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Supporting Utah's Parents in Preventing Adolescent Suicide: A Literature Review and Handouts for Utah's Youth Suicide Prevention Manual

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Supporting Utah's Parents in Preventing Adolescent Suicide: A Literature Review

and Handouts for Utah's Youth Suicide Prevention Manual

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ABSTRACT

Supporting Utah's Parents in Preventing Adolescent Suicide: A Literature Review
and Handouts for Utah's Youth Suicide Prevention Manual

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Suicide, a public health problem on a global scale, has become the focus in many domains across the United States. With the recent push to provide solutions to the adolescent suicide rate in the U.S., the school setting has become an important venue for prevention and intervention efforts. While there are many risk and protective factors, the majority of suicide completions are concurrent with psychiatric disorders among adolescents; as such, this is an area that warrants further investigation. Additionally, school resources are often overwhelmed by the magnitude of need among the student population; therefore, effective interventions must be identified that can feasibly be implemented in the schools. Research has suggested that parent-adolescent relationships are key in the prevention of suicide, yet minimal research has been conducted towards promoting healthy parent-adolescent relationships for at-risk adolescents. Additionally, some research suggests that school and community interventions are only more effective than parental support when negative parent-adolescent relationships are present. This implies that fostering parental support should be a top priority in school-based suicide prevention efforts. This literature review identifies and summarizes pertinent scholarly research and resources for schools to better support parents of adolescents who struggle with suicidal thoughts and previous attempted suicides. As part of an intervention plan which increases home/school collaboration in adolescent suicide prevention, handouts were developed for parents (found in the appendix), which include information on warning signs of suicide, risk factors for suicide, and methods of responding to suicidality. After adapting these handouts to best meet their students' needs, school-based mental health professionals may consider including these handouts in their school's crisis plan and suicide prevention efforts.

Keywords: suicide, suicide prevention, suicide attempt, suicide risk factors, warning signs, adolescent, school, family, mental health, parent support

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Introduction

On July 28, 1999, *The Surgeon General's Call to Action to Prevent Suicide* was issued to provide possible solutions, promote research, and encourage the development of programs to prevent suicide in the United States (U.S. Public Health Service, 2001). This call to action cited three main overarching categories which include (a) increasing public awareness of suicide and the risk factors associated with suicide; (b) focusing on intervention by increasing access to clinical and community support services; and (c) strengthening research methodology to advance the research basis for suicide prevention (U.S. Public Health Service, 2001).

Among U.S. adolescents, suicide is the third leading cause of death (Gould, Greenberg, Velting, & Shaffer, 2003), accounting for over 4,000 deaths per year for youth between the ages of 10 and 24 (Centers for Disease Control and Prevention [CDC], 2009). However, suicide completion rates fail to capture the pervasiveness of this problem, as suicide attempts greatly outnumber suicide completions. It is estimated that there are 25 to 100 suicide attempts for each completed suicide (CDC, 2009; Moskos, Achilles, & Gray, 2004; National Institute of Mental Health [NIMH], 2009)—with nearly 150,000 youth receiving medical treatment each year for injuries sustained in suicide attempts (CDC, 2009).

Youth Suicide in Utah

Utah had the 12th highest suicide rate among adolescents from 2005-2009, with 22 teens (ages 15-19) completing suicide per year, making suicide the second leading cause of death among this age group (Utah Department of Health, 2011). Similar to national data, Utah males are more likely to complete suicide, though females are more likely to attempt suicide (National Alliance on Mental Illness [NAMI], n.d.; NIMH, 2009; Utah Department of Health, n.d.). On average, two adolescents, ages 15-19, receive emergency medical care for a suicide attempt per day (Utah Department of Health, 2011).

The suicide rates among adolescents in Utah indicate that over 60% of suicide completions were concurrent with a previously diagnosed psychiatric disorder (Utah Department of Health, n.d.), when compared with roughly a 90% comorbidity rate with a previously diagnosed psychiatric disorder nationwide (Gibbons, Hur, Bhaumik, & Mann, 2006).

School-based Suicide Prevention and Intervention

Because of the high rate of suicide attempts and completions among adolescents, there is an immediate need for schools to implement research-based screening and referral plans that address both suicide prevention and intervention (Miller, Eckert, & Mazza, 2009). Over the past several decades schools have struggled in addressing this urgent need to implement school programs that aid in the prevention of youth suicide (Lieberman, Poland, & Cassel, 2008; Miller, 2011; U.S. Public Health Service, 2001). Hallfors et al. (2006) found that current screening measures identify nearly 30% of high school students, overwhelming school resources and, consequently, reducing the likelihood of school implementation of these screeners. Because of these findings, it was suggested that screening measures must specifically and simply identify students at greatest risk for suicide in order to realistically implement and guide prevention and intervention efforts in the schools (Hallfors et al., 2006; Miller, 2011).

Utah schools have a higher student-to-teacher ratio and lower funds per student than the national average; this increases the level of difficulty for providing additional services to students. While the national student/teacher ratio for 2007 was 15.5, Utah schools had the highest student/teacher ratio in the nation, with 23.7 students per teacher. In the same year, the national spending average per student was $9,683; in Utah, the average was $5,706 per student (National Center for Education Statistics [NCES], 2009). Therefore, prevention and intervention efforts need to balance strategies and programs that are highly effective and low-cost.

Home/school collaboration. 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). In the U.S. during 2002, only five suicides were completed at school, compared to 1,772 suicides completed away from school (DeVoe et al., 2005). These statistics, combined with data indicating that family and community support strengthen protective factors, are important considerations in reducing youth suicide risk (U.S. Public Health Service, 2001; Utah Department of Health, n.d.; World Health Organization [WHO], 2000). In order to reduce youth suicide risk factors and increase protective factors—moving beyond merely *considering* family and community support—schools must *promote* family and community support (LeBlanc, Lazear, & Roggenbaum, 2012).

The need for the development of home/school collaborative efforts to decrease adolescent suicide risk has been suggested by several studies and may directly answer the deficit of school resources when addressing such a large need in the schools (LeBlanc et al., 2012). Speaker and Petersen (2000) developed a model for reducing violence and suicide in the schools, with increasing family involvement as a key component of the model. Moskos, Olson, Halbern, Keller, and Gray (2005) identified the need for training parents and friends of adolescents to identify "significant emotional and behavioral symptoms often associated with risk for suicide" (p. 542). Connor and Rueter (2006) found that adolescent report of suicide ideation decreased as perceptions of support from parents increased.

In another study, Randell, Wang, Herting, and Eggert (2006) suggested that increasing school-parental collaboration may help parents provide the support teens perceive as helpful when dealing with suicidal ideation. Kalafat (2003) found that school interventions that target the entire student population have overwhelmed school resources; he further suggested that

implementing general prevention programs that target protective factors, including connections with school and family, could address large numbers of students in need without reducing effectiveness. Because family and community support are one of the protective factors against suicide (U.S. Public Health Service, 2001; Utah Department of Health, n.d.; WHO, 2000), it is essential for schools to promote family support for students and identify best practices in supporting families.

Parent support in Utah's Youth Suicide Prevention Manual. A new Youth Suicide Prevention Manual is being developed for the state of Utah (G. Hudnall, personal communication, December 9, 2009). The committee responsible for researching and developing this manual includes community and school-based mental health professions, school personnel, and parents. This committee expressed the need for information that can be given to parents regarding warning signs of suicide, how to respond to suicidal thoughts or attempts, and information on risk factors, such as mental illness. Lack of information in this area has been noted in current state prevention manuals by the head of Utah's Youth Suicide Prevention Task Force (G. Hudnall, personal communication, December 9, 2009). Based on this observed need, Utah's Youth Suicide Prevention Task Force intends to include parent handouts as part of the state manual. As an integral part of suicide prevention efforts, supporting parents and providing them with basic information will better support parents in addressing youth suicidal ideation and attempts.

Based on a review of the literature and considering feedback from the Utah Suicide Prevention Task Force, the following points were identified: Including parent information that addresses (a) basic information regarding suicidal ideation, attempts, and completion; (b) signs of youth suicide risks and how to respond to these signs; (c) where to access information on risk

factors for suicide (e.g., mental illness); (d) community resources for adolescents, their parents, and families; and (e) information for educators on collaborating with parents and families to improve suicide prevention efforts.

Purpose of this Study

A state-wide youth suicide prevention manual is currently being developed for Utah school districts. The purpose of this research was to summarize suicide prevention information for schools and parents and to incorporate this information into the state's suicide prevention plan. Prepared handouts are included in Appendix A and will be included in Utah's Youth Suicide Prevention Manual. The end-product—handouts—are based on current research and evidence-based practice but written in a way that is helpful and easily accessible to parents.

Literature Review

According to the National Institute of Mental Health (NIMH, 2009), in 2006, 1.3 out of every 100,000 children, ages 10-14, and 8.2 out of every 100,000 adolescents, ages 15-19, died by suicide. As such, suicide has been identified as the third leading cause of death for adolescents in the United States (CDC, 2009; Gould et al., 2003; National Adolescent Health Information Center [NAHIC], 2006; NAMI, n.d.; NIMH, 2009; Substance Abuse and Mental Health Services Administration [SAMHSA], 2007), with over 4,000 completions a year (CDC, 2009).

Even more alarming, however, are the sheer number of suicides attempted by youth each year. Although the number of suicide attempts is difficult to determine, as not every attempt may be treated in a hospital or accurately identified, it is estimated that for every suicide completion there are 25 suicide attempts by adolescents (CDC, 2009; NIMH, 2009). Studies have suggested that it is fairly common for adolescents to think about suicide (WHO, 2000), but every year in the United States, 20 out of 100 adolescents report seriously considering suicide (CDC, 2009; Gould et al., 2003; NAHIC, 2006; SAMHSA, 2007), 13 of whom make plans to attempt suicide (CDC, 2009; SAMHSA, 2007), and 8 of whom attempt suicide (CDC, 2009; Gould & Kramer, 2001; SAMHSA, 2007), "representing approximately 1 million teenagers, of whom nearly 700,000 receive medical attention for their attempt" (Gould et al., 2003, p. 286).

Youth Suicide in Utah

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average, two adolescents, ages 15-19, receive emergency medical care for a suicide attempt per day (Utah Department of Health, 2011). The suicide rates among adolescents in Utah indicated that over 60% of suicide completions were concurrent with a psychiatric disorder (Utah Department of Health, n.d.), when compared with roughly a 90% comorbidity rate with a psychiatric disorder nationwide (Gibbons, Hur, Bhaumik, & Mann, 2006). In order to create and implement effective prevention, intervention, and postvention strategies to reduce suicide, the problem must first be adequately defined and understood prior to exploring and identifying potential solutions.

Utah schools have a higher student-to-teacher ratio and lower funds per student than the national average; this increases the level of difficulty for providing additional services to students. While the national student/teacher ratio for 2007 was 15.5, Utah schools had the highest student/teacher ratio in the nation, with 23.7 students per teacher. In the same year, the national spending average per student was $9,683; in Utah, the average was $5,706 per student (National Center for Education Statistics [NCES], 2009). Therefore, prevention and intervention efforts need to balance strategies and programs that are highly effective and low-cost.

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moving beyond merely considering family and community support—schools must promote family and community support (LeBlanc et al., 2012).

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Suicide Risk Factors

There are several risk factors that have been associated with suicide ideology, attempts, and completions. Among these are gender, ethnicity, mental health concerns, family history and dynamics, prior suicide attempts, as well as others. Each of these factors will be discussed.

Gender. In the United States, females are significantly more likely to attempt suicide than their male counterparts; however, the reverse is true for suicide completions, as males are significantly more likely to complete suicide than their female counterparts (CDC, 2009; Gould et al., 2003; Moskos et al., 2004; NAHIC, 2006; NIMH, 2009; SAMHSA, 2007; Utah Department of Health, n.d.; WHO, 2000). Some studies suggest that suicidal ideation and planning are also more common among females (Gould et al., 2003).

Ethnicity. In the United States, the highest adolescent suicide rates are among the Native American and Inuit populations, followed closely by Caucasians of non-Hispanic descent (Gould et al., 2003; NAHIC, 2006; NIMH, 2009). The lowest completion rate of suicide is represented by the Asian and Pacific Islander population (Gould et al., 2003; NAHIC, 2006; NIMH, 2009).

Though there are different suicide rates reported among the Hispanic population (CDC, 2009; Gould et al., 2003; NIMH, 2009), it is suggested that the rate of suicide attempts is greater among Hispanics than their peers but that they have a generally low completion rate (CDC, 2009; Gould et al., 2003; NIMH, 2009; U.S. Public Health Service, 2001.).

Globally, indigenous populations are more likely to complete suicide than their non-native counterparts (WHO, 2000), which is similar to the rate of Native American and Inuit populations in the United States (see above). However, the suicide rates among male Caucasians of non-Hispanic origin account for most suicide deaths (Moskos et al., 2004; SAMHSA, 2007).

While the African American population has a generally low suicide completion rate, the completions among African American males is increasing (Miller & Eckert, 2009; NIMH, 2009; SAMHSA, 2007). Moskos et al. (2004) suggest that the suicide rate among this population "is increasing faster than any other ethnic group (p. 178).

Prior suicide attempts. One of the strongest predictor of a future suicide attempt or completion is a previous suicide attempt (CDC, 2009; Gould et al., 2003; NIMH, 2009; U.S. Public Health Service, 2001; SAMHSA, 2007; WHO, 2000). It is estimated that 25-35% of adolescents who complete suicide have had a previous suicide attempt (Gould et al., 2003).

History of adjudication. It has also been suggested that adjudicated youth and others who have been involved in the legal system show an increased risk for suicide (CDC, 2009; NIMH, 2009; U.S. Public Health Service, 2001; Utah Department of Health, n.d.; WHO, 2000). Gray et al. (2002) found that 63% of Utah youth who completed suicide had a connection to the Juvenile Justice System. Additionally, greater than 15% of adjudicated youth met the criteria for a mental disorder, which may increase risk for suicide among this adolescent population; as such, it has been suggested that mental health screenings and interventions should be an integral part of the services provided to adjudicated youth (Moskos, Halbern, Alder, Kim, & Gray, 2007).

Sexual orientation and gender identity. Some studies suggest that when adolescents who identify themselves as lesbian, gay, bisexual, transgender, or questioning (LGBTQ) experience family rejection, they report higher levels of suicidal ideation, suicide attempts, and completed suicides (Illinois Department of Public Health, n.d.; Ryan, Huebner, Diaz, & Sanchez, 2009; Suicide Prevention Resource Center [SPRC], 2008; Marshal et al., 2011). As many of these students report increased family and peer relational problems, they are also at greater risk for depression, a risk factor for suicidality (Kosciw, Grevtak, Diaz, & Bartkiewicz, 2010; Ryan

et al., 2009; SPRC, 2008). Because of the inverse link between family support and suicide, it has been suggested that fostering family support may help to reduce the risk of suicide for LGBTQ youth (Gay & Lesbian Alliance Against Defamation et al., 2011; Illinois Department of Health, n.d.; SPRC, 2008).

Mental health. Over 90% of youth who attempt or complete suicide have been diagnosed with one or more psychiatric disorders (Gould et al., 2003; Miller & Eckert, 2009; Moskos et al., 2004; NIMH, 2009). The disorders that are significantly associated with suicide ideation, attempts, and completion are depression, bipolar, anxiety disorders, alcohol and drug abuse, eating disorders, psychotic disorders, and panic attacks (CDC, 2009; Gould et al., 2003; NAMI, n.d.; NIMH, 2009; SAMHSA, 2007; WHO, 2000). Those adolescents with an affective disorder a more likely to attempt and complete suicide than those with other disorders (Gould et al., 2003), and the comorbidity of an affective disorder with substance abuse was consistently found among those who had attempted and completed suicide (Gould et al., 2003; NIMH, 2009; U.S. Public Health Service, 2001; SAMHSA, 2007).

Because of the high association of suicide with these mental health issues, it is believed that most instances of suicide are highly preventable if adolescents receive the right care from a health care professional (NAMI, n.d.; U.S. Public Health Service, 2001; Utah Department of Health, n.d.). Additionally, there has been a decrease of suicide completions in the last 10 years (CDC, 2009; Gould et al., 2003); this may be attributed to higher awareness among those working with adolescents (CDC, 2009) but may also be attributed to an increase in the use of psychiatric medications in therapy (Gould et al., 2003).

Family history and dynamics. There have been several notable family concerns that are suggested to be significant risk factors for suicide, among which are a family history of mental

illness (NIMH, 2009; WHO, 2000), family history of suicide (CDC, 2009; Moskos et al., 2004; SAMHSA, 2007; WHO, 2000), family rejection (Ryan et al., 2009; SPRC, 2008), and family violence (NIMH, 2009; Utah Department of Health, n.d.; WHO, 2000).

Some studies suggest that parent-child relationships with impaired communication or positive involvement are another significant risk factor (NAMI, n.d.; WHO, 2000). Others have suggested that, while this conflict does have a correlation with suicide attempts and completion, this may be related to the presence of a mental illness and may not be a significant risk factor for suicide after controlling for psychopathology (Gould et al., 2003, Moskos et al., 2004).

Protective Factors

While family conflict is considered a risk factor for suicide, family cohesion and support are considered to be protective factors against suicide (Gould et al., 2003; U.S. Public Health Service, 2001; Utah Department of Health, n.d.; WHO, 2000). "Students who described family life in terms of a high degree of mutual involvement, shared interests, and emotional support were 3.5 to 5.5 times less likely to be suicidal than were adolescents from less cohesive families who had the same levels of depression or life stress" (Gould et al., 2003, p. 394). One study found that survivors of suicide found familial relationships to be a resource for support (McMenamy, Jordan, & Mitchell, 2008). Another study even suggests that family relationships are more important than peer relationships in preventing suicide attempts (Chesley & Loring-McNulty, 2003).

Other factors that are associated with reduced risk for suicide are adolescents with good interpersonal skills, help-seeking behaviors, openness to new experiences and others' perspectives, social connections with community, and good relationships with peers and significant adults (WHO, 2000). Additionally, connections with a community of worship also

contribute to fewer attempts among students with suicidal ideation (Chesley & Loring-McNulty, 2003).

Prevention Approaches for Families

To date, the vast majority of youth suicide prevention programs are for implementation in the schools, in emergency rooms, and in treatment centers for psychological distress (Gould et al., 2003). However, as family members are in a position to be the first to notice the signs of suicidal ideation and may be the first responders to a suicide attempt (Gould et al., 2003), it is important to look at the prevention strategies that parents and family members can implement within the home. Families need to be informed in order to both watch for signs of suicidal ideation as well as have prevention plans in place (Barrero, 2008). This is not to say that families should be left on their own to prevent suicide (Miller & Eckert, 2009), but rather that they can implement specific strategies in conjunction with the strategies already in place in professional fields.

> The importance of parents in protecting against progressively increasing suicidal behavior underlines the need to evaluate and develop parent-adolescent relationship in prevention and intervention work. [Additionally], the interactive effects between social domains suggest that, in working with youth who are suicidal, it would likely be advantageous to explore ways in which the different support elements might be integrated. (Kidd et al., 2006, p. 393)

The importance of interventions for suicide attempts should not be overlooked as family members and other professionals are instrumental in unsuccessful suicide attempts (Chesley & Loring-McNulty, 2003). Especially in the domain of mental health, a suicide prevention program would educate parents and family members regarding mental illness and signs of

suicide. When speaking specifically about bipolar disorder, Miklowitz and Taylor (2006) suggest:

> If family members are educated about the nature, causes and precipitants of bipolar
> episodes; learn to identify and avert precipitants of suicidal impulses; and incorporate
> skills to improve communication and manage family conflict, the incidence of suicidal
> episodes among bipolar patients may diminish. (p. 641)

This idea is applicable across the entire mental health domain. Many studies have underscored the need to educate parents and family members about adolescent suicide—the signs to watch for and what to do if someone in their care expresses thoughts of suicide—in order to promote prevention and intervention strategies (Asarnow, Berk, & Baraff, 2009; Barrero, 2008; Kelly, Jorm, Kitchener, & Langlands, 2008; Kidd et al., 2006; Power et al., 2009; Sun & Long, 2008). However, few programs which focus on educating and treating the family as a whole have been implemented.

Specific intervention programs. In a study looking at the survivors of a suicide attempt, there were several factors that prevented them from repeating a suicide attempt, among which were personal relationships with family members, friends, or significant others. This study further suggests that the factors that help to prevent a repeat suicide attempt may be helpful for use as an intervention for adolescents who are at-risk for suicide (Chesley & Loring-McNulty, 2003).

Family Intervention for Suicide Prevention. Asarnow et al. (2009) conducted a study on the efficacy of the Family Intervention for Suicide Prevention (FISP) program, which was initially developed, using family systems theory and social learning theory, for emergency personnel to implement in the event of a suicide attempt within the context of the entire family.

The goals of this program are to help the family reframe the event as an episode of maladaptive coping or problem solving, to teach strategies for healthy coping and problem solving, and to promote and improve family communication. The focus is on strengthening the family system, rather than working with separate individuals (Asarnow et al., 2009). The underpinnings of this program are that suicide ideation and attempts can be reduced if the family is empowered. As most suicide attempts are among those with mental health problems, this program encourages further treatment.

FISP is divided into three response sections. The first is the general intervention care that they receive in the hospital or emergency department. The second is a therapy session with the family. In this step, the adolescent creates an emergency kit in which they put tangible reminders of reasons to live, the numbers of people they can contact, and other calming techniques that they can use whenever their emotional "temperature" is getting high. During this stage, adolescents also create a response plan for these emotional crises; the parents and family members all become familiar with the plan and are enabled to help the adolescent with executing this plan in an emergency. In addition to the plan the adolescent develops, parents and family members are also given different strategies they can implement to improve family communication and interactions. The third stage is the follow-up stage, in which

1. contact is made between the therapist and the adolescent to check-in with the client as well as to assure the client that the therapist is still available when needed,

2. a list of resources are given to the parents that they may contact for support or in an emergency, and

3. further psychological counseling is encouraged for the adolescents and/or further family counseling (Asarnow et al., 2009).

Supporting Parents and Carers (caregivers). While the FISP program focuses on family interventions on a holistic level, another program, the SPACE program (Supporting Parents and Carers), instead focuses on increasing parental reports of self-efficacy and relationship health with their at-risk adolescents. This program includes information on adolescent suicide (ideation, attempts, and completion), adolescent depression, medication (used to treat psychological disorders), increasing positive communication, creating suicide prevention plans, community resources, and the importance of parents practicing self-care. Participating parents reported lower levels of distress and higher levels of satisfaction both immediately following the termination of the group and at a follow-up six months later (Power et al., 2009).

Family-focused Treatment. Another program, the Family-Focused Treatment (FFT) model, consists of three different phases to educate family members of someone with bipolar disorder, specifically in working with the disorder and preventing suicide. The first phase is an educational section in which the family is taught about the disorder and different risk and protective factors associated with it. The family also learns about different medications and therapy options. This stage includes making a plan for emergency situations and suicide prevention; the family learns to recognize signs of mood shifts and emotional cues of escalating suicidal intentions. The second phase is a communication section in which families are taught strategies to improve communication and interactions between family members. The final phase is developed to help the family discover problem solving strategies for disagreements or problems (Miklowitz & Taylor, 2006).

Intervention strategies. Information is vital for families in the prevention of suicide, as they are the first line of defense against suicide. Four strategies have been suggested for family members in order to prevent suicide when it is being contemplated: a) never leave the person

alone, b) prevent access to materials for the chosen method, c) make all family members aware of the intention so they can help to prevent the suicide as well as give emotional support, d) contact a mental health practitioner for professional help (Barrero, 2008). It is important to note that asking questions is key in determining the adolescent's current level of risk for suicide (Barrero, 2008; Kelly et al., 2008).

A second theory developed for caring for people who attempt suicide may add to the previous intervention strategies. While this study was conducted in Taiwan, the implications of the study may be pertinent for families in the U.S. as well:

- Understand causal conditions (or reasons) that adolescents attempt suicide and watch for signs of these conditions.

- Understand the role of family beliefs about suicide and cultural stigma regarding suicide and those influences in help-seeking behavior. Create a safe home environment to promote suicide prevention.

- Develop a family climate with good coping strategies and strong support systems.

- Build strong family communication, develop a plan to prevent future suicide attempts, continually seek professional help when necessary, and foster compassion and hope.

- Implement a strategy for continual evaluation: if suicide ideation continues, search for causal conditions while maintaining prevention strategies and strengthening parent-child relationships (Sun & Long, 2008).

The core underlying principle in this theory is to prevent burn-out among the caregivers. This is influenced by seeking professional help and familial support; fostering positive parent-child relationships, communication, and interaction; and developing healthy patterns of problem

solving (Sun & Long, 2008). This correlates well with the FISP program, suggesting that appropriate self-care will also be essential in preventing burn-out, which is important as burn-out tended to allow an environment for additional attempts (Power et al., 2009; Sun & Long, 2008).

School-based Suicide Prevention Programs and Endeavors

The following section describes a variety of school-based suicide prevention efforts that consider family involvement. In particular, programs from the following states are highlighted: Oregon, Maine, Alaska, and Utah.

Oregon's RESPONSE system. Oregon has developed a suicide prevention program called RESPONSE that districts and schools have the option of adopting. This program requires the development of a Suicide Prevention Team, with each of the members receiving training and over-seeing specific responsibilities. In conjunction with organizing the team, a curriculum was developed to be delivered to students in four different lesson segments. The goals of these lessons are educating students regarding the signs and identification of suicide, developing help-seeking attitudes and behaviors, identifying what resources are available to the students, and demonstrating appropriate responses to peers with suicidal ideation. The third component of the RESPONSE program consists of a parent mailing explaining the curriculum to the parents of all incoming freshmen and an optional psycho-educational parent workshop (Youth Suicide Prevention Program, 2007).

The Maine Youth Suicide Prevention Program. This program developed and adopted within the state of Maine has four major components. The first is access to statewide prevention and resource centers, with mental health services being offered within the schools. The second is training Crisis Intervention Teams within the schools that are responsible for instructing all school personnel in suicide prevention measures and education. The third is a student

curriculum (delivered in health classes) that covers both risk-behaviors and increases help-seeking skills. The fourth initiative is educating the general public, especially parents, regarding how to reduce access to lethal means (Maine Department of Health & Human Services, n.d.).

  The Alaska Youth Suicide Prevention Project. While this is a state-wide initiative, there are several components that occur within the schools. This program divides services into three tiers: universal (whole communities), selective (high risk groups), and indicated (high risk individuals). On the universal level, they have school-based programs that educate youth and their parents regarding signs of suicide and appropriate responses to youth at risk for suicide. Additionally, educating the general public about mental illness and resources for treatments and how to restrict access to lethal means is included in this tier. One central focus of this program is to increase access to resources and collaboration between communities and professionals (Statewide Suicide Prevention Council, 2004).

  The Utah Suicide Prevention Plan. Utah schools have various suicide prevention and intervention plans across the state. In Provo (UT) School District, prevention efforts incorporate a peer mentor program in secondary schools. Students select members to serve on the HOPE Squad (Hold on. Persuade. Empower). The HOPE Squad meets once a month for training; they also plan school-wide suicide prevention activities (Moskos & Halbern, 2007). Additionally, brochures are made available in many schools to help families find resources in the community.

  Postvention strategies in some Utah schools consist of a Crisis Team that responds to a suicide by meeting with students and staff most affected by the suicide, meeting with parents, and in general helping the school to return to normalcy (Moskos & Halbern, 2007). Additionally, a support group for families (*Heart & Soul Survivors*) is available to help families access resources and support within the community.

Purpose of this Study

Considering the amount of time adolescents spend in school, schools have increasingly and appropriately been a site for suicide prevention initiatives (Miller & Eckert, 2009; U.S. Public Health Service, 2001). Although most adolescent suicides occur in the home (Miller & Eckert, 2009), very little is studied about home/school collaboration when it comes to preventing suicide. Studies have found that the majority of parents are unaware of their child's suicidal ideation (Miller & Eckert, 2009; Youth Suicide Prevention Program, 2007), and therefore, increasing collaboration and communication between schools and families can begin to address suicide prevention as schools help parents reduce access to lethal items and gain access to community resources (Maine Department of Health & Human Services, n.d.). There are several models and interventions for behavior that include home/school collaboration (Christenson, 2003; Cox, 2005; Crothers, Hughes, & Morine, 2008; Minke & Anderson, 2005), but this has not been generalized to suicide behaviors.

With the push for schools to "[increase] child and family services in schools that promote health and mental health" (Miller & Eckert, 2009, p. 162), it is reasonable that more should be done to increase home/school collaboration and communication in the effort to support families and adolescents with regards to suicide prevention. Not only should community collaboration be fostered in extending services and resources to families and adolescents (Miller & Eckert, 2009), it is important to establish suicide prevention procedures that involve "family members, peers, professionals, members of the community, schools and school psychologists…." (Miller & Eckert, 2009, p. 163). As one study found that parental and school involvement and relationships were particularly helpful in preventing suicide among adolescent males who had previously attempted suicide, especially where peer relations were low (Kidd et al., 2006),

developing a program in which schools and parents collaborate to prevent suicide should be a high priority.

A state-wide youth suicide prevention manual is currently being developed for Utah school districts. The purpose of this research was to summarize suicide prevention information for schools and parents, incorporating this information into the state's suicide prevention plan. The prepared handouts are included in Appendix A and will be included in Utah's Youth Suicide Prevention Manual. As the majority of adolescents who attempt suicide have mental illness (Gould et al., 2003), "the most common of which are mood disorders" (Miller & Eckert, 2009, p. 157), handouts include information for parents of adolescents with mood disorders, especially bipolar disorder and depression. The end-product— handouts— are based on current research and evidence-based practice, but written in a way that is helpful and easily accessible to parents.

A review of the literature and an exploration of local, state, and national resources were conducted to help prepare the handouts included in Appendix A. These handouts help schools strengthen support for parents by providing answers to the following questions:

1. Where can parents access information on suicide ideation, attempts, and completion?

2. What signs of suicide can parents watch for and how can they respond appropriately to suicidal ideation?

3. Where can parents access information on risk factors for suicide, such as mental illness?

4. What community resources are available for adolescents and their parents and families?

5. What information is available to educators on collaborating with parents and families to improve suicide prevention efforts?

Method

        This study involved a review of the literature on the topic of parental support in preventing adolescent suicide. Scholarly literature and model state-wide prevention programs were systematically reviewed.

Collecting Materials Based on Criteria for Inclusion

        Articles and pamphlets were selected from reputable resources with current, research-based information (determined by dates of publication for articles or the last revised date for online PDF documents). Studies selected had to be accessible to parents, based on availability online (could be downloaded for free by the general public) and appropriate reading level. Information from sites that were not research based was excluded; these included personal, anecdotal experiences or advice from non-professional sources (such as blogs).

        Basic criteria for inclusion were that the study/article (a) was available online to increase accessibility for parents and school personnel, and that it (b) provided information regarding adolescent suicide, warning signs of suicide, how parents can respond to suicidality, and how schools can increase parental support as part of a suicide prevention program.

        Data were collected from online sources. First, abstracts retrieved from PsycINFO or Google Scholar were reviewed to identify articles that addressed one or more of the research questions. In these searches, the phrase *adolescent suicide* was crossed with *parent support, school support,* and specific mental illnesses that were identified as high risk factors (*bipolar, bipolar disorder, depression, mood disorder*). If the full articles were not available online, those articles were not included as part of the study. Second, additional data were sought by using a search engine (Google) to find current school suicide prevention programs that included information for parents and information for schools on increasing parental support. Primary search phrases included *youth suicide* and *school-based suicide prevention*. The following

search terms and phrases were included with the primary search phrases: *parent support; school resources to support parents; parent handouts; parent involvement in suicide prevention; school and parent collaboration in suicide prevention*; and *improving parent and youth communication*.

Sorting Materials to Align with Pre-Specified Questions

After the collection phase, data were grouped based on pre-specified questions previously listed in the introduction: (a) Where can parents access information on suicide ideation, attempts, and completion? (b) What signs of suicide can parents watch for and how can they respond appropriately to suicidal ideation? (c) Where can parents access information on risk factors for suicide, such as mental illness? (d) What community resources are available for adolescents and their parents and families? (e) What information is available to educators on collaborating with parents and families to improve suicide prevention efforts?

Creating Handouts

Grouped data were then summarized and listed on separate handouts with the online reference (URL) from which the full articles could be retrieved by parents or school personnel for additional information. The purpose of these handouts was to better support parents in preventing youth suicide. These handouts contain basic and easy-to-understand information for parents regarding warning signs of suicide; steps to take if it is suspected that an adolescent may be considering or planning suicide; and information regarding mental illness, a risk factor for suicide. Community resources, including groups, counseling, and crisis hotlines are included and were identified through school district referrals. These resources were then reviewed and approved by Utah's Youth Suicide Prevention Committee for inclusion in Utah's Youth Suicide Prevention, Intervention, Postvention Manual.

Results

A total of 23 online handouts, booklets, and brochures were located that met the inclusion criteria. These resources were categorized according to which research question they addressed. Each group of data was then organized and the information synthesized to develop the handouts in this study. These handouts include three parent informational handouts, one school informational handout, and two handouts identifying community resources.

The first handout specifically answers the research question on where parents can find information on adolescent suicide: ideation, attempts, and completion. Adolescent suicide statistics specific to Utah and specific steps that parents can take if they are concerned that their adolescent may be considering or planning suicide can be found on this handout. Also provided are resources for families that identify normal adolescent development and a few resources for when and where to seek help.

The second handout addresses the research question identifying information that is available to parents regarding mental illness, a major risk factor for suicide. Included is information on mood disorders, especially bipolar disorder and depression, including what symptoms adolescents may experience, what roles parents take regarding treatment, how parents can advocate for their adolescent in the schools, and the connection with suicide.

The third handout specifically answers the research question regarding warning signs of suicide and how parents can respond if suicidal ideation is suspected. Specific questions that parents can ask their adolescents regarding suicidal ideation and suicide planning are provided. Steps to take if their adolescent is suicidal are also detailed.

The fourth handout provides information regarding the research question of how educators can increase collaboration with parents as part of suicide prevention efforts. These resources include information on how fostering home/school collaboration can support protective

factors against suicide, ways to build collaborative relationships with parents, warning signs of suicide to watch for in students, statistics about adolescent suicide, how to notify parents of suicide risk, and questionnaires for schools to use to assess their crisis plans and collaborative relationships with parents.

The fifth and sixth handouts provide a list of community resources that provide counseling and support groups in Salt Lake and Utah counties, in English and Spanish respectively. These resources are geared towards individual and family counseling; support groups for those who have experienced a suicide, a suicide attempt, or are living with mental illness; and classes that educate families on mental illness.

The seventh handout provides information on community resources available through the National Alliance on Mental Illness (Utah Chapter). These include support groups, classes, and other programs for individuals with mental illness and their families. Additional resources include trainings for mental health professionals, educators, and clergymen, and education classes for community members.

The eight, and final, handout also provides resources for parents and adolescents to access if struggling with suicidal ideation, but is specific to hotlines and online chats that provide support and referrals in an effort to prevent suicide.

Table 1

Parent Handouts Addressing Research Questions

Research question	Parent handout(s)
Where can parents access information on suicide ideation, attempts, and completion?	• No. 1 – Parent Information and Resources: Understanding Suicide: Statistics and How to Respond
What signs of suicide can parents watch for and how do they respond appropriately to suicidal ideation?	• No. 3 – Parent Information and Resources: What to Do if You Suspect Your Teen May Be Suicidal: Signs to Watch for and How to Respond • No. 1 – Parent Information and Resources: Understanding Suicide: Statistics and How to Respond
Where can parents access information on risk factors for suicide, such as mental illness?	• No. 2 – Parent Information and Resources: Risk Factors of Suicide: Understanding Mental Illness
What community resources are available for adolescents and their parents and families?	• No. 5 & 6 – Community Resources: Salt Lake and Surrounding Counties (English and Spanish versions) • No. 7 – Community Resources: National Alliance on Mental Illness • No. 8 – Utah County and National Suicide Prevention Hotlines and Online Chats: Crisis Intervention Resources
What information is available to educators on collaborating with parents and families to improve suicide prevention efforts?	• No. 4 – School Collaboration with Parents: Building Relationships to Prevent Suicide: Information and Resources

Discussion

An important protective factor against suicide attempts and completion are family cohesion and support (Chesley & Loring-McNulty, 2003; Gould et al., 2003; U.S. Public Health Service, 2001; Utah Department of Health, n.d.; WHO, 2000). Following a suicide attempt, familial relationships are an essential resource for support (McMenamy, Jordan, & Mitchell, 2008).

As schools are increasing their roles in suicide prevention initiatives (Miller & Eckert, 2009; U.S. Public Health Service, 2001), increasing collaboration between the schools and parents is an important part of these efforts (Randell et al., 2006; LeBlanc et al., 2012), especially as most adolescent suicide attempts do not happen while at school (DeVoe et al., 2005). With the unique position of Utah schools, where school spending is well below the national average and the student-to-teacher ratio is well above the national average (NCES, 2009), increasing prevention efforts that focus on home/school collaboration may help reconcile the need for increased effectiveness of suicide prevention efforts with the deficit of school resources (Connor & Rueter, 2006; Kalafat, 2003; LeBlanc et al., 2012; Moskos et al., 2005; Randell et al., 2006; Speaker and Petersen, 2000). As part of a state-wide suicide prevention manual for Utah school districts, information regarding mood disorders, adolescent suicide, and community resources should be available for schools and parents, as part of school-parent collaborative efforts in suicide prevention.

Summary of Essential Information for Parents and Schools

There are many articles and handbooks that are available to the general public that provide information on mood disorders, especially bipolar disorder, and suicide (American Academy of Child and Adolescent Psychology [AACAP], 2006, 2009; Families for Depression

Awareness, 2007; Society for the Prevention of Teen Suicide [SPTS], 2011a, 2011b); references for these articles can be provided to parents as part of school-based suicide prevention efforts.

AACAP (2009) provides parents with information on bipolar disorder, including emotions, cognitions, and behaviors associated with this disorder. Statistics and information on the link between bipolar disorder and suicide is also provided (AACAP, 2011). Families for Depression Awareness (2007) provides information on what treatments are available for adolescents with bipolar disorder or depression, where parents can access treatment for their adolescent, and what role parents play in monitoring treatment. For parents who are unsure what steps to take in discussing suicide with their adolescent and how to address suicide risk, SPTS (2011) has developed handouts that address these concerns, along with warning signs to watch for.

Additionally, there are articles that are appropriate for school-based practitioners that provide information on suicide and bipolar disorder and address collaboration with parents in suicide prevention efforts (LeBlanc et al., 2012; Maine Youth Suicide Prevention Program [MYSPP], 2009a, 2009b, 2009c, 2011). School personnel who work with adolescents in crisis should have access to this information as part of suicide prevention efforts.

Limitations and Recommendations

One of the major limitations of this literature review is that it is solely based off of scholarly research that is currently available. Future research should begin to address parent perspectives of school-based support following an adolescent suicide attempt. This will help to identify what resources are currently available to parents, which resources they feel would be helpful for future intervention efforts, and how schools can best help them access those resources.

Additionally, future research should develop supplementary parent handouts that (a) address additional risk factors as identified in this literature review and other scholarly research, and (b) provide a list of community resources for other counties in Utah.

It is also important to provide handouts to parents in their native language; because of the specific needs of Utah's schools, handouts should be translated into Spanish so all parents can access this information.

These handouts developed for this study (see Appendix A) should be available for schools and parents to use in suicide prevention efforts. These resources were developed to begin to address some of the barriers to home/school collaboration through (a) being implemented as a regular part of suicide prevention efforts and crisis intervention; (b) providing schools with readily available information regarding adolescent suicide, mood disorders as a risk factor of suicide, specific steps they can take to help identify suicidality and get help for their adolescents; and (c) identifying ways in which schools can more conscientiously build home/school collaborative relationships and measure their effectiveness in these efforts.

The roles of school psychologists, school counselors, administrators, and other school personnel in suicide prevention efforts include identifying students at risk for suicide and notifying parents of that risk. These handouts will enable school personnel to provide information to parents that can further help to prevent adolescent suicide.

Conclusion

Over the last decade, suicide prevention efforts have been a major focus of scholarly research and program development in the schools and in the community (Hallfors et al., 2006; Lieberman, Poland, & Cassel, 2008; Miller, 2011; U.S. Public Health Service, 2001). Suicide prevention efforts can overwhelm school resources (Hallfors et al., 2006), yet it is very

appropriate for adolescent suicide prevention efforts to be a major focus in this domain, as students spend a majority of their time in the schools (Miller & Eckert, 2009; U.S. Public Health Service, 2001). Utah schools have a large student-to-teacher ratio and a low average of funding per student, resulting in the need for suicide prevention efforts that are highly effective while low in cost (NCES, 2009). Developing home/school collaborative partnerships are recommended in the research in order to promote protective factors against suicide (Connor & Rueter, 2006; Kalafat, 2003; LeBlanc et al., 2012; Moskos et al., 2005; Randell et al., 2006; Speaker & Peterson, 2000; U.S. Public Health Service, 2001; Utah Department of Health, n.d.; WHO, 2000), which may increase the effectiveness of suicide prevention programs while not overwhelming school resources. As part of a state-wide Youth Suicide Prevention Manual in Utah, handouts that can be given to parents and school personnel that attend to different aspects of suicide prevention efforts and increase home/school collaboration may begin to address this need.

The findings of this study have been synthesized into different handouts that schools can provide to parents that include information regarding adolescent suicide, warning signs to watch for, steps parents can take if suicidal ideation or planning is suspected, and community resources available for parents and adolescents. These handouts will be made available in Utah's Youth Suicide Prevention Manual currently being developed as part of home/school collaborative suicide prevention efforts.

References

American Academy of Child and Adolescent Psychology. (2006). *Facts for families*. Retrieved

from http://www.aacap.org/cs/root/facts_for_families/facts_for_families

American Academy of Child and Adolescent Psychology. (2009). *Bipolar disorder: Parent's

medication guide for bipolar disorder in children and adolescents*. Retrieved from

http://parentsmedguide.org/bipolarmedicationguide.pdf

Asarnow, J. R., Berk, M. S., & Baraff, L. J. (2009). Family intervention for suicide prevention: A

specialized emergency department intervention for suicidal youths. *Professional

Psychology: Research and Practice, 40*(2), 118-126. doi:10.1037/a0012599

Barrero, S. A. P. (2008). Preventing suicide: A resource for the family. *Annals of General

Psychiatry, 7*:1. doi:10.1186/1744-859X-7-1

Centers for Disease Control and Prevention. (2009). *Injury prevention & control: Youth suicide.*

Retrieved 02/25, 2010, from

http://www.cdc.gov/violenceprevention/pub/youth_suicide.html

Chesley, K., & Loring-McNulty, N. (2003). Process of suicide: Perspective of the suicide

attempter. *Journal of the American Psychiatric Nurses Association, 9*(2), 41-45.

doi:10.1016/S1078-3903(03)00051-X

Christenson, S. L. (2003). The family-school partnership: An opportunity to promote the

learning competence of all students. *School Psychology Quarterly 18*(4), 454-482.

Connor, J. J., & Rueter, M. A. (2006). Parent-child relationships as systems of support or risk

for adolescent suicidality. *Journal of Family Psychology 20*(1), 143-155. doi:

10.1037/0893-3200.20.1.143

Cox, D. D. (2005), Evidence-based interventions using home-school collaboration. *School Psychology Quarterly, 20*(4), 473-497.

Crothers, L. M., Hughes, T. L., & Morine, K. A. (2008). *Theory and cases in school-based consultation: A resource for school psychologists, school counselors, special educators, and other mental health professionals.* New York, NY: Taylor & Francis Group.

DeVoe, J. F., Peter, K., Noonan, M., Snyder, T. D., & Baum, K. (2005). *Indicators of School Crime and Safety: 2005* (NCES 2006–001/NCJ 210697). U.S. Departments of Education and Justice. Washington, DC: U.S. Government Printing Office.

Families for Depression Awareness. (2007). Depression and bipolar wellness guide for parents of children and teens with depression or bipolar disorder, version 2. Retrieved from http://www.projectinterface.org/docs/DepressionWellnessParents.pdf

Gay & Lesbian Alliance Against Defamation, Movement Advancement Project, American Foundation for Suicide Prevention, Gay Lesbian & Straight Education Network, Johnson Family Project, & The Trevor Project. (2011). Talking About Suicide & LGBT Populations. Retrieved from http://www.lgbtmap.org/file/talking-about-suicide-and-lgbt-populations.pdf

Gibbons, R. D., Hur, K., Bhaumik, D. K., & Mann, J. J. (2006). The relationship between antidepressant prescription rates and rate of early adolescent suicide. *American Journal of Psychiatry 163*(11), 1898-1904.

Gould, M. S., Greenberg, T., Velting, D. M., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(4), 386-405. doi:10.1097/01.CHI.0000046821.95464.CF

Gould, M. S., & Kramer, R. A. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior, 31*, 6-31. doi:10.1521/suli.31.1.5.6.24219

Gray, D., Achilles, J., Keller, T., Tate, D., Haggard, L., Rolfs, R., Cazier, C., Workman, J., & McMahon, W. M. (2002). Utah youth suicide study, phase I: Government agency contact before death. *American Academy of Child & Adolescent Psychiatry 41*(4), 427-434.

Hallfors, D., Brodish, P. H., Khatapoush, S., Sanchez, V., Cho, H., & Steckler, A. (2006). Feasibility of screening adolescents for suicide risk in "real-world" high school settings. *American Journal of Public Health 96*(2), 282-287.

Illinois Department of Public Health. (n.d.). Injury prevention: Sexual orientation, gender identity, and youth suicide. Retrieved from http://www.idph.state.il.us/about/chronic/Suicide_Sexual_Orientation_in_Youth.pdf

Kalafat, J. (2003). School approaches to youth suicide prevention. *American Behavioral Scientist, 46*, 1211-1223.

Kelly, C. M., Jorm, A. F., Kitchener, B. A., & Langlands, R. L. (2008). Development of mental health first aid guidelines for suicidal ideation and behaviour: A delphi study. *BMC Psychiatry, 8*:17.

Kidd, S., Henrich, C. C., Brookmeyer, K. A., Davidson, L., King, R. A., & Shahar, G. (2006). The social context of adolescent suicide attempts: Interactive effects of parent, peer, and school social relations. *Suicide and Life-Threatening Behavior, 36*(4), 386-395.

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

Network. Retrieved from http://pennsec.org/wp-content/uploads/2011/05/2009-National-School-Climate-Report-Full.pdf

LeBlanc, A., Lazear, K. J., & Roggenbaum, S. (2012). Family Partnerships (Issue Brief 8). Youth suicide prevention school-based guide-Issue brief 8: Family partnerships. Tampa, FL: University of South Florida, College of Behavioral and Community Sciences, Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies (FMHI Series Publication #218-8-Rev 2012). Retrieved from http://theguide.fmhi.usf.edu/pdf/2012PDFs/IB-8.pdf

Lieberman, R., Poland, S., & Cassel, R. (2008). Best practices in suicide intervention. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology V* (pp. 1457-1472). Bethesda, MD: National Association of School Psychologists.

Maine Department of Health & Human Services. (n.d.). *Maine Youth Suicide Prevention Program.* Retrieved from http://www.maine.gov/suicide/professionals/program/index.htm

Maine Youth Suicide Prevention Program. (2009a). Suggestions that may help enlist parental cooperation. In *Youth suicide prevention, intervention, and postvention guidelines, 4th edition* (Appendix G: Sample handouts). Retrieved from http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf

Maine Youth Suicide Prevention Program. (2009b). Supporting parents through their child's suicidal crisis. In *Youth suicide prevention, intervention, and postvention guidelines, 4th edition* (Appendix G: Sample handouts). Retrieved from http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf

Maine Youth Suicide Prevention Program. (2009c). Youth suicide prevention, intervention, and

   postvention guidelines, 4th edition. Retrieved from

   http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf

Maine Youth Suicide Prevention Program. (2011a). Frequently asked questions for parents.

   Retrieved from http://www.maine.gov/suicide/parents/faq.htm

Maine Youth Suicide Prevention Program. (2011b). Working with parents of suicidal youth.

   Retrieved from http://www.maine.gov/suicide/professionals/program/five.htm

Marshal, M. P., Dietz, L. J., Friedman, M. S., Stall, R., Smith, H. A., McGinley, J., Thoma, B.

   C., Murray, P. J., D'Augelli, A. R., & Brent, D. A. (2011). Suicidality and depression

   disparities between sexual minority and heterosexual youth: A meta-analytic review.

   Journal of Adolescent Health, 49, 115–123. doi:10.1016/j.jadohealth.2011.02.005

Mayo Foundation for Medical Education and Research. (March 26, 2012). Suicide: What to do

   when someone is suicidal. Retrieved from

   https://www.mayoclinic.com/health/suicide/MH00058

McMenamy, J. M., Jordan, J. R., & Mitchell, A. M. (2008). What do suicide survivors tell us

   they need? Results of a pilot study. *Suicide and Life-Threatening Behavior 38*(4), 375-

   389.

Miklowitz, D., & Taylor, D. O. (2006). Family-focused treatment of the suicidal bipolar patient.

   Bipolar Disorders, 8, 640-651.

Miller, D. N. (2011). *Child and adolescent suicidal behavior: School-based prevention,*

   assessment, and intervention. New York, NY: Guilford.

Miller, D. N, & Eckert, T. L. (2009). Youth suicidal behavior: An introduction and overview.

   School Psychology Review, 38(2), 153-167.

Miller, D. N., Eckert, T. L., & Mazza, J. J. (2009). Suicide prevention programs in the schools: A review and public health perspective. *School Psychology Review, 35*(2), 168-188.

Minke, K. M., & Anderson, K. J. (2005), Family-school collaboration and positive behavior support. *Journal of Positive Behavior Interventions 7*(3), 181-185.

Moskos, M. A., Achilles, J., & Gray, D. (2004). Adolescent suicide myths in the United States. *Crisis 25*(4), 176-182. doi: 10.1027/0227-5910.25.4.176

Moskos, M. A., & Halbern, S. R. (2007, May). *Utah suicide prevention plan.* Retrieved from http://www.hsdsa.utah.gov/docs/utah_state_suicide_prevention_plan051007.pdf

Moskos, M. A., Halbern, S. R., Alder, S., Kim, H., & Gray, D. (2007). Utah youth suicide study: Evidence-based suicide prevention for juvenile offenders. *Journal of Law & Family Studies 10*, 127-145.

Moskos, M., Olson, L., Halbern, S., Keller, T., & Gray, D. (2005). Utah youth suicide study: Psychological autopsy. *Suicide and Life-Threatening Behavior 35*(5), 536-546.

National Adolescent Health Information Center. (2006). *Fact sheet on suicide: Adolescents & young adults.* Retrieved from http://nahic.ucsf.edu/downloads/Suicide.pdf

National Alliance on Mental Illness. (n.d.). *Teenage suicide.* Retrieved from http://www.nami.org/Content/ContentGroups/Helpline1/Teenage_Suicide.htm

National Alliance on Mental Health, KUED 7, & Spy Hop Productions. (n.d.). Voices of hope: Teen suicide in Utah. Retrieved from http://www.kued.org/productions/voicesofhope/resources/discussionGuide.pdf

National Center for Education Statistics. (2009, May). *Digest of Education Statistics: 2009.* Retrieved from http://nces.ed.gov/programs/digest/d09/

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

Power, L., Morgan, S., Byrne, S., Boylan, C., Carthy, A., Crowley, S., Fitzpatrick, C., & Guerin,
S. (2009). A pilot study evaluating a support programme for parents of young people with
suicidal behaviour. *Child and Adolescent Psychiatry and Mental Health, 3*(20), 8 pages.
doi:10.1186/1753-2000-3-20

Randell, B. P., Wang, W., Herting J. R., & Eggert, L. L. (2006). Family factors predicting
categories of suicide risk. *Journal of Child and Family Studies 15*(3), 255-270. doi:
10.1007/s10826-006-9020-6

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of
negative health outcomes in White and Latino Lesbian, Gay, and Bisexual young adults.
Pediatrics, 123(1), 346-352. doi: 10.1542/peds.2007-3524

Society for the Prevention of Teen Suicide. (2011a). For parents: Important things to remember.
Retrieved from http://www.sptsusa.org/parents/important.html

Society for the Prevention of Teen Suicide. (2011b). Parent awareness series: Talking to your
kids about suicide. Retrieved from http://www.sptsusa.org/pdfs/parent-awareness-
handout.pdf

Speaker, K. M., & Petersen, G. J. (2000). School violence and adolescent suicide: Strategies for
effective intervention. *Educational Review 52*, 65-73.

Statewide Suicide Prevention Council. (2004, September). *Alaska Suicide Prevention Plan.*
Retrieved from
http://www.hss.state.ak.us/suicideprevention/pdfs_sspc/SuicidePrevPlan050505.pdf

Substance Abuse and Mental Health Services Administration. (2007). *Teenage mental health,*

suicide prevention: A family guide. Retrieved from

http://family.samhsa.gov/get/suicidewarn.aspx

Suicide Prevention Resource Center. (2008). *Suicide risk and prevention for lesbian, gay,*

bisexual, and transgender youth. Newton, MA: Education Development Center, Inc.

Retrieved from http://www.sprc.org/sites/sprc.org/files/library/SPRC_LGBT_Youth.pdf

Sun, F., & Long, A. (2008). A theory to guide families and carers of people who are at risk of

suicide. *Journal of Clinical Nursing, 17*(14), 1939-1948. doi:10.1111/j.1365-

2702.2007.02230.x

United States Public Health Service. (2001). *National Strategy for suicide prevention: Goals and*

objectives for action. Rockville, MD: U.S. Department of Health and Human Services.

Utah Department of Health. (n.d.). *2001-2005 Utah suicide data.* Retrieved from

http://health.utah.gov/vipp/pdf/FactSheets/suicide%202007.pdf

Utah Department of Health. (2011). *Teen Suicide in Utah, 2005-2009.* Retrieved from

http://www.namiut.org/images/stories/TeenSuicide.pdf

World Health Organization [WHO]. (2000). *Preventing suicide: A resource for teachers and*

other school staff. Retrieved from http://www.who.int/mental_health/media/en/62.pdf

Youth Suicide Prevention Program. (2007, September 22). *Response: A comprehensive high*

school-based suicide awareness program. Retrieved from

http://www.oregon.gov/DHS/ph/ipe/ysp/docs/responseoverview.pdf

Appendix A: Parent Handouts

1. Annotated Bibliography – Parent Handout

   - Parent Information and Resources: Understanding Suicide: Statistics and How to Respond

2. Annotated Bibliography – Parent Handout

   - Parent Information and Resources: Risk Factors of Suicide: Understanding Mental Illness

3. Responding to Suicide – Parent Handout

   - Parent Information and Resources: What to Do if You Suspect Your Teen May Be Suicidal: Signs to Watch for and How to Respond

4. Annotated Bibliography – School Practitioner Handout

   - School Collaboration with Parents: Building Relationships to Prevent Suicide: Information and Resources

5. Community Resources (English version)

   - Community Resources: Salt Lake and Surrounding Counties

6. Community Resources (Spanish version)

   - Recursos a la Comunidad: Salt Lake y los condados circundantes

7. Community Resources (additional)

   - Community Resources: National Alliance on Mental Illness – Utah Chapter

8. National and Local Suicide Hotlines

   - Utah County and National Suicide Prevention Hotlines and Online Chats: Crisis Intervention Resources

Parent Information and Resources
Understanding Suicide: Statistics and How to Respond

Utah Department of Health. (2011). *Teen Suicide in Utah, 2005-2009.* Retrieved from
http://www.namiut.org/images/stories/TeenSuicide.pdf

> This is a short facts sheet on teen suicide, including risk factors, gender differences, and other
> suicide statistics pertinent to the state of Utah.

American Academy of Child and Adolescent Psychology. (2006). Facts for Families.
Retrieved from http://www.aacap.org/cs/root/facts_for_families/facts_for_families

> This series of handouts for parents and families regarding various mental illnesses, disorders,
> or other concerns are provided. Helpful handouts include:

> (1) *Children's Threats: Are They Serious?* Identifies which threats should be taken seriously
> (harming self, harm ing others, damaging prop erty, runn ing away) and when there is
> more risk associated with those threats (p ast behavior, access to lethal m eans, fam ily
> history, bullying, etc.).

> (2) *Parenting: Preparing for Adolescence.* Tips for developing relationships with children
> and creating an environm ent that provide s opportunities to keep communication open,
> develop mutual trust and respect, and increase responsibility.

> (3) *Normal Adolescent Development.* Middle school and early high school years,
> developmental changes include stru ggling with sense of identity, moodiness, interest in
> present roles and relationships, worries a bout being norm al, frequently changing
> romantic relationships, testing rules and limits set by authority figures.

> (4) *Normal Adolescent Development.* Late high school years and beyond, developm ental
> changes inc lude seekin g independe nce, inte rest in f uture roles, grea ter m aturity with
> regards to sexuality, self-directed goals and morals.

> (5) *When to Seek Help for Your Child.* Identify signs that children m ay benefit from
> emotion or behavior evaluations by ag e (younger children, pre-adolescent and
> adolescent).

> (6) *Where to Find Help for Your Child.* Suggestions of where to look for help for emotional
> and m ental needs; explanation of the diffe rences and sim ilarities between child an d
> adolescent psychiatrists, general psychiatrists, psychologists, and social workers.

(7) *Teen Suicide.*   Primary and secondary signs that   parents should watch for in their adolescents, including changes in behaviors or personality, withdrawal, drug and alcohol use, verbal hints, etc.

Society for the Prevention of Teen Suicide. (2011). For parents: Important things to remember. Retrieved from http://www.sptsusa.org/parents/important.html

Provides a list of steps parents can take with th eir adolescent to help dete rmine if something is wrong. This list includes sp   ecific questions to ask an a   dolescent, steps to use in the communication process, and steps to take if they   (the parents) have co ncerns about suicide, including getting help from mental health and medical professionals.

Society for the Prevention of Teen Suicide. (2011). Parent awareness series: Talking to your kids about suicide. Retrieved from http://www.sptsusa.org/pdfs/parent-awareness-handout.pdf

This handout focuses on the prevalence of su   icide am ong adolescents. Additionally, it details how parents should approach their adolescent about suicide and specific questions that they should ask. Warning signs that parents should watch for are included.

Parent Information and Resources
Risk Factors of Suicide: Understanding Mental Illness

American Academy of Child and Adolescent Psychology. (2009). Bipolar disorder: Parent's medication guide for bipolar disorder in children and adolescents. Retrieved from http://parentsmedguide.org/bipolarmedicationguide.pdf

This is a thorough introduction to bipolar disorder (60 pages). It is geared for parents and children and adolescents with bipolar disorder. Information about the disorder is provided; it defines bipolar disorder as a disorder of the brain which influences emotions, cognitions, and behavior. Mood swings are comprised of mania, depression, mixed episodes, and hypomania (irritability). Symptoms of the disorder are described, including those associated with mood, thinking, energy, and behavior, for both manic and depressive episodes. Helpful questions to distinguish between bipolar mood cycles and normal mood swings are suggested. Information about the connection between bipolar disorder and suicide is provided; questions parents can ask their child/adolescent regarding suicide are included. A discussion on how parents can help their child/adolescent with bipolar disorder includes their roles in accessing treatment, monitoring the effectiveness of treatment, and networking to a supportive community. Information about bipolar disorder and school is included; how bipolar disorder may affect learning, how the school can support the child/adolescent, and how parents can advocate for their child/adolescent are discussed. Additionally, the impact of bipolar disorder on peer relationships at school and in the community is also addressed.

Families for Depression Awareness. (2007). Depression and bipolar wellness guide for parents of children and teens with depression or bipolar disorder, version 2. Retrieved from http://www.projectinterface.org/docs/DepressionWellnessParents.pdf

This is a family-centered approach to mood disorders, including information about depression and bipolar disorder, what treatments are available, and the role parents take in accessing and monitoring treatment. Information provided includes signs that parents may notice indicating that their child/adolescent may have clinical depression and bipolar disorder; parenting do's and don'ts for children with mood disorders; treatment options and questions to ask clinicians; tips for monitoring treatment collaboratively with clinicians and school personnel; suicide signs to watch for and ways to help prevent suicide; and a guide for parents and their child/adolescent to define what is going well and not going well with their current treatment or behaviors, charts for daily records of moods, and ideas for journals (personal, sleep, and mood); and additional resources for parents and families.

American Academy of Child and Adolescent Psychology. (2006). Facts for Families. Retrieved from http://www.aacap.org/cs/root/facts_for_families/facts_for_families

This series of handouts for parents and families provides information regarding various mental illnesses, disorders, or other concerns. Helpful handouts include:

(1) *Children's Threats: Are They Serious?* Identifies which threats should be taken seriously (harming self, harming others, damaging property, running away) and when there is more risk associated with thos e threats (p ast beha vior, access to lethal m eans, fam ily history, bullying, etc.).

(2) *Parenting: Preparing for Adolescence.* Tips for developing rela tionships with ch ildren and creating an environm ent that provide s opportunities to k eep com munication open, develop mutual trust and respect, and increase responsibility.

(3) *Normal Adolescent Development.* Middle school and early high school years, developmental changes include struggling with sense of identity, m oodiness, interest in present roles and relationships, worries about being normal, frequently changing romantic relationships, testing rules and limits set by authority figures.

(4) *Normal Adolescent Development.* Late high school years a nd beyond, developm ental changes include seeking independe nce, in terest in f uture r oles, gr eater m aturity with regards to sexuality, self-directed goals and morals.

(5) *Bipolar Disorder for Children and Teens.* Outline of manic sym ptoms, depres sive symptoms, and current treatment options.

(6) *When to Seek Help for Your Child.* Identify signs that children may benefit from emotion or behavior evaluations by age (younger children, pre-adolescent and adolescent).

(7) *Where to Find Help for Your Child.* Suggestions of where to look for help for em otional and m ental needs; exp lanation of the dif ferences and sim ilarities between child and adolescent psychiatrists, psychiatrists, psychologists, and social workers.

(8) *Teen Suicide.* Primary and secondary signs that parents should watch for in their adolescents, including change s in behaviors or personality , withdrawal, drug and alcohol use, verbal hints, etc.

Parent Information and Resources
What to Do if You Suspect Your Teen May Be Suicidal:
Signs to Watch for and How to Respond

Watching for Signs of Suicide

Keeping communication open betw een you and your teen and being aware of any significant changes to his or her behavior and activities are the first steps in preventing teen suicide. Here is a list of common signs to watch for:
- Saying things like, "I wish I was dead," "I wish I hadn't been born," or "Everyone would be better off without me."
- Changes in behavior, such as withdrawing from an active s ocial life o r changing fro m being shy to being outgoing.
- Changes in normal activities such as eating, sleeping, or increasing risky behavior such as driving irresponsibly or abusing drugs or alcohol.
- Giving away belongings and saying good-bye to people as if they won't see them again.
- Severe mood swings.
- Feeling hopeless or trapped after a significant life event (for teens this can be the loss of a loved one, the loss of a relationship, the loss of a friendship, etc.)

Talking to Your Teen about Suicide

Talking to teens about suicide can be difficult. Most parents worry that they may give their teens ideas about suicide if they talk to them about it openly, but the realit y is that m ost teens who are suicidal have already thought about suicide.
If any of these changes or signs of suicide becom e apparent, st art a conversation with your teen to see what suicidal thoughts they've had and how extensive and explicit their plans have become.
- You haven't seemed like yourself recently, what's been going on?
- I know that som e difficult th ings have happened recently, and I'm concerned about how you're feeling.

It's im portant to ask directly about suicide. These words can be difficult to say, so practice saying the words aloud before approaching your teen if you need to.
- Do you feel like things will never get better?
- Have you been feeling like killing yourself is an answer to your problem?
- Have you ever considered suicide? Are you suicidal now?

If they mention they have thought about suicide, it is important to ask for more information.
- Have you thought about how you would do it?
- Do you have access to _____? W here would you get _____? (*fill in the blank with whatever method they mentioned, i.e. pills, a gun, etc.*)
- Have you thought about when you would do it?

Tips for Talking with Your Teen

- Keep your voice and your facial expressions calm.
- Ask questions, but focus on listening.
- Avoid interrupting, yelling, threatening, or being demeaning. Avoid words like "always" and "never."
- Don't try to get the last word or insist that you are right.
- If things get heated, take a break to cool off and then try again.
- Make allowances for the other person; this is a very em otional topic, and you both m ay say things you did not mean. If this happens, apologize and try again.
- Focus on the present not the past.

If your teen tells you that you won't or don't unde rstand, reassure them that you care for them and are willing to try to understand. Remember that they may not know how to express how they are f eeling. If they can't or won't talk to you, ask if they would be willing to speak with someone else, like a counselor or clergyman.

What to Do if Your Teen is Suicidal

- Don't leave him or her alone.
- Tell them t hat you care about them and want to find ways to get them help. Do not promise not to tell someone or not to get help. Do not judg e them or their reasons for feeling suicidal. Reassure them that you will do all you can to help them get through this safely.
- Get help, either by calling 911 or taking them to the nearest emergency room.
- Remove all lethal m eans from the household; if this isn't possible, make sure all guns, medication, etc. are locked away in a safe place that your teen cannot access.
- If your teen has attem pted suic ide in the past, let them know that you are there to help and that people do care for them. Whatever painful experiences they are currently dealing with will pass or change. No issue they m ay currently be facing is worth taking their life over. There is help.

Adapted From:

Maine Youth Suicide Prevention Program. (2011). Frequently asked questions for parents. Retrieved from http://www.maine.gov/suicide/parents/faq.htm

Mayo Foundation for Medical Education and Research. (March 26, 2012). Suicide: What to do when someone is suicidal. Retrieved from https://www.mayoclinic.com/health/suicide/MH00058

National Alliance on Mental Illness, KUED 7, & Spy Hop Productions. (n.d.). *Voices of hope: Teen suicide in Utah*. Retrieved from http://www.kued.org/productions/voicesofhope/resources/discussionGuide.pdf

School Collaboration with Parents
Building Relationships to Prevent Suicide: Information and Resources

LeBlanc, A., Lazear, K. J., & Roggenbaum, S. (2012). *Youth suicide prevention school-based guide-Issue brief 8: Family partnerships* **Family partnerships (Issue Brief 8).** Tampa, FL: University of South Florida, College of Behavioral and Community Sciences, Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies (FMHI Series Publication #218-8-Rev 2012). Retrieved from http://theguide.fmhi.usf.edu/pdf/2012PDFs/IB-8.pdf

> Suggestions for school personnel to develop hom e/school partnerships in order to empower parents and fa milies to participate in school p rograms to prevent ado lescent suicide, as well as to know the warning signs of suicide to watch for in the adolescents they interact with.

Utah Department of Health. (2011). *Teen Suicide in Utah, 2005-2009.* Retrieved from http://www.namiut.org/images/stories/TeenSuicide.pdf

> This is a short facts sheet on teen suicide, including risk factors, gender differences, and other suicide statistics pertinent to the state of Utah.

Maine Youth Suicide Prevention Program. (2011). Working with parents of suicidal youth. Retrieved from http://www.maine.gov/suicide/professionals/program/five.htm

> An outline of how to n otify parents of the risk of suicide for their adolescent prov ides three subject areas that can be covered in a five m inute conversation: (a) why school personnel believe their adolescent is at risk f or suicid e; (b) how they can reduce this risk through limiting access to lethal means in their homes; and (c) ways they can dispose of firearms.

Maine Youth Suicide Prevention Program. (2009). Youth suicide prevention, intervention, and postvention guidelines, 4th edition. Retrieved from http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf

> This is a c omprehensive suic ide cris is plan f or the sta te of Maine. Inf ormation in th is document is beneficial for school personnel a nd professionals working with parents of

children and adolescents who have suicidal ideati on or have attempted or completed suicide. Important information includes a school questionnaire to identify effectiveness of their crisis plans and appropriate communication with and resources for parents and families; guidelines for helping students transition back into the school setting following a suicide attempt; ways to collaborate with parents and outside mental health providers; training that can be provided for school personnel who m ay help in or respond to a suicide crisis situation; inform ation about suicide and adolescents, including risk a nd protective factors; ho w to help suicidal youth; how to notify parents of suicide risk; how to help parents and fam ilies gain access to school-based and community-based resources; national resources for fa milies an d youth; sample handouts for students and parents (suicide facts, stressful events, reactions to suicide, supporting grieving youth).

Maine Youth Suicide Prevention Program. (2009). Supporting parents through their child's suicidal crisis. In *Youth suicide prevention, intervention, and postvention guidelines* (4th edition; Appendix G: Sample handouts). Retrieved from http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf

Family support and access to information is cr itical for suicide prevention; school personnel who reach out to supp ort fam ilies can help to foster this protec tive factor and increa se school/home collaboration. Steps schools can take during and after suicide crisis are provided.

Maine Youth Suicide Prevention Program. (2009). Suggestions that may help enlist parental cooperation. In *Youth suicide prevention, intervention, and postvention guidelines* (4th edition; Appendix G: Sample handouts). Retrieved from http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf

Steps that school personnel can take to in crease school/hom e colla boration in preventing adolescent suicide are provide d, including getting parent pers pectives, using em pathetic listening, asking questions, providing parents wi th local and school resources, and form ing an alliance with the parent to better support the student.

Community Resources
Salt Lake and Surrounding Counties

COUNSELING

Heber Valley Counseling   435-654-1618
provides substance abuse treatment and general counseling at a sliding-scale rate

LDS Family Services   801-422-7620
provides counseling and counsels families, spouses, children and   or 796-9509*
individuals

Valley Mental Health   801-949-4864
provides individual therapy/counseling, family therapy/counseling,   Suicide Prevention
group therapy, medication evaluation and management, and crisis   lifeline: 800-273-
intervention   TALK (8255)

Wasatch Mental Health   801-373-4760
provides intake, group and individual therapy for mental illnesses and
offers referrals to other mental illness facilities

SUPPORT GROUPS AND CLASSES

Utah Valley Regional Medical Center   801-357-4200
Suicide Support Group

National Alliance on Mental Illness   801-373-2688
provides a variety of services to educate and support families and   or 877-230-6264
caregivers of those who live with mental illness

Connection
support groups for individuals living with mental illness

Family to Family
12-week course for family caregivers of individuals with severe mental
illnesses

Bridges
12-week course for individuals living with mental illness

Recursos a la Comunidad
Salt Lake y los condados circundantes

CONSEJO

Heber Valley Counseling se proporciona tratamiento para abuso de drogas y consejo general (cargas de inscripción según sus ingresos)	435-654-1618
LDS Family Services se aconsejan familias, esposos, niños, individuos y en casos de adopción	801-422-7620 or 796-9509*
Valley Mental Health Ofrece terapia individual / asesoramiento, terapia familiar / consejería, terapia de grupo, evaluación de medicamentos y la gestión y la intervención en crisis.	801-949-4864 Suicide Prevention lifeline: 800-273-TALK (8255)
Wasatch Mental Health se proporciona intervención en situaciones de crisis y servicios de asesoramiento a clientes con Medicaid	801-373-4760

GRUPOS RUPOS DE APOYO Y CLASES

Utah Valley Regional Medical Center Suicidio de Grupos de Apoyo	801-357-4200
National Alliance on Mental Illness se proporciona apoyo y defensa de las personas que tienen enfermedades mentales severas y de sus familiares y amigos	801-373-2688 or 877-230-6264

Conexión
grupos de apoyo gratuitos para las personas

Familia a familia
Curso de 12 semanas para los cuidadores familiares de personas con enfermedades mentales graves

Puentes
Curso de 12 semanas para las personas que viven con enfermedad mental

Community Resources
National Alliance on Mental Illness – Utah Chapter
www.namiut.org * (801) 323-9900 or (877) 230-6264

CLASSES AND TRAININGS

BRIDGES
  A free 12-week recovery course for individuals living with mental illness
Progression
  A free course for youth between the ages of 15 and 21 dealing with mental health issues.
Family-to-Family
  A free 12-week course for family caregivers of individuals with severe mental illnesses.
NAMI Basics
  An education program for parents and other caregivers of children and adolescents living with
  mental illnesses.   The course consists of six classes, each lasting for 2 ½ hours.
Hope for Tomorrow
  A Mental Health Education Program to help parents, teachers, students and communities
  understand mental illness.
Clergy Seminar
  Training for clergy, general health and mental health providers on mental illness, ways to offer
  support to both the consumers and the families, and community resources available.
Professional Trainings
  The Lived Experience
  An interactive training on mental illness, recovery, signs and symptoms, what it feels like to
  live with these disorders, and predictable emotional reactions of family members and those
  living with mental illness.
  Other Professional Trainings
  Trainings and presentations on various topics including basic Mental Health, Children's
  Mental Health, School Issues, Criminal Justice Issues, Wellness, and Suicide Prevention.

SUPPORT GROUPS AND PROGRAMS

Family Support
  An important free resource for families who have a loved one with mental illness.
Connection
  Support groups for individuals living with mental illness.
Hearts & Minds
  An online, interactive, educational initiative promoting wellness in both mind and body.
Mentoring
  Peer mental health consumers and/or family members who have experience dealing with the
  effects of mental illness encourage others on the path to recovery.

Utah County and National Suicide Prevention Hotlines and Online Chats
Crisis Intervention Resources

National Suicide Prevention Lifeline 1.800.273.8255 (national)
http://www.suicidepreventionlifeline.org/Default.aspx
Master's level clinicians and therapists answer phones calls from anyone in crisis or individuals concerned about a friend or loved one. After taking the initial call, the therapists refer individuals to local numbers for long term support and crisis intervention.

Wasatch Mental Health 801.373.7393 (local)
Trained workers who answer these phones assess for immediate risk, and refer these calls to trained psychologists or social workers.

National Alliance on Mental Illness 1.800.950.6264 (national) & **801.323.9900** (local)
www.nami.org *(national)* & www.namiut.org *(local)*
This is an information and "warm line." Warm lines are for people who want to talk but are not feeling suicidal (e.g., people with depression who are feeling sad, kids who want to talk about divorce or mental health issues, etc.). The volunteers are trained to listen and keep information confidential. If people are feeling suicidal, they are referred to the national suicide prevention lifeline or the teen crisis line (called the Covenant House Nine line, 1.800.999.9999) or to local offices for ongoing help and support via classes and support groups.

Kristin Brooks Hopeline   1.800.SUICIDE   1.800.784.2433 (national/local)
http://www.hopeline.com/
This service rings through to 150 crisis centers nationwide. Some of the people answering calls are locally trained volunteers and others are fully paid and licensed clinicians.

Online Internet chat support (not available 24/7 but they will tell you if someone is online):
http://www.crisischat.org
http://newhopeonline.org/counseling/liveperson.html
http://www.realmentalhealth.com/chat/default.asp
http://www.suicidepreventionlifeline.org/Veterans/Default.aspx

Online support groups for people who have recently lost a loved one to suicide:
Please note that these do not provide and should not replace professional counseling
http://health.groups.yahoo.com/group/FFofSuicides/ - must be 21 or older
http://www.suicidegrief.com/
http://www.friendsforsurvival.org/

Additional crisis lines in Utah are listed on the following website:
http://www.suicidehotlines.com/utah.html