

FACT: Children may reference suicide or self-harm for a variety of reasons. Not all references to suicide are necessarily communicating a wish to die. For example, a child may repeat a song lyric or refer to a dialogue in a television show. Each comment needs to be taken seriously and thoroughly assessed to understand the context and determine the level of risk. Suicidal statements that involve a wish to die or harm oneself are an indicator of significant pain and distress that requires attention. It's important to keep in mind that children may express their distress differently than adolescents; for example, they may enact their thoughts and feelings in their pretend play.

MYTH: Suicide is an issue among White people, not in communities of color.

FACT: Suicide affects people across every racial and ethnic group. Although suicide rates have historically been higher among White children, the rate of suicide for Black male children increased by nearly 50% from 2013 to 2019, and American Indian/Alaskan Native youth are at the highest risk of suicide (Ramchand et al., 2021). While we need more research to fully understand these trends, we know that structural oppression and racism are harmful to children's mental health (and their families and communities) and they contribute to disparities in access to care (Cave et al., 2020; Cook et al., 2017).

MYTH: Talking to children about suicide will put ideas in their minds that they wouldn't otherwise have.

FACT: Talking about suicide does not cause suicide. Children need a calm, supportive, nonjudgmental adult with whom to share their pain. By using developmentally appropriate language to discuss self-injury and suicide, we can identify students at risk and intervene effectively.

How Do Children Make Sense Of Death, And, More Specifically, Suicidal Thoughts And Behaviors?

YOUNG CHILDREN

Key Points

- It is a common myth that young children are incapable of thinking about suicide.
- Death by suicide is rare in young children; however, it may be underreported due to stigma or conflation with accidental death.
- To help prevent future suicide attempts in adolescence, it is important to identify and support young children who are thinking about suicide.
- All comments about suicide, no matter how realistic or not, should be taken seriously and assessed.

How do young children understand death?

Like motor and speech development, a child's understanding of death typically develops in a standard sequence (Slaughter, 2005). By age four, children can typically categorize things that die and things that do not die. By age six, children start to understand that death is permanent and irreversible, and at about age seven, children start to understand that death has a biological cause (Slaughter, 2005).

Some life experiences can accelerate a child's understanding of or relationship with death. Children who experience the death of a loved one, such as a grandparent, and children who have chronic physical illnesses may have more mature or proximate understandings of death than others their age (O'Halloran & Altmaier, 1996; Reilly et al., 1983). Children with depression and suicidal ideation may also have a more advanced understanding of death (Hennefield et al., 2019).

Families and caregivers also influence how children understand death. They may express various religious or spiritual beliefs about what happens when someone dies. Children may hear phrases such as, "He is in a better place," and not fully understand the totality of death. When children don't have a caregiver to help explain death, they may use their imagination to fill in the gaps (Longbottom & Slaughter, 2018). Children may see death by suicide portrayed in media, where context is lost, and it is rarely framed as preventable. When under extreme stress, children may lose track of the insight that death is permanent and view it as a temporary solution to a painful situation.

There is no evidence that understanding death as a normal part of the life cycle increases the risk of suicide in children. However, the death by suicide of a loved one or peer has been identified as a risk factor for suicidal ideation and behavior in children (Hawton et al., 2020; Hua et al., 2019).

Understanding how children make sense of death and more specifically, death by suicide, is foundational for educators; it helps grow confidence in the ability to respond effectively when a child talks about topics related to death.

Do young children engage in suicidal thoughts and behaviors?

It is difficult to know how many young children experience suicidal thoughts. This is because most of our existing estimates for children come from emergency room visits. From 2007 to 2015, 43.1% of the STB-related emergency room visits for children were for children aged 5 to 10 years; of those, a very small percentage (2.1%) were hospitalized (Burstein et al., 2019). These numbers likely underrepresent the number of young children who communicate suicidal thoughts to family members, peers, and educators, but who are not seen for crisis intervention in a hospital setting.

Suicide among very young children is rare; it is not among the leading causes of death for children ages 0-4 years (NIMH, 2022a; Sheftall et al., 2016). Between ages 5-9, suicide remains rare, ranking as the 10th leading cause of death in this age group (NIMH, 2022a). In 2020, there were 20 recorded deaths by suicide among children ages 5-9 in the United States (NIMH, 2022a). Although recorded deaths by suicide are uncommon for this age group, many children likely suffer with thoughts of suicide, and communicating about suicidal thoughts in childhood is a risk factor for suicide attempts and mental health challenges in adolescence (NIMH, 2022a).

EARLY ADOLESCENTS

Key Points

- The stage of puberty, often between ages 10-12, brings an increased risk of suicide for children. Educators serving youth in this developmental stage must be aware of the signs of STBs and work to install and improve prevention and intervention supports in their schools.
- Conflicts with peers are commonly identified precursors to suicidal ideation among early adolescents. Educators should take seriously conflicts occurring among their students and should install prevention and intervention supports to develop conflict management skills among students.
- Early adolescents may act impulsively when in heightened emotional states. Educators should be attentive to students who appear distressed and having made themselves aware of school-based supports, connect those students immediately.

For specific and detailed prevention and intervention recommendations, refer to Part 6.

How do early adolescents understand death?

Children in early adolescence begin to have a more complex understanding of death. They recognize that all living things die, that death is permanent, that death has a biological cause, and that all bodily processes end upon death.

Do early adolescents engage in suicidal thoughts and behaviors?

The federal government does not survey youth in elementary school; therefore, the national prevalence of suicidal thoughts and behaviors in early adolescent children is difficult to estimate. However, evidence from statewide population-based surveillance surveys provides some insights. Results from Minnesota suggest that, among 11 and 12-year-olds reporting in 2010, the rate of self-reported past-year suicidal ideation was 9.25% and the rate of past-year suicidal attempts was just under 2% (Walsh

et al., 2021). Among those who reported suicidal ideation, less than one-quarter (17%) reported making a suicide attempt (Walsh et al., 2021).

Do early adolescents die by suicide?

At about the time when children enter puberty, between ages 10 and 12, the risk for suicide grows, with suicide climbing to the second leading cause of death for this age group (NIMH, 2022a). In 2020, there were 581 deaths by suicide in this age group in the United States (NIMH, 2022a). The suicide rate per 100,000 individuals between ages 10-14 is higher for boys (3.6 per 100,000) than for girls (2 per 100,000; NIMH, 2022a).

Why does the risk for suicide increase in early adolescence?

There is no definitive answer to this question, yet scientists have considered the role of social and biological mechanisms. Some scientists have suggested that puberty-associated biological changes at this stage of development affect the brain's regulation of emotions and impulses and sensitize youth to difficult experiences in their social and personal lives (Owens et al., 2020; Rice & Sher, 2015). Early adolescents may act impulsively when in heightened emotional states, which at this stage of development are frequently caused by stressful events in their interpersonal relationships (Heilbron & Prinstein, 2010; Owens et al., 2020).

How Might The Identities (Race, Ethnicity, Sexual Orientation, Gender Identity) Of Children And Early Adolescents Relate To Suicidal Thoughts And Behaviors?

Key Points

- Minority stress, or the psychological burden of experiencing discrimination, prejudice, or oppression based on identity, is understood to contribute to suicide risk. Students with multiple marginalized identities, for example, Black LGBTQ+ children, are at an even higher risk. Educators must work actively to build a culture that supports and represents the multidimensional self-identities of all youth.
- Due to past experiences of bias and prejudice in education and medical settings, some families may hesitate to seek out prevention and intervention supports. Educators can work to build a welcoming and culturally responsive school climate and culture where caregivers feel included and represented.
- More research is needed to understand the disparities in suicide risk and support culturally responsive, equitable, accessible approaches to addressing the root causes of suicide.
- Proximity to mental health resources, community attitudes toward seeking help, and effective and efficient referral systems affect whether or not children receive care.

Variability by Race and Ethnicity. Troubling disparities exist in suicide risk among various populations. The rate of death by suicide is the highest among American Indian/Alaskan Native/ Indigenous youth, followed by White youth (Ramchand et al., 2021). Within Native communities, the risk varies across tribes, regions, and geographies. Critical risk factors for Native youth include historical trauma, poverty, geographic isolation, and cultural loss; while protective factors include a culture of collective wellness, connection to ancestral practices and traditions, tribal spirituality, and self-determination (National Council of Urban Indian Health, 2022).

While overall rates of suicide for African American youth are lower than for white or Indigenous youth, there has recently been an alarming increase in suicide among Black youth, especially males (Ramchand et al., 2021). The rate of suicide in Black children ages 5-12 is about twice that of White children of the same age (Bridge et al., 2018). Socioeconomic stress, community violence, discrimination, and stigma are shown to heighten this suicide risk (Sheftall et al., 2022). Bias and structural racism in health care and educational systems contribute to mental health conditions in Black youth being labeled as behavioral problems and therefore undertreated (Sheftall et al., 2022). A sense of belonging, spirituality, community and family cohesion, and positive racial socialization are factors found to be supportive of Black youth mental health (Mushonga & Henneberger, 2020).

Variability by Sexual Orientation and Gender Identity. Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning (LGBTQ+) youth are more than four times as likely to attempt suicide than their peers (Johns et al., 2019). Transgender and nonbinary youth are 2-2.5 times as likely to seriously consider or attempt suicide than their cisgender LGB peers. This risk is not attributed to the identities themselves, but rather the stress associated with experiencing victimization, rejection, and discrimination (Fulginiti et al., 2021). Youth living at the intersections of multiple marginalized identities, such as LGBTQ+ youth of color, are at disproportionately high risk of suicide (The Trevor Project, 2020). This is especially true for Black and Indigenous transgender and nonbinary youth (Price-Feeney et al., 2020). LGBTQ+ youth who experience acceptance and protection at home and school, including the use of affirmed names and pronouns, have a markedly reduced suicide risk (The Trevor Project, 2020).

Variability by Geographic Region. Youth living in rural regions of the United States are at a higher risk of suicide than those living in urban areas with higher population density (CDC, 2022; NIH 2020). Rural areas tend to have fewer youth-serving mental health facilities and lower access to suicide prevention resources (NIH, 2020).

PART: **5**

Learning To Recognize The Signs: Risk Factors And Warning Indicators Of Suicidal Thoughts And Behaviors Among Children And Early Adolescents

Key Points

- Risk factors are often an indicator that a child needs attention and support.
- Identifying risk factors can help schools respond with appropriate resources and referrals. Educators should be aware of the signs of STBs and the referral system for connecting children to school-based professionals who are trained to perform a risk assessment.
- Risk factors should be evaluated by trained mental health clinicians or child welfare personnel.
- No single risk factor is known to cause suicide; most children who die by suicide have several risk factors.
- Children can be exposed to suicide-related content in the media. For children already experiencing depressive symptoms or having thoughts of suicide, this can increase risk. Educators should be aware of popular media or viral trends related to suicide, as this can influence children's behavior.
- Educators may use school social media pages to proactively post public service announcements and to bring attention to school referral pathways and resources.

What experiences make our children and students more vulnerable to self-harm or suicidal thoughts/behaviors?

Although more research is needed to understand suicidal thoughts and behaviors in children, we know that certain experiences place children at risk. Without adults to help them cope, **Adverse Childhood Experiences (ACEs)**, such as abuse, neglect, exposure to violence, or other unresolved trauma can impact children's mental, emotional, and physical development and increase the risk of suicide (Hughes et al., 2017). It is important to remember that *no single risk factor is known to cause suicide; most children who die by suicide have several risk factors.*

Environmental and social factors also contribute to toxic levels of stress. Chronic stressors such as poverty, discrimination, community violence, environmental racism, and other social injustices affect overall well-being. Oppression and experiences of marginalization contribute to disproportionately high rates of suicide and mental health conditions in BIPOC Trent et al., 2019) and LGBTQ+ communities (Johns et al., 2019).

With early identification of warning signs and the appropriate support, children can heal and integrate difficult experiences.

Knowing common risk factors is important for preventing suicide among elementary-aged children [Sources: Brausch & Gutierrez, 2009; Burstein et al., 2019; Hawton et al., 2020; Ruch et al., 2021; Walsh et al., 2021]:

- ***Trauma.*** Victimization by emotional, physical, and/or sexual abuse, neglect, or domestic violence.
- ***Peer-related problems.*** Experiences of peer victimization through bullying, either as someone who was targeted, caused harm, or both; difficulty making or keeping friends.
- ***School problems.*** Challenges with learning, impulsivity, or disruptive behavior at school.
- ***Family-related problems.*** Severe family conflict and/or family problems such as caregiver substance abuse, divorce, and custody disputes.
- ***Familial rejection.*** Rejection from caregivers, including rejection due to sexual orientation, gender identity, or expression.
- ***Recent loss.*** Death of a loved one, separation from caregivers, or other loss of important relationships.
- ***Family history of mental health conditions and/or suicide.*** Having a loved one who struggles with mental health conditions or who has died by suicide.
- ***Low supervision by caregivers.*** Caregivers can't closely monitor a child's whereabouts due to financial, health-related, or other reasons.
- ***Access to unprotected firearms in the home.*** Firearms are present in unsecured locations in the home.
- ***Childhood mental illness.*** Existing childhood diagnoses of mood disorders, attention-deficit/hyperactivity disorder, and/or disruptive disorders.
- ***Exposure to suicide within social networks.*** Knowing or hearing about someone at school, and/or in the media who died by suicide. Relating to peers over suicidal thoughts and behaviors. Perceiving that suicide is widespread.
- ***Previous suicidal ideation.*** Prior history of suicidal thoughts, statements, and/or self-injury.
- ***Interactions with law enforcement.*** Disruptive and/or illegal behavior resulting in interactions with law enforcement, either at school, in the home, or the community.
- ***Disordered eating.*** Unhealthy eating behaviors, including binge eating and restrictive eating.

Unless they have specialized training, it is best if educators do not ask questions of children to determine the presence of these risks. If, on the other hand, an educator becomes aware of these risk factors in the course of their regular duties, they can best help by connecting the child to appropriate school-based care. All educators have an important role in recognizing risks, knowing about their school's referral system, and connecting children to school-based professionals who are trained to perform risk assessments and intervene as appropriate. Once a child has been identified as at risk of suicide, the next appropriate step is a referral to a qualified mental health professional. *Only trained mental health clinicians or child welfare personnel should conduct this level of assessment in the school environment.*

The role of the media in suicidal thoughts and behaviors among elementary-aged

children and early adolescents

The relationship between the media (i.e., the internet, social media, films, and television) and suicidal thoughts and behaviors is complex. Children may be exposed to suicide-related content without the appropriate support from adults. They may also use social media to communicate about their suicidal thoughts.

Regular exposure to media involving suicide may increase the risk of *social contagion*. Children are more likely than adults to experience suicide clusters; suicidal ideation or behavior among children in a shared setting, such as a school, increases following exposure to suicide-related content (Hawton et al, 2020). Educators should be aware of trends in popular culture that glorify suicide, such as television series or viral trends. Children with pre-existing depression and/or suicidal ideation are most vulnerable to the effects of media (Leaune et al., 2022).

Using Media in the Fight Against Suicide

While media may expose elementary-aged children to suicide-related content, the platforms also hold tremendous promise for prevention and early intervention. First and most simply, media portrayals of natural death can be helpful for caregivers and educators to teach children how to communicate about and cope effectively with death (Longbottom & Slaughter, 2018). Second, with the help of new software, the social media posts of elementary-aged children can be monitored by educators, families, and peers (Byars et al., 2020). Relatedly, educators can use social media proactively to post prevention-related messages and resources and to communicate about self- and peer-referral processes.

Identifying Suicidal Thoughts And Behaviors In Elementary-Aged Children And Early Adolescents: Key Considerations And Techniques For Elementary School Educators And Other School-Based Professionals

Key Points

- Children may show signs of depression and/or suicidal ideation differently than teens or adults. Warning signs include drastic changes in mood or behavior, impulsivity, talking, drawing, or writing about death, somatic complaints, or risky behavior.
- Self-injury is a deliberate act to hurt one's body, such as cutting or burning one's skin. It is often not a suicide attempt but rather an effort to cope with difficult emotions, but it should always be taken seriously and thoroughly assessed by a mental health professional.
- If a child is self-injuring or expressing thoughts of suicide, care should be taken to respond non-judgmentally and with open curiosity.

What are the warning signs of suicide?

Just because an elementary-aged child has one or more risk factors does not mean that they will consider suicide. That said, it is important to connect children to support early before a crisis. Students often show that they are hurting through their behavior. Educators are well positioned to notice early warning signs of a crisis, including:

- Dramatic changes in mood or behavior
- Drops in academic performance
- Loss of interest in normal activities
- Tiredness, fatigue, and loss of energy
- Talking, writing, or drawing about death
- Pretend play using storylines involving death
- Symptoms of depression, which may include aggression, anger, irritability, sadness, or feelings of low self-worth
- Making statements such as "I wish I could disappear," "I hate my life," "I hate myself" or "My family would be better off without me."
- Frequent visits to the school nurse with vague physical complaints, such as stomachaches and headaches
- Impulsive or risky behavior, such as running into the street or climbing at an unsafe height

How do we recognize and respond to self-injury?

Self-injury is when a child does something to hurt their body, such as scratching, picking, or burning their skin, or otherwise injuring themself. Sometimes self-injury is a sign of suicide risk. Other times, a child may be doing it to cope with overwhelming feelings, fit in with peers, or due to a disability. Self-injurious behavior can include:

- Scratching self with fingernails or objects like thumbtacks
- Using sharp objects to cut their skin
- Burning skin with an eraser
- Hitting or choking oneself
- Picking at skin or nails causing bleeding
- Pulling one's own hair out
- Banging one's head against the wall

Students who self-injure should be assessed for suicide risk. Even if they are not suicidal, if they rely on self-injury to cope with their emotions, they should speak with a mental health professional. It's important to remain calm and nonjudgmental when talking to students about self-injury; consequences can inadvertently reinforce the behavior. If a group of children has all been identified as self-injuring, assess each child individually. Warning signs may include:

- Unexplained cuts, bruises, or burns
- Wearing long sleeves or bracelets to cover marks
- Avoiding activities that require less clothing, such as swimming
- Possessing razors or other sharp objects
- Writing or talking about self-injury, posting on social media

What helps protect elementary-aged children and early adolescents from suicide?

Just as there are factors that increase a student's risk of suicide, there are also protective factors that mitigate that risk. Suicide risk is a complex interaction between risk and protective factors. Schools have a unique opportunity to impact students' mental and emotional well-being, including by adequately supporting educators and families. Some protective factors include:

- A sense of belonging and connection, both at school and in the broader community
- Positive relationships with peers and adults at school
- Experiencing success academically or in extracurricular activities
- The ability to identify feelings, utilize coping skills, and solve social problems
- Being able to talk to trusted adults about their problems
- Safe, stable living environments with access to essential resources and free from violence
- Involvement with faith communities and cultural or other community groups
- A positive sense of identity, including healthy racial socialization and support for all sexual orientation and gender identities
- For Native youth, a connection to tribal culture and spirituality
- Strong familial support, especially for LGBTQ+ children

What Can Elementary School Educators And Other School-Based Professionals Do To Prevent Suicide Among Children And Early Adolescents?

Key Points

- Suicide prevention requires multi-tiered systems of support, including universal, targeted, and intensive interventions.
- Collection of universal screening for social, emotional, and behavioral needs is a key component of multi-tiered systems of support.
- Universal interventions include school-wide positive behavior supports and social-emotional learning programs and all-staff training on suicide awareness and crisis response.
- Targeted interventions include small group counseling and/or social-emotional learning programs, multidisciplinary team meetings, and restorative approaches to discipline.
- Intensive interventions include individual counseling, safety planning, and individualized behavior support plans.

Elementary schools can play a crucial role in building students' capacities for emotion regulation, coping skills, and social problem-solving. These competencies guard against suicide risk over the lifespan. Schools can support families to develop strong family relationships, recognize early indicators of crisis, and seek mental health care. Elementary schools are uniquely positioned to foster resilience through multi-tiered universal, targeted, and intensive approaches to suicide prevention.

The following strategies are appropriate for both young children and early adolescents, though they should be tailored to the child's developmental level.

Universal Supports: Universal supports are designed to be implemented school-wide and are meant to prevent suicidal thoughts and behaviors before they occur. All children benefit from universal supports.

- Select and implement universal screening tools and procedures for identifying children at risk before a crisis occurs.
- Train educators, including all non-mental health staff, to identify warning signs and make appropriate referrals. Many suicide gate-keeper trainings exist, including QPR Gatekeeper Training for Suicide Prevention, Kognito Suicide Prevention Simulations-Educators, SOS Signs of Suicide, Sources of Strength, and Applied Suicide Intervention Skills Training (ASIST).

- Develop, maintain, and enforce up-to-date district and schoolwide anti-bullying policies and policies against discrimination and harassment.
- Implement evidence-based social-emotional learning (SEL) programs to build students' emotion regulation, inhibitory control, coping, and interpersonal skills. At the universal level, these interventions are designed to be implemented in classrooms by classroom teachers.
- Utilize school-wide positive behavior interventions and supports to foster a positive school climate. The Good Behavior Game is an effective classroom support tool with evidence for reducing suicidal thoughts over the long term (Kellam et al., 2011).
- Hire teams of professionals such as clinical social workers, school psychologists, nurses, and other staff who can support students holistically. Refer to school-based mental health professional associations for recommended staffing ratios.
- Strengthen families by educating parents and caregivers on social-emotional learning strategies, such as feelings identification, communication skills, adaptive coping skills, and strategies for emotion regulation. One example of an evidence-based program for supporting family relationships is the Strengthening Families Program.
- Develop multidisciplinary care teams to (a) review universal screening data, office discipline referral data, and other sources of evidence for social, emotional, and behavioral concerns, (b) develop networks with community-based psychological and medical professionals for referrals to community-based mental health services, and (c) make referrals for children according to their profiles.
- Develop effective and efficient referral pathways. Create partnerships with local agencies to support linkage to care and promote needed social services for families.
- Students play an essential role in keeping each other safe. Provide training for youth about how to recognize the warning signs of a crisis, identify trusted adults, and get help. Discuss the difference between "safe secrets" and "unsafe secrets." Make information about hotlines and chat resources readily available. Encourage students to identify trusted adults whom they can turn to with a problem or if they are worried about a friend.
- Support identity-affirming clubs and activities, such as Black Student Unions and Genders & Sexualities Alliances (GSA).
- Develop social media interaction plans. Monitor the social media posts of students for suicide-related content. Develop and communicate to students a procedure for school-based reporting of online social media posts involving safety concerns. Use social media to disseminate prevention resources.

Targeted Supports: Targeted supports should be in place to address the needs of youth who have risk factors for suicide, but who are not currently in crisis. Targeted supports are meant to be provided in addition to Universal Supports.

- With a multidisciplinary care team, implement a process for following up with any child who is identified by a universal screener. An appropriately-trained staff member should meet with the student to assess their needs, communicate with caregivers, and make referrals, as appropriate.
- Provide customized small group social-emotional interventions with credentialled and/or licensed mental health professionals to build coping skills. Use evidence-based social-emotional learning (SEL) approaches, as well as evidence-based therapeutic approaches such as cognitive-behavioral therapy and dialectical behavioral therapy. Refer to SAMHSA's Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts for details of specific therapeutic interventions.

- Engage with the child's family and network of caregiving support. Offer referrals for family therapy, especially to therapists using evidence-based approaches such as parent-child interaction therapy. Encourage caregivers to attend any family strengthening programs being offered by the school. Encourage caregivers to carefully monitor the child's well-being, including monitoring their behavior on social media.
- Take restorative approaches to student conflict and unkind behavior.

Intensive Supports: Intensive supports are necessary for children who have a history of suicidal ideation and/or are actively engaged in suicidal behavior. Intensive supports are customized and delivered on a one-to-one basis. They should be provided in addition to universal and targeted supports.

- With a school-based mental health professional, develop individual safety plans for any child currently presenting with suicidal ideation.
- Provide regular, ongoing therapeutic intervention using evidence-based approaches (e.g., cognitive behavioral therapy, dialectical behavior therapy) with a school-based mental health clinician. Refer to SAMHSA's Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts for details of specific therapeutic interventions.
- Provide referrals for community-based mental health services and follow-up to ensure that the referral resulted in service access. Whenever possible, provide a "warm connection," accompanying the child to the next step in care.
- Build relationships with community groups providing culturally specific and linguistically appropriate services.
- Recommend the child's caregiver immediately seek an appointment with the child's primary medical care provider, who will provide referrals to other medical providers as appropriate.
- Make an individualized plan for preventing and responding to challenging behaviors and/or mental health crises in school. An example of a trauma-informed process is provided by Los Angeles Unified School District.
- Carefully monitor media use for suicide-related statements and interaction with suicide-related content.
- If the child's suicidal thoughts and behaviors are interfering with their ability to benefit from public education, consider referring the child for an assessment for special education supports and services. Of course, not all children with mental health needs require special education to learn and grow in school.
- If a child is hospitalized, hold a multidisciplinary team meeting to support their reentry to school. Make accommodations to their course schedule and course-related assignments as needed to support their transition and monitor stress levels. Children may need to return on a reduced schedule, gradually increasing to a full day. Missed assignments may need to be modified to support the child's ability to reenter without overwhelming pressure. An example of re-entry planning is provided by Oregon's Willamette Education Services District.

How Should Elementary Schools Respond When Children And Early Adolescents Reveal Suicidal Thoughts And Behaviors?

Key Points

- Prepare in advance by understanding your role as a mandated reporter.
- All educators can be supportive by recognizing signs of STBs in children; however, only trained professionals should perform risk assessments.
- Before discussing any suicidal thoughts or behaviors, clearly state the limits of confidentiality. Remind the student that to keep them safe, you may need to get help.
- Use a calm, non-judgmental tone when asking questions about suicide. Emphasize that the student is not in trouble and you're glad they're coming to you for help.
- Depending on the child's age and developmental level, you may have to rephrase questions in different ways to ensure understanding. Be mindful not to ask leading questions but instead focus on open-ended prompts.
- Educators should take care to monitor their emotional reactions while speaking with the young person.
- Use calm, matter-of-fact language and communicate nonjudgmental curiosity.
- Avoid lectures, shaming, or guilt trips.
- Remind the student that they are not in trouble and that you're glad they reached out for support.

Suicide risk may come to our attention in a variety of ways, including direct statements, notes, pictures, or as reported by a classmate or parent. Even seemingly casual statements or jokes should be assessed thoroughly and can provide a teachable moment about using safe language. Schools should regularly review protocols so that both employees and students know how to report safety concerns.

School adults should be aware of the state and local policies that apply to them, especially policies related to child welfare. School adults should never promise to keep safety concerns a secret. As **mandated reporters**, educators must remind students early on that there are limits to confidentiality. If a child is experiencing suicidal ideation, most state law requires schools to notify parents. If a child is at imminent risk of harming themselves or others, schools have the responsibility to connect them to emergency psychiatric or medical care.

Use developmentally appropriate language to assess the child's understanding of death and suicide, conceptualize what is causing them distress, and express hope for a safe resolution. Take care to

avoid leading questions and be prepared to ask questions in multiple ways to ensure understanding. Here are some questions to consider:

- "_______ was worried about you and came to me for help. They said that you were talking about killing yourself. You're not in trouble and I'm not mad. I really care about you. Can you tell me what happened?"
- "Are you having thoughts of hurting yourself or killing yourself now?"
- "What does it mean to die? If you die, can you come back or is it forever?"
- "What are you thinking about doing to kill yourself?"
- "What is making you so upset that you want to hurt yourself?"
- "How long have you been feeling this way?" [clarify time points using concrete, child-friendly language, like "before winter break" or "before 2nd grade"]
- "Have you ever tried to hurt/kill yourself before? When was that?" [clarify time points using concrete, child-friendly language]
- "If you [describe a child's plan, e.g., stab yourself in the stomach], what do you think would happen next?"
- "I want to make sure you're safe. If I hear that you could be in danger, it's my job to get you help. Have you talked to (parent/guardian) about this? Let's talk to them together."

Safety Plans

Key Points:

- Any student having suicidal thoughts and behaviors should have a safety plan.
- Safety plans help students and their support system recognize warning signs of a crisis, make the environment as safe as possible, promote safe coping skills, identify trusted adults who can help, and link to appropriate community resources.

Any child experiencing suicidal ideation should be assessed by a mental health professional. If a student may be at imminent risk of harm to themself or others, supervise the student closely and arrange for a psychiatric evaluation at a nearby hospital. If a student's risk of suicide is low, create a safety plan that identifies triggers, coping skills, trusted adults, and emergency numbers. Maintain a list of mental health referrals for families in your community. This may include suicide prevention hotlines, your local department of mental health, nearby free or low-cost clinics, and any crisis services available in your community.

A thorough **safety plan** should include securing the student's environment relative to their risk. If the student has self-injured at school, increase supervision. If they have been displaying risky behavior, such as climbing on high structures, reduce their access to heights. Here are some other examples:

- If possible and relevant, change their classroom from upstairs to downstairs
- Have an adult escort them for bathroom breaks or have them use the nurse's restroom
- Restrict their access to sharp objects, such as scissors and pencil sharpeners
- To ensure that no self-injury-producing objects are transported to or from school, ask caregivers to look through their backpack before and after school
- Provide structured activities for recess, such as board games or "lunch bunch" with a trusted adult

Counsel parents/guardians to make the home environment as safe as possible, as well. The most common method of child suicide is hanging or suffocation, followed by the use of firearms. Every family of any suicidal child should be asked if there are guns in the home and advised of the risk. It is best to encourage them to remove guns from their home during the crisis. At a minimum, ensure that they lock and store the gun and ammunition separately. Other things that can make the environment safer include:

- Do not leave the child alone in non-supervised rooms
- Secure all medications in a lockbox
- Remove guns or other weapons from the home
- Lock up knives or sharp objects
- Have children keep doors open
- Ensure adequate supervision by trusted adults

The safety plan should be reviewed and agreed to by the child, caregiver, and school site. It may include regular check-ins with trusted school staff or school-based counseling. If ongoing mental health conditions are impacting a child's access to education, consider a referral for a psychoeducational assessment or develop a 504 Plan. In this case, consult with the school's special education team.

Educate parents and caregivers about risk and protective factors for suicide, warning signs of a crisis, and how to get help if they're worried about their child. Model how to ask children direct questions about suicide risk, such as:

- "I know you've been really sad. Sometimes when people are super sad, they have thoughts about hurting themself. Have you ever thought about hurting yourself?"
- "Have you ever done anything to hurt yourself?" If so, "What did you do?"
- "What is making you so upset that you're wanting to die? What do you wish was different?"
- "You must have been feeling really bad to do that/have those thoughts. I'm so glad you're telling me about it."
- "I believe that we can solve these problems together. I'm going to find us some help because I know things can get better."

Help break the silence about suicide and combat the stigma related to seeking help. Host parent workshops about suicide awareness and prevention and build partnerships with community groups that can offer enrichment and wellness programming to your school community. Maintain a list of culturally responsive mental health providers in your local region and refer children, as necessary.

Peer-to-Peer Referral Supports

Key Points:

- As part of a broader social-emotional learning program, schools should teach students about the difference between typical emotional states and warning signs of a crisis.
- Encourage students to identify trusted adults they can go to if they're worried about a friend.
- Provide anonymous reporting avenues and advertise them widely.

As part of a broader social-emotional learning program, schools should teach children how to seek help if they're worried about a friend or peer. Schools can raise awareness about distinguishing typical emotional ups and downs from warning signs of a mental health crisis. Review safe coping skills and

help students identify trusted adults at school and in their community. Discuss the difference between safe secrets (what you got someone for their birthday) and unsafe ones (if a friend could get hurt). Some suicide prevention programs are designed to train peers to notice and report signs of suicide. Kognito Suicide Prevention Simulations-Friend2Friend is designed for youth as young as age 13.

Talking to parents and caregivers about their child's suicide risk

Key Points:

- Notify parents and caregivers of any warning signs of suicidal ideation or behaviors.
- Emphasize that their child is not in trouble and reiterate your desire to support the family.
- Connect families to community resources, such as medical and mental health care providers.

After gathering information and securing the student's safety, schools should refer to the child's approved contact information to notify the parent or legal guardian of the concern. Exceptions include if there is reasonable suspicion of child abuse or that informing the caregiver would put the child in danger. In this case, educators should refer to their local child abuse and neglect reporting requirements.

Be prepared to communicate clearly with parents and caregivers. Engage language interpreters and cultural brokers to ensure your communication is effective. Some parents may not be surprised and may acknowledge that their child has expressed similar sentiments at home. Others may be shocked and frightened. Parents' and caregivers' fear and concern may be expressed in a variety of ways, including disbelief, anger, or denial. Caregiver responses may also vary by cultural norms tied to geographic region, race, ethnicity, and/or language. When talking to parents, take a non-judgmental stance, and emphasize that the child is currently safe and supervised. Share the information about how you became aware of the suicidal ideation or behavior and the results of your assessment.

Encourage parents and caregivers to take time to express their difficult emotions before engaging directly with their child. Emphasize that their child is not in trouble and that you're glad they are being open about their suicidal ideation. Be mindful of the stigma and fear surrounding conversations about suicide. Reassure parents that there are effective supports available and underscore your desire to connect their child to resources.

Family beliefs about suicide vary widely. It is helpful to ask parents open, non-judgmental questions about how they understand their child's feelings or behaviors. They may express religious or spiritual beliefs about suicide that will inform their response. Gather information respectfully and provide education about suicide risk without judgment. Some examples include:

- " I can imagine how it could be scary to get a call like this. I want to reassure you that ____ is safe and being supervised."
- "It may be a shock to hear that…."
- "Sometimes children let us know that something is bothering them through their behavior. ______ was acting differently than usual, so I asked them if anything was wrong."

Caregivers are uniquely positioned to share relevant information about changes in their child's mood, behavior, sleeping or eating patterns, and/or relationships. However, families may be wary of referrals for mental health services. Historically, many marginalized groups such as BIPOC communities,

individuals with disabilities, LGBTQ+ people, immigrants, and others, have experienced abuse, neglect, and discrimination in healthcare systems. Parents may worry that their child will be diagnosed, labeled, or medicated without their consent.

They may also fear that their child will be removed from the home. It's important to remind parents that you're there to help find support for the child/family, while also being transparent about the limits of confidentiality. If parents and/or caregivers share something that requires a child abuse or neglect report, let them know that you will need to get additional help. Most families will be open to some sort of referral or services; however, in circumstances where a child is experiencing suicide risk and the parent is not seeking treatment and/or able to keep the child safe, consultation with a child welfare agency may be indicated.

Parents and caregivers are a child's most powerful protective factor. Of course, many parents and caregivers are spread thin between work, caregiving, health, and other responsibilities. Help parents and caregivers access the resources and support they need to spend quality time with their child, supervise them appropriately, respond to their needs, and ask for help when needed. Appropriate referrals may include the child's primary care physician, a mental health professional, mentoring programs, extracurricular activities, or youth groups. By providing stigma-free, culturally responsive support, educators are positioned to affirm and encourage families as they work to protect their children from harm.

Maintaining Records of STB Interventions

Key Points:

- Determine in advance what information will be documented and how such information will be stored regarding STB interventions for individual students.
- Prioritize student privacy at all times. Do not keep STB intervention records in a child's cumulative academic file.

Given the sensitive nature of suicide interventions, take care to protect the child's privacy. Carefully follow school district procedures for maintaining records. Suicide risk assessments and safety plans are confidential and should only be shared on a need-to-know basis. Documentation should be kept in a separate, locked file and not as part of the student's cumulative education record. Incident reports or documentation in pupil records should include the minimum necessary information.

Personal information about a student's mental health is protected under the Family Education Rights Protection Act (FERPA). Information should be shared with staff on a strictly need-to-know basis. Schools should not discuss a child's mental health with other students or families except in specific circumstances where the student and family have given written consent.

HIPAA does not typically apply to schools. An exception is when a healthcare provider is delivering a service on school grounds which will result in medical billing. This may occur if a health center is present on school grounds. If integrating healthcare professionals is part of your school's suicide prevention plan, considerations for HIPAA should be made in advance.

Guidance regarding FERPA and HIPAA can be found at the U.S. Department of Education.

Special Considerations for Children with Disabilities

Key Points:

- When intervening for STBs, determine whether the child has an Individualized Education Plan (IEP).
- If the child has an IEP, engage the child's IEP case manager. An IEP meeting may be necessary to determine whether additional special education-related supports and services are necessary to support the child to meet their IEP goals.

Individuals with disabilities are at a higher risk of STBs than their non-disabled peers (Moses, 2018). Special considerations must be made if a child with a disability engages in STBs. Many children with disabilities haveIEPs, for which they are assigned a case manager. If an intervention for STB occurs, determine whether the child has an IEP. If they do have an IEP, the child's special education case manager should be engaged. The STB may be considered to be related to the child's disability, and an IEP team meeting may be necessary to ensure that the behavior is properly addressed in the child's IEP. Accommodations, modifications, and related supports and services may need to be added to the child's IEP to support their ability to meet their IEP goals.

Addressing Challenging Behaviors at School

Key Points:

- Children experiencing mental health crises often show their distress through their behavior. Schools should take care to respond therapeutically and restoratively, rather than punitively.
- All children benefit from clear, consistent limits. Utilize restorative practices to help students learn from their mistakes, take accountability, and repair any harm caused.
- Students with a history of suicidal thoughts or behaviors should be closely supervised after incidences of school discipline.

Children often show their mental and emotional distress through their behavior. Children at risk of suicide are more likely to struggle with impulsivity and emotion regulation. If a child with known suicide risk exhibits challenging, disruptive, or unkind behavior, take care in determining the appropriate response. All children benefit from clear expectations and consistent limits. Challenging behaviors should be viewed in the context of the child's circumstances. Discipline at school often causes discord between the child and parent/caregivers and may add to punishment that involves social isolation (Ruch et al., 2021). Research into case files of children who have died by suicide suggests that school-based discipline is a common precipitant of death by suicide.

It is therefore best not to assign out-of-school suspensions to children with suicide risk. Instead, use therapeutic, skill-building alternatives to school exclusion. When discussing challenging behaviors with the caregivers of children at risk of suicide, emphasize what the child has done to learn from the behavior and describe positive, skill-building supports the parent can provide. Emphasize that the child should not be left alone, or unsupervised.

Case Scenarios: Preparing To Respond

Good preparation is key to the prevention of STBs. To assist elementary school personnel in planning their policies and procedures, four scenarios are offered below. Consider working in small multi-disciplinary groups to read each scenario and discuss the guiding questions provided. By thinking through the complexities of these situations as a team, you may find that you surface opportunities for improving and expanding your prevention and intervention supports.

Scenario #1: Leilani

Leilani is a 3rd-grader who is new to your school. She and her mother live in a nearby transitional living shelter. Her mother's work schedule prevents her from attending in-person school activities; however, she stays in close communication with Leilani's teacher. Leilani participates in the after-school program. While she has always been quiet, she appears increasingly withdrawn and sad. Instead of playing four square like she used to, she's taken to drawing alone. An employee of the after-school program checks on her one day and asks to see her picture. She shows a gruesome image of a girl with blood coming out of her eyes. When the employee asks her about it, she says "This is me."

Guiding questions:

- What are some of the risk factors or warning signs in this scenario?
- What are some of the protective factors?
- What steps should be taken to assess the risk?

Example resolution:

The after-school employee sat down and asked Leilani to tell her more about the picture. Leilani shared that she has been having disturbing dreams and difficulty sleeping ever since moving into the shelter. She said that she wishes she were dead so that the nightmares would stop. When asked if she had plans of killing herself, she stated that she wanted to go to sleep and never wake up. The after-school employee told Leilani that she cared about her and needed to make sure she was safe. They met with her mother, who disclosed that they were in a shelter for survivors of domestic violence. She informed the school that Leilani is receiving individual and family therapy. They developed a safety plan, which included signing a release of information so that the outside therapist and school social worker could consult. The plan outlined trusted adults that Leilani could check in with during the school day and in the after-school program. The after-school program provided additional support to facilitate Leilani's participation in activities and help her get to know other children.

Scenario #2: Paris

Paris is a 5th-grade student who has been at your school since kindergarten. Over the years, Paris has struggled with attention and impulsivity in class and in the yard. His current teacher has a strict "no tolerance" discipline policy in her classroom and Paris is often sent to the office. One day, Paris storms into the office and turns over some chairs. He yells, "I hate this place- I want to kill all of them!"

Guiding Questions:

- What are some possible factors that contributed to this crisis point?
- What questions would help you understand Paris's risk of harm to himself or others?
- What are some immediate steps that you could take to ensure safety?

Example Resolution:

The principal came out of his office and calmly thanked Paris for coming to him for help. He said, "Something really hard must have happened to make you feel so bad." Paris broke down crying and shared that his teacher had just told him he couldn't go to the 5th-grade picnic because he hadn't completed his science project. "It's not fair, she just doesn't like me. She's always picking on me," he cried. The principal asked Paris if he was feeling like hurting someone and he replied, "No, I just think it would be better if I disappeared." After determining that the student was not planning to harm himself or others, the principal created a safety plan with Paris, his parents, and his grandmother. They identified that many of the triggers to Paris's despair occurred in the classroom or yard. It became clear that Paris was experiencing anti-Black bullying from peers and the staff was not effectively intervening. The principal convened a School Climate Committee, which developed a plan to address school-wide positive behavior supports, provide staff training on implicit bias and anti-bias education practices, and promote values of inclusivity, equity, and justice on campus. A multidisciplinary team met with Paris and his family to develop a plan to check in regularly with Paris and ensure the behavior has stopped. The school social worker included Paris in a social skills group which provided Paris with a smaller group of peers to build relationships with and support problem-solving, communication, and emotion regulation skills.

Scenario #3: Valentina

Valentina is a kindergartener new to the United States. She speaks Spanish and a Mayan language called Q'anjob'al. She comes to school crying in the mornings and constantly asks for her mother. She complains of frequent stomachaches and asks to go to the nurse several days per week. One day, her teacher notices that she's digging her fingernails into her arm hard enough to break the skin.

Guiding Questions:

- What are some possible risk factors?
- How can you best assess Valentina's safety?
- What are some important developmental considerations?

Example Resolution:

The teacher called the office and asked for assistance in the classroom. After being examined by the nurse, Valentina met with the school psychologist while a Spanish-speaking staff member interpreted. Valentina said that she was scared and wanted to be with her mother. She repeated that she wanted to go home. When the school psychologist spoke to the mother, she learned that Valentina's family had been separated at the border and spent a month in an immigrant detention facility. Ever since Valentina has been having difficulty eating and sleeping. The school psychologist obtained consent to meet with Valentina to practice relaxation strategies. She also included Valentina in a small lunch bunch to help her make friends. The family was linked to a nearby community mental health agency, which provided trauma treatment for the whole family in their languages. The school psychologist and mother checked in regularly to monitor Valentina's adjustment.

Scenario #4: Alex

Two students come to the office with a note that they found the bathroom. The note says "I hate my life. I just want to be me." They report that it was written by a 5th grader named Alex. Alex is an autistic student who was designated female at birth. Although Alex's parents use "she/her" pronouns for Alex, Alex has made it clear that they prefer the pronouns "they/them."

Guiding Questions:

- How might you approach Alex about the note?
- How could you speak to the other two students about the note?
- What are other important considerations?

Example Resolution:

The school social worker asked to speak to Alex and assured them that they were not in trouble. She showed them the note and stated that a couple of classmates were concerned. Alex acknowledged that they wrote the note. They explained that they were sick of everyone teasing them about how they talked and look. They say that their parents don't understand them and they would be better off dead. When asked if they had plans of killing themself, they share that they have a rope and plan to hang themself. The social worker told Alex that she cared about them and wanted to help him stay safe. They discussed some of the things that caused the suicidal ideation and many of them related to their parents' response to their gender identity. Alex agreed to the social worker speaking to the parents about gender identity and offering support and resources. The social worker arranged for the local psychiatric crisis team to assess Alex at the school. They ultimately recommended hospitalization and referred the parents to family therapy and support groups for parents of LGBTQ+ youth.

A Call To Action And Related Resources

Educators do tremendous good in the lives of children. In addition to amplifying the strengths and assets of the children in their schools, they work diligently to prevent them from harm. As rates of STBs increase among young children and preteens, elementary school educators seek best-practice guidance to prevent and respond effectively when STBs occur. By becoming knowledgeable and confident in their ability to respond, and by contributing to schoolwide efforts to build prevention and intervention systems, educators can limit the impact of STBs on the lives of the children in their communities.

Related Resources

24/7 Hotlines

- National Suicide Prevention Lifeline: (800) 273-TALK (8255) or dial 988
- The Trevor Project (LGBTQ+ youth): (866) 488-7386
- National Domestic Violence Hotline: (800) 799-7233
- Childhelp National Child Abuse Hotline: (800) 422-4453

24/7 Text and Chat Lines

- Crisis Text Line: Text HOME to 741741
- Lifeline Chat: www.suicidepreventionlifeline.org/chat

More Resources

- Preventing Suicide: Guidelines for Administrators and Crisis Teams, National Association of School Psychologists
- Children and Suicide, Centre for Suicide Prevention
- Sounding the alarm on black youth suicide, American Psychological Association
- AAPI Heritage Month: We Aren't Doing Enough to Help AAPI Youth, National Council for Mental Wellbeing
- Suicide Prevention in Indigenous Communities, NAMI: National Alliance on Mental Illness
- LGBTQ Youth Suicide Prevention in Schools, The Trevor Project
- Preventing Youth Suicide: Tips for Parents & Educators, National Association of School Psychologists
- Choosing a Suicide Prevention Gatekeeper Training Program: A Comparison Table, Suicide Prevention Resource Center

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