Indiana Suicide Prevention Resources Toolkit

Suicide Learning Collaborative
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Indiana Department of Health

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Introduction

Death rates for suicide have continued to rise both nationally and in Indiana, despite efforts to curtail these trends. Based on recent data (2018), suicide is a top 10 leading cause of death in Indiana for people aged 10-64 years, and is the 11th overall leading cause of death for all ages.[1] While each suicide death or attempt is different, there are ways to address the multiple factors involved. Suicide prevention efforts must utilize different strategies, require a wide range of partners, coordinate community response language, and draw on a diverse set of resources and tools.

This toolkit is aimed to help address the need for practical, and when possible, Indiana-specific tools for various sectors/professionals. Within this document, the first portion details new suicide trends based on 2018 data and the second portion includes best practice tools for the following professional groups: healthcare, first responders, government, stakeholder groups, justice, employers, faith-based, media, coroners, family, education, and populations of special consideration.

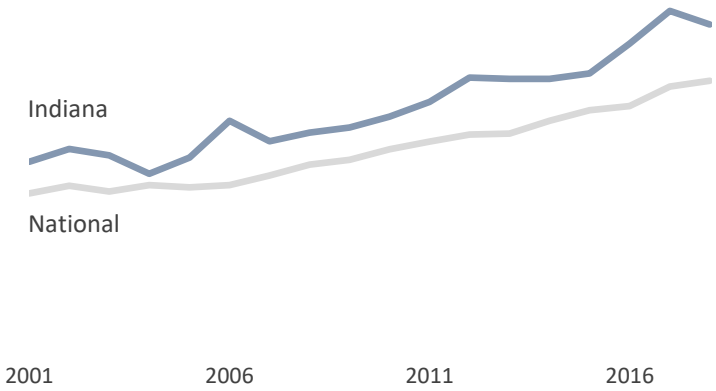
This toolkit was developed in partnership between the Suicide Learning Collaborative, a multi-disciplinary working group addressing suicide in Indiana, and the Indiana Department of Health's Fatality Review and Prevention Division. Throughout the development process, members of the Collaborative were asked to supply relevant tools to their topical area as well as provide feedback on proposed tools.

The hope for this document is that professionals from these various subgroups can utilize these tools in their work. While none of these sections are fully comprehensive for suicide prevention, there are many toolkits that specialize in just one of these topics. This toolkit serves as a simplified, action-oriented version of the other toolkits. The tools highlighted in this toolkit are primarily based off of existing national toolkits and best practice guides. We do recommend professionals read through other profession-specific toolkits referenced for further context and detail.

Data

Indiana has a consistently higher suicide rate when compared with the national rate.

CDC Web-based Injury Statistics Query and Reporting System, National Center for Injury for Injury and Prevention Control, Rate per 100,000, 2011-2018.

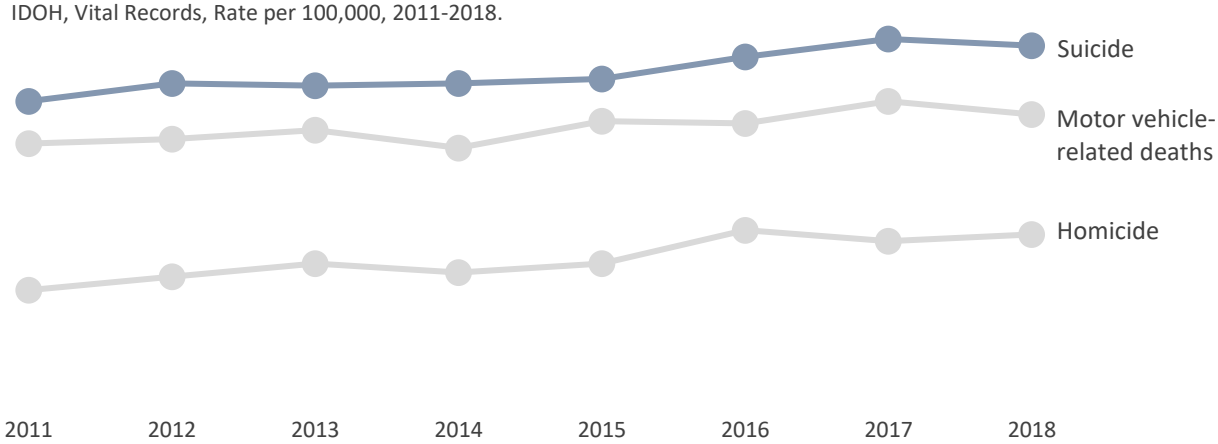


Suicide is the most preventable cause of death and yet it continues to be a tragic, frustratingly neglected issue for Indiana. According to the CDC Web-based Injury Statistics Query and Reporting System (WISQARS), the average 1-year rate of suicide in the US overall between 2015 and 2018 was 14.25 per 100,000 people. The suicide rate in Indiana was slightly higher, at 15.66 per 100,000. Likewise, suicide has continued to surpass both motor vehicle-related deaths and homicides, per the graph below.

Suicides occurred at twice the rate of homicides. In Indiana, based on 2018 data, suicide is the 11th leading cause of death among all age groups.[1] Death due to suicide is most prevalent in younger age groups, 10 to 54 years, where suicide ranks among the top 5 causes of death. According to IDOH Vital Records data, between 2015 and 2018 there have been 4,177 deaths by suicide in Indiana. This equates to around 3 deaths a day in the state of Indiana alone.

Suicide deaths have continued to surpass both motor vehicle-related and homicide deaths in Indiana.

IDOH, Vital Records, Rate per 100,000, 2011-2018.



Means of deaths:

There are multiple means of death due to suicide. Firearm related deaths account for the greatest share of suicide deaths in Indiana. This is followed by deaths due to hanging, strangulation and suffocation, which account for another 27.4% of suicide deaths. Self-poisoning and intentional overdoses account for 11.4% of suicide deaths.

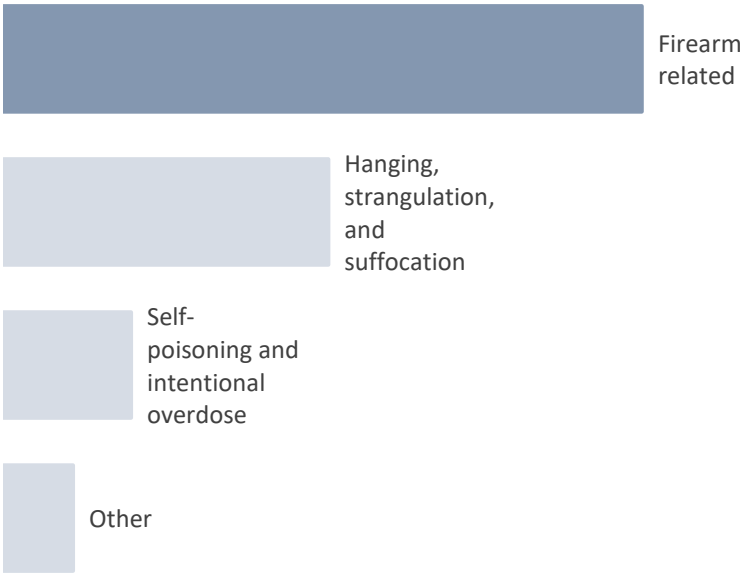
55%

Of suicide deaths in Indiana are firearm related.

IDOH, Vital Records, 2015-2018.

The majority of suicide deaths in Indiana are firearm-related.

IDOH, Vital Records, Rate per 100,000, 2015-2018.



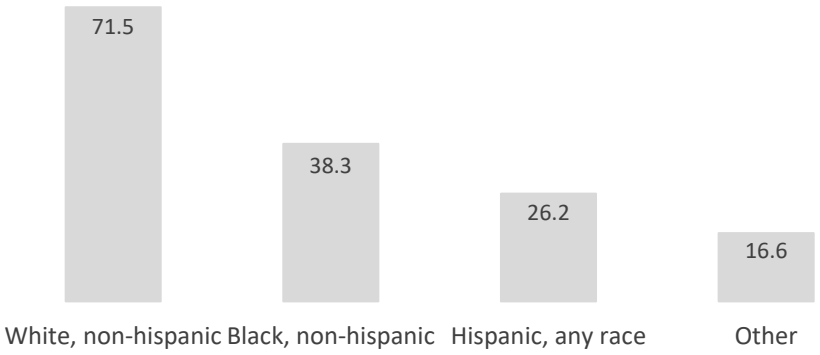
Other means of intentional self-injury deaths are much less common, and include intentional drowning, jumping from a high place, jumping before a moving object, crashing a motor vehicle. Collectively, these other causes account for only 6.1% of suicide deaths in Indiana.

Race:

The prevalence and risk of suicide differs by race/ethnicity in Indiana. White, non-Hispanic people account for 90% of all suicide deaths in Indiana during 2015-2018. Black non-Hispanic people accounted for 6%, followed by Hispanic (any race) with 3% and all other races account for 1% of suicide deaths. These percentages, however, must be looked at proportionally in comparison to the entire population. That is why, in the graph to the left, rates were used.

In Indiana, the white population had the highest rate of suicide deaths, almost twice as high as the rate among the black population.

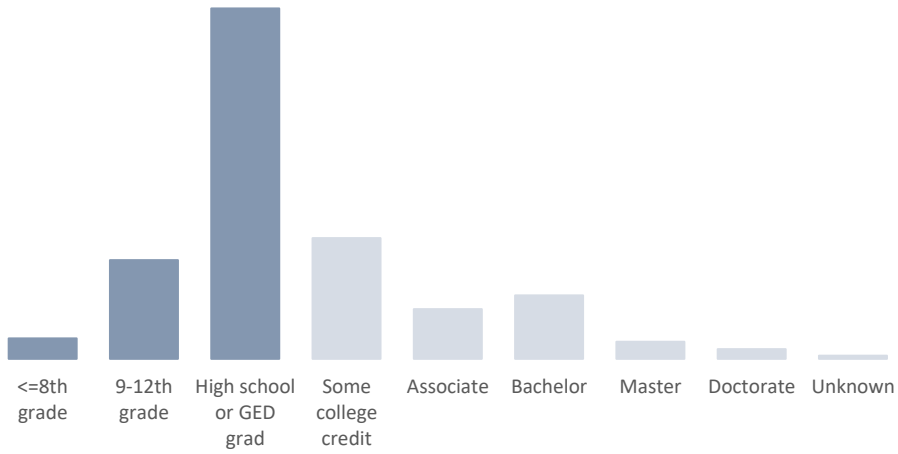
IDOH, Vital Records, Rate per 100,000, 2015-2018.



Education:

One key demographic difference in suicide deaths in Indiana is individuals' education levels at the time of their death. From 2015-2018, the data shows that 64% of individuals who died by suicide in the State of Indiana had a high school diploma or less. This is high when compared to the general population's percentage of 38.6%.

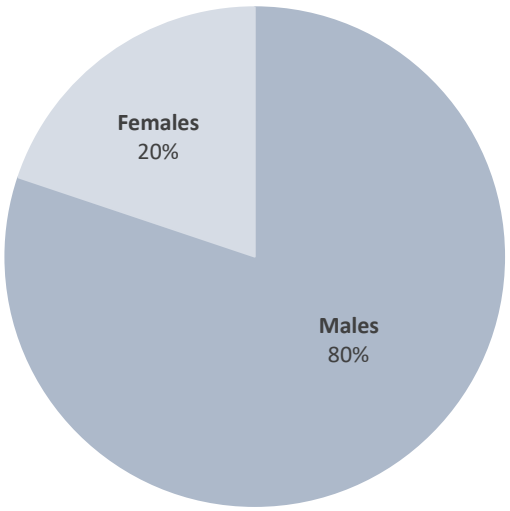
Of individuals who died by suicide in Indiana from 2015-2018, 64% had a high school diploma or less.
IDOH, INVDRS, Count, 2015-2018.



Gender:

Deaths due to suicide occurred much more frequently among males than females in Indiana. During this time period (2015-18), Indiana saw over 4 times as many male lives lost to suicide as female lives as shown in the graph to the left.

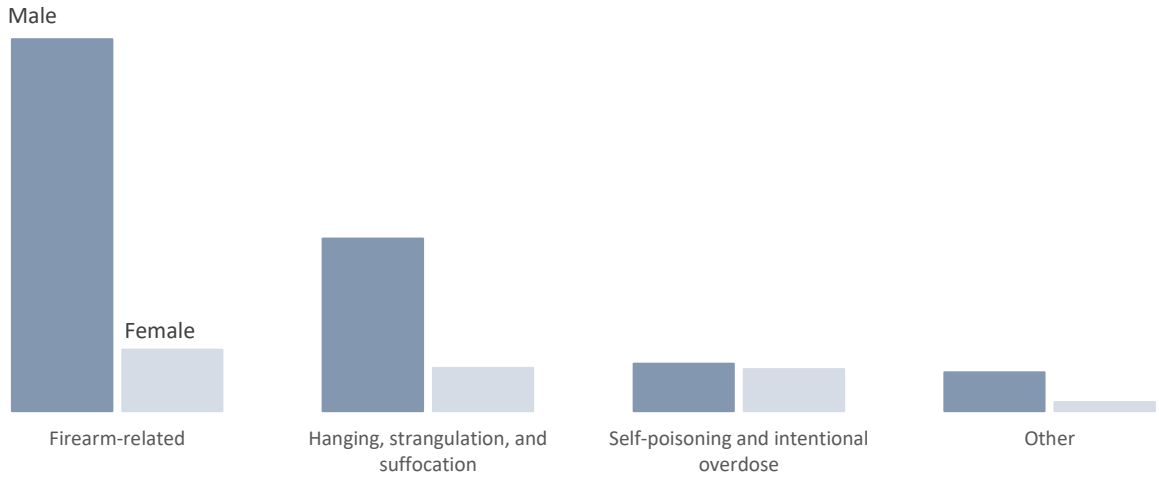
Males in Indiana experienced 4x as many deaths to suicide in Indiana when compared to females.
IDOH, Vital Records, Count, 2015-2018.



This disparity between genders cannot be overlooked as it has significant influence on other trends. For example, national research has shown that more women attempt suicide, but more men die by suicide.[18] One reason being that men use more lethal means.[17]

In Indiana, men are more likely to die by suicide through firearm-related self-injury or hanging, strangulation and suffocation self-injury deaths. This information is reflected in the graph on the next page. This trend in men being more likely to utilize firearms is seen on a national level as well.[17]

Males in Indiana had higher numbers of suicide deaths due to all means when compared to females. The disparity was largest among firearm-related and hanging-related deaths.
IDOH, Vital Records, Count, 2015-2018.

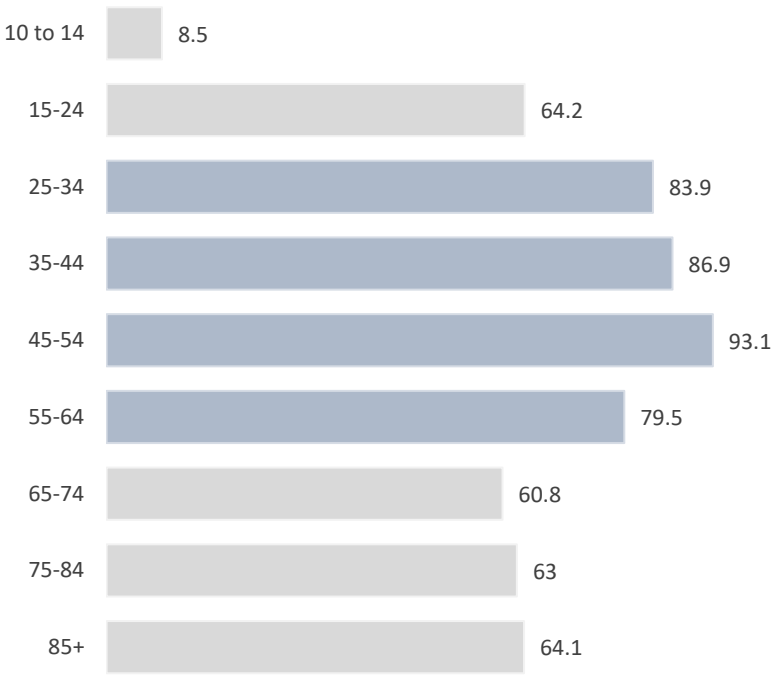


Age:

Women who died by suicide were on average younger than men, with an average age of 43.5 years compared to 45.4 years among men. When broken down into age groups, 70% of suicide deaths in Indiana occurred between the ages of 25 and 64. Deaths within these age categories have significant impact on the population as these ages are typically reflective of working-aged adults. Youth suicide rates have recently been increasing, with Indiana ranking in the top ten states for percentage increase in suicide death rates among persons aged 10-24. The percentage increase rate from 2007-2009 to 2016-2018 was 59.2.[20] In 2016-2018, the suicide death rate for persons aged 10-24 in Indiana was 12.1 per 100,000, falling above the U.S. rate at 10.3.[20]

45yrs.
The average age of all suicide deaths in Indiana.
IDOH, Vital Records, Rate per 100,000, 2015-2018.

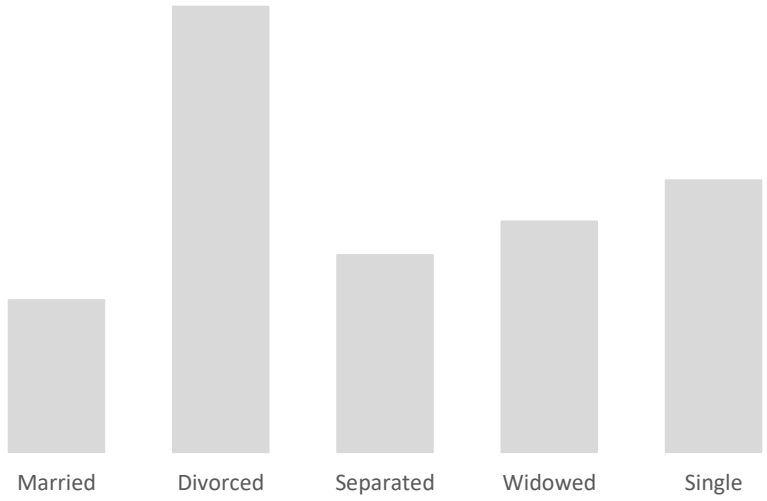
70% of suicide deaths in Indiana occurred between the ages of 25-64.
IDOH, Vital Records, Rate per 100,000, 2015-2018.



Marital status:

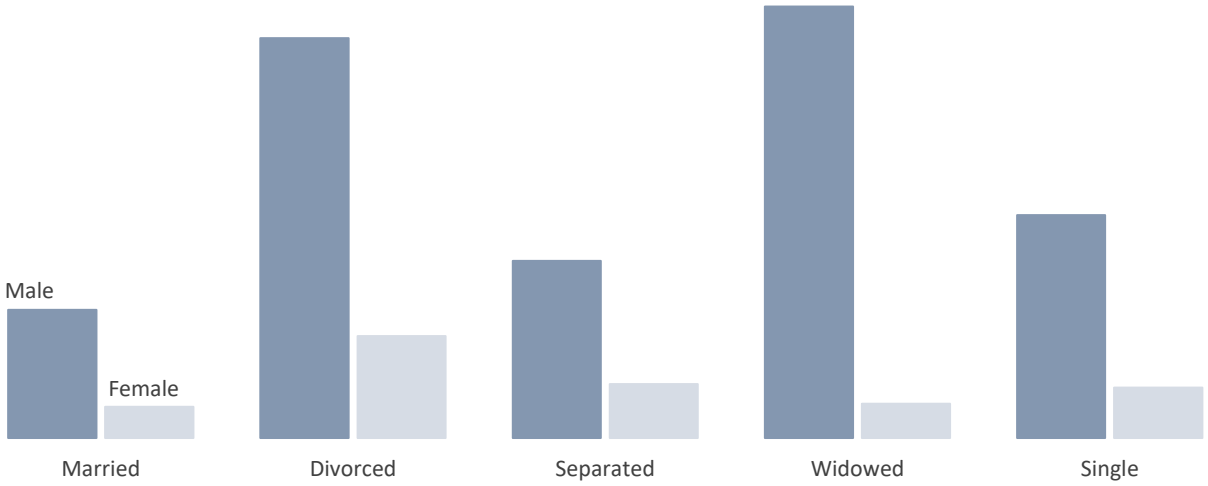
Relationship troubles or changes in relationship status are thought to be major stressors in life. These stressors can factor into the circumstances behind deaths by suicide. In suicide deaths between 2015-2018, at least 512 individuals (27%) were documented to have interpersonal violence and 127 individuals (5.4%) were documented to have a family relationship issue.

Individuals who were married at the time of death had the lowest rate of death by suicide, compared to individuals who were divorced who died at a rate almost 3x as high.
IDOH, Vital Records, Rate per 100,000, 2015-2018.



The marital status of people at the time of their death can estimate this effect, though it does not measure how recent changes in marital status may have occurred. The different rates of suicide among marital groups differs between genders.

Males in Indiana died by suicide at a higher rate than females in Indiana for all marital status types. While the rate of death by suicide was high among divorced men and women, the rate for widowed males and females had the widest gender gap.
IDOH, Vital



Veteran status:

Among adult deaths due to suicide in Indiana, 701 (21.2%) were noted as having ever been a part of the US Armed Forces. Using 5-year Census estimates, the rate of suicide among veteran adults in Indiana was found to be significantly higher the non-veteran adult rate.

Adult veterans are

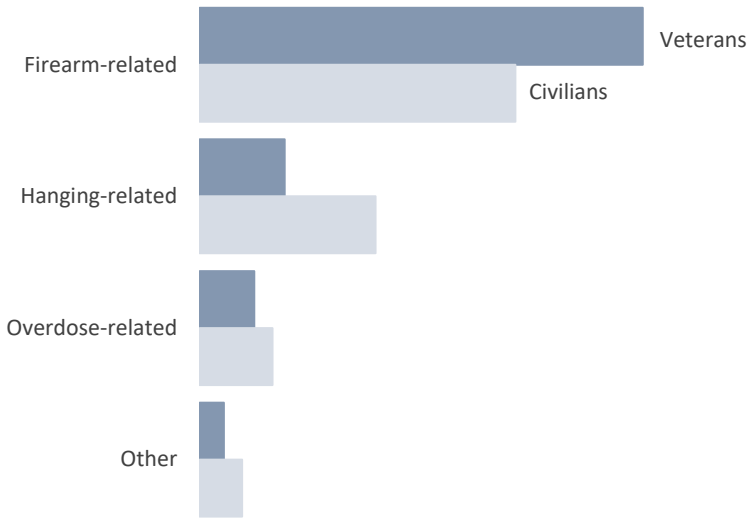
2.5x

more likely to die by suicide than non-veteran adults.

IUS Census Bureau, Rate.

When comparing veteran and civilian suicide death rates, veterans were more likely to have a firearm-related suicide.

IDOH, Vital Records, Rate per 100,000, 2013-2018.



Of individuals who died by suicide with a documented mental health diagnosis, 75% were diagnosed with depression.

IDOH, INVDRS, Count, 2015-2018.

Circumstances:

The IDOH Division of Trauma and Injury investigates deaths due to injury, including those due to intentional self-injury. This information is all input into the Indiana Violent Death Reporting System (INVDRS), a database run in partnership with the Centers for Disease Control and Prevention. While data on circumstances is limited from the INVDRS, in well-detailed reports, there is some circumstantial information. For example, from 2015-2018, 46.4% of cases where circumstances were available documented some type of mental illness. These mental illnesses from that time period are shown in the graph on the left. The most frequent diagnosis among individuals where circumstances were reported was depression or dysthymia.

This type of investigation captures measures surrounding the circumstances of the death beyond the demographics listed on the death certificate. The circumstances to every question are not always available or known, however, looking at what is known can give a picture of common circumstantial trends.

For example, in the same sample looked at previously (2015-2018), it was found that at least 633 individuals who later died by suicide had a history of suicidal thoughts (27%) and at least 462 individuals expressed suicidal intent (19.7%). Though these data are not reflective of all suicide deaths in the 2015-2018 time period, it helps to illustrate some of the circumstances surrounding the death.

Location of Death

IDOH, INVDRS, Count, 2018.

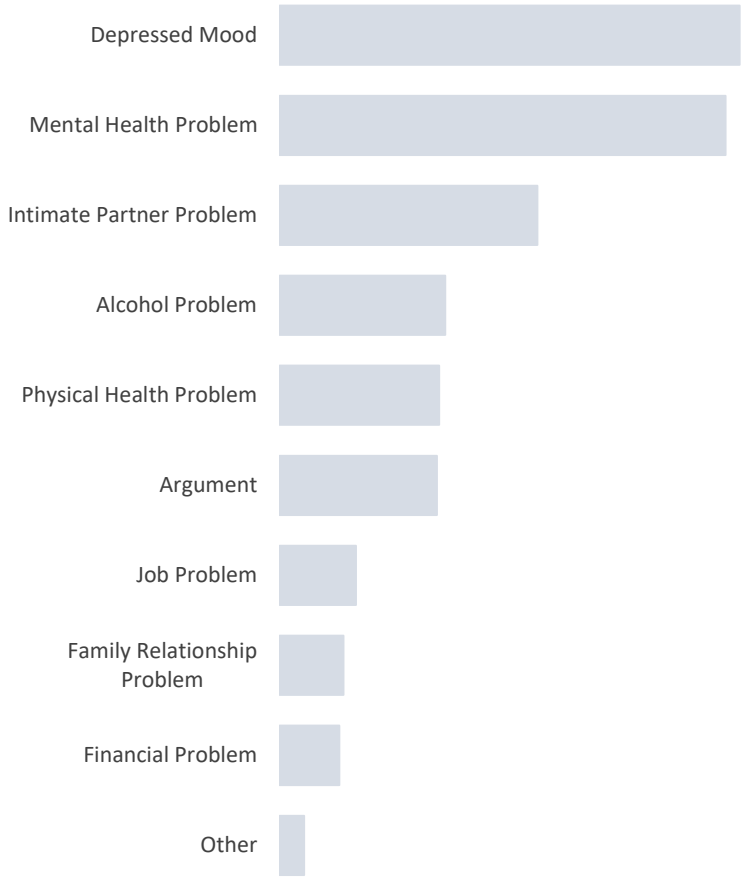
78% House/Apartment

5% Motor Vehicle

4% Natural Area

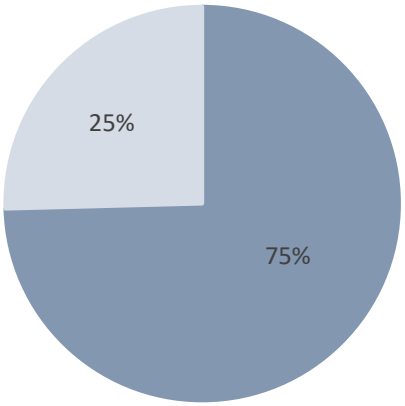
Of individuals who died by suicide where circumstances were known between 2015-2018, 39% were documented to be in a depressed mood.

IDOH, INVDRS, Count, 2015-2018.



Of individuals who died by suicide in Indiana, the majority of cases did not include a suicide note.

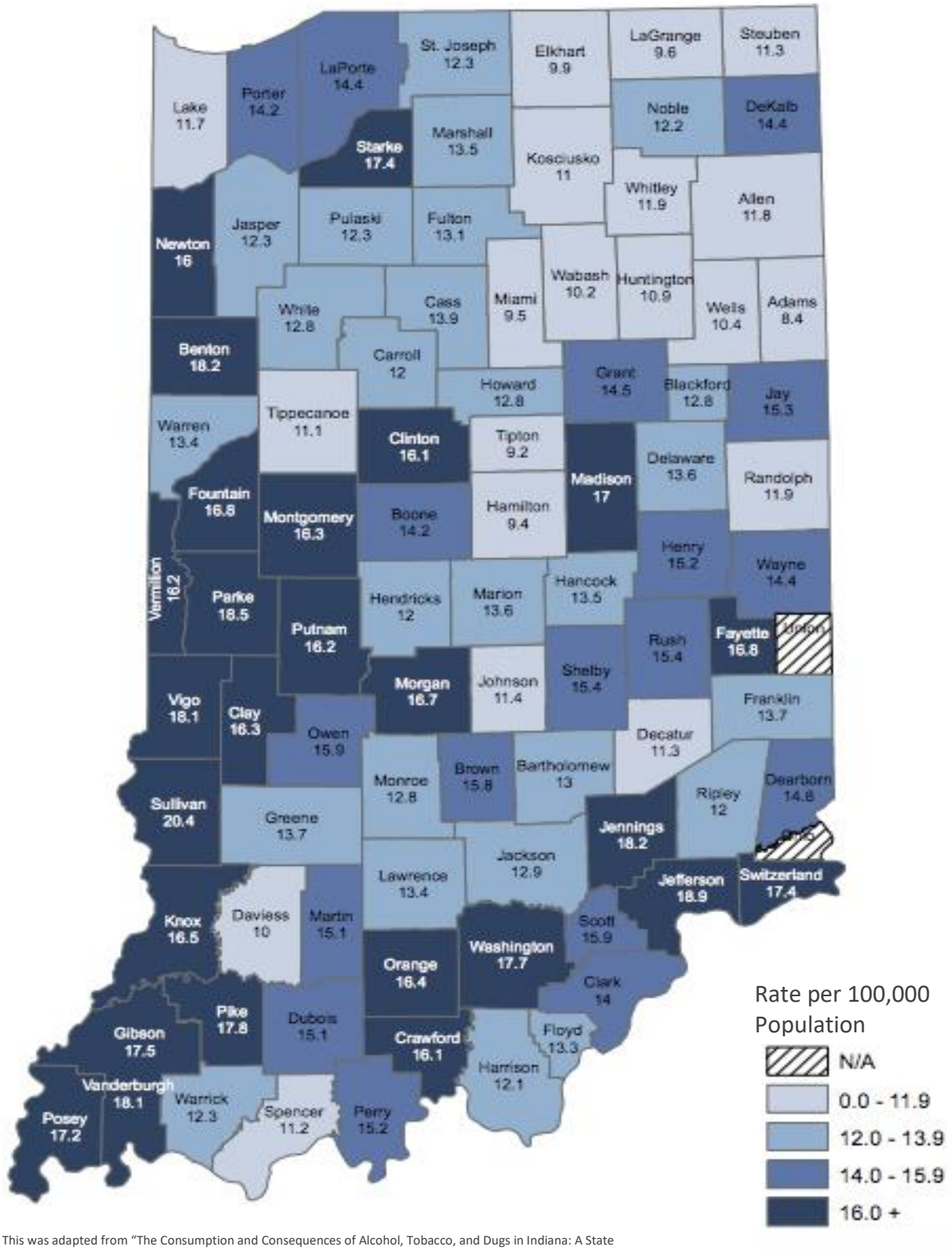
IDOH, INVDRS, Count, 2015-2018.



The graphics from were taken from Noun Project (House by Тимур Минвалеев,Car by Cho Nix, Christmas Tree by Daniela Baptista), found here:thenounproject.com.

Deaths by suicide in Indiana

CDC, 1999-2018.



This was adapted from "The Consumption and Consequences of Alcohol, Tobacco, and Dugs in Indiana: A State Epidemiological Profile 2018," found here: https://fsph.iupui.edu/doc/research-centers/EPI_2019_Web.pdf

Healthcare

Introduction

Healthcare professionals work every day to improve the health and wellness of their patients. As such, healthcare professionals should be prepared to treat a patient experiencing suicidal ideation or following a suicide attempt. Being prepared can simply mean screening every patient and having the policies and protocols in place to address patients presenting with suicide risk. On an individual level, this can be having a protocol in place after a patient discloses they are experiencing suicidal ideation. On a population-level, this can be evaluating the current hospital screening and discharge protocol.

As far as data, there is a clear trend showing need for greater healthcare engagement. For example, after patients leave inpatient psychiatric care, their suicide death rate is 300 times higher in the first week and 200 times higher in the first month when compared with the general population's.[2] The individual's suicide risk remains high for up to three months after discharge and for some, their elevated risk persists longer.[3-5] Additionally, a recent study found that individuals who presented in emergency departments (EDs) with deliberative self-harm had a suicide rate of 56.8 times higher than demographically similar individuals the year after their visit.[19] Those with suicidal ideation had a 31.4 times higher rate.[19] In fact, one out of seven people in the United States who died by suicide had contact with inpatient mental health services in the year before their death.[6] Of individuals who later died by suicide, 46% had a mental health diagnosis and 90% had shown symptoms of a known mental health condition.[7]

Healthcare Resources:

- Warning Signs of Suicide
- Screening Tools Guide
- Safety Planning Guide
- Suicide Safety Planning Template
- Discharge Protocol
- After a Suicide Attempt: What Family Members Need to Know
- After a Suicide Attempt: What Family Members Need to Know
    - *Also included in the Family and First Responder sections of the toolkit
- Provider Self-Care Checklist
- Suicide Training: Healthcare (p. 205-208)

Warning Signs of Suicide

Talking about wanting to die or to kill oneself

Looking for a way to kill oneself

Talking about feeling hopeless or having no purpose

Talking about feeling trapped or being in unbearable pain

Talking about being a burden to others

Increasing the use of alcohol or drugs

Acting anxious, agitated, or reckless

Sleeping too little or too much

Withdrawing or feeling isolated

Showing rage or talking about seeking revenge

Displaying extreme mood swings

If a patient is showing some or all of these signs, the provider should connect the patient with further care.

This was adapted from SAVES's "Warning Signs," which can be found here: https://www.sprc.org/edguide and Zero Suicide's "Identify" page, found here: https://save.org/about-suicide/warning-signs-risk-factors-protective-factors/

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SCREENING TOOLS GUIDE

There are several different screening tools that healthcare facilities can utilize to decide what course of action needs to be taken with a patient presenting with suicidal ideation or following a suicide attempt. Below is a guide of the tools that will be mentioned in the subsequent pages. Of course, this screening process may look different depending on the healthcare facility's admission process and none of these tools should ever replace a provider's best judgment or experience.

Type of Tool	Used With	Tells You
Primary Screening Tool	Every ED patient or patients with known risk factors	Whether suicide risk is present or absent
Secondary Screening Tool (Decision Support Tool)	Patient with some suicide risk as identified through primary screening, patient disclosure, or other indicators	Whether discharge following ED-based interventions may be appropriate or further assessment by a mental health specialist is needed to make a disposition determination
Comprehensive Suicide Risk Assessment	Patients with suicide risk who score positive (greater than or equal to 1) on the Decision Support Tool Note: If resources permit, a suicide risk assessment may be used with any patient with suicide risk.	Information about a patient's risk and protective factors, immediate danger, and treatment needs

If providers are implementing a screening protocol in a clinical practice, it can be helpful to refer to tools such as the Suicide Prevention Resource Center's Suicide Prevention Toolkit for Primary Care Practices. http://www.sprc.org/sites/default/files/Final%20National%20Suicide%20Prevention%20Toolkit%202.15.18%20FINAL.pdf.

This was adapted from SPRC's "Caring for adult patients with suicide risk: A consensus guide for ED's," which can be found here: https://www.sprc.org/edguide and Zero Suicide's "Identify" page, found here: http://zerosuicide.edc.org/toolkit/identify.

Primary Screening Tool

Different healthcare entities use different types of primary screening tools. Sometimes, this can be explained by examining whether the organization itself will provide the comprehensive care after a patient is found to be at risk. Some initial primary screening tools organizations can include:

- Patient Health Questionnaire (PHQ)
- Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)
- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Ask Suicide-Screening Questions (ASQ)
- Patient Safety Screener (PSS-3)

If organizations hare having difficulty choosing a primary screening tool, they can refer to: http://zerosuicide.edc.org/webinar/screening-and-assessment-suicide-health-care-settings.

Secondary Screening Tool (Decision Support Tool)

The Decision Support Tool is a secondary screening instrument developed to help ED providers make decisions about the care of adult patients with suicide risk. It indicates whether a patient's health and safety needs may be met in the outpatient environment following a brief ED-based intervention or whether evaluation from a mental health specialist may be needed first. The tool is designed for use with adult patients who have been identified as having suicide risk and who have the capacity to make health care decisions. In the Decision Support Tool, the following questions are asked:

- *Transition Question: Confirm Suicidal Ideation (not a part of scoring)*
  - *Have you had recent thoughts of killing yourself?*
  - **Is there other evidence of suicidal ideation, such as reports from family or friends?*
- *Thoughts of carrying out a plan*
  - *Recently have you been thinking how you might kill yourself?*
  - **If yes, consider the immediate safety needs of the patient.*
- *Suicide intent*
  - *Do you have any intention of killing yourself?*
- *Past suicide attempt*
  - *Have you ever tried to kill yourself?*
- *Significant mental health condition*
  - *Have you had treatment for mental health problems?*
  - *Do you have a mental health issue that affects your ability to do things in life?*
- *Substance use disorder*
  - *Have you had four or more (female) or five or more (male) drinks on one occasion in the past month or have you used drugs or medication for non-medical reasons in the past month?*
  - *Has drinking or drug use been a problem for you?*
- *Irritability/Agitation/Aggression*
  - *Recently, have you been feeling very anxious or agitated?*
  - *Have you been having conflicts or getting into fights?*
  - *Is there direct evidence of irritability, agitation, or aggression?*

A quick guide of the Decision Support Tool can be found here: https://www.sprc.org/sites/default/files/EDGuide_quickversion.pdf.

Comprehensive Suicide Risk Assessment

Mental health evaluations conducted during the ED visit should include a comprehensive suicide risk assessment that goes beyond the secondary screening. The purpose of the risk assessment is to determine whether the patient is in immediate danger and to make decisions about treatment. Three direct warning signs, listed below, predict the highest likelihood of suicide-related behaviors occurring in the near future. Observing these warning signs warrants immediate attention, mental health evaluation, referral, or consideration of hospitalization to ensure the safety, stability and security of the individual.

Communication with Signs of Suicidal Ideation - writing or talking about suicide, wish to die, or death (threatening to hurt or kill self) or intention to act on those ideas Patients should be directly asked if they have thoughts of suicide and to describe them. The evaluation of suicidal ideation should include the following:

- *Onset (When did it begin)*
- *Duration (Acute, Chronic, Recurrent) Intensity (Fleeting, Nagging, Intense)*
- *Frequency (Rare, Intermittent, Daily, Unabating)*
- *Active or passive nature of the ideation ('Wish I was dead' vs. 'Thinking of killing myself')*
- *Whether the individual wishes to kill themselves, or is thinking about or engaging in potentially dangerous behavior for some other reason (e.g., cutting oneself as a means of relieving emotional distress)*
- *Lethality of the plan (No plan, Overdose, Hanging, Firearm)*
- *Triggering events or stressors (Relationship, Illness, Loss)*
- *What intensifies the thoughts and what distracts the thoughts?*
- *Association with states of intoxication (Are episodes of ideation present or exacerbated only when individual is intoxicated? This does not make them less serious; however, may provide a specific target for treatment)*
- *Understanding regarding the consequences of future potential actions*

Preparations for Suicide - evidence or expression of suicide intent, and/or taking steps towards implementation of a plan, making arrangements to divest responsibility for dependent others (children, pets, elders), or making other preparations such as updating wills, making financial arrangements for paying bills, saying goodbye to loved ones, etc. Patients should be asked about the following:

- *The evaluation of intent to die should be characterized by:*
  - *Intensity of the desire to die*
  - *Intensity of determination to act*
  - *Intensity of impulse to act or ability to resist the impulse to act*
- *The evaluation of intent should be based on indication that the individual:*
  - *Wishes to die*
  - *Means to kill him/herself*
  - *Understands the probable consequences of the actions or potential actions*
  - *Has thought about a lethal plan, has the ability to engage that plan, and is likely to carry out the plan*

Seeking Access or Recent Use of Lethal Means - such as weapons, medications, toxins or other lethal means. Clinicians should evaluate preparatory behaviors by inquiring about:

- *Preparatory behavior like practicing a suicide plan. For example:*
  - *Mentally walking through the attempt*
  - *Walking to the bridge*
  - *Handling the weapon*
  - *Researching for methods on the internet*
- *Thoughts about where they would do it and the likelihood of being found/ interrupted?*
- *Action to seek access to lethal means or explored the lethality of means. For example:*
  - *Acquiring a firearm or ammunition*
  - *Hoarding medication*
  - *Purchasing a rope, blade, etc.*
  - *Researching ways to kill oneself on the internet*
- *Action taken or other steps in preparing to end one's life:*
  - *Writing a will, suicide note*
  - *Giving away possessing*
  - *Reviewing life insurance policy*
- *Obtain information from sources such as family members and medical records.*

Throughout all these steps, keep in mind the following:

- Treat patients with suicide risk in the same manner you would treat those with other medical emergencies.
- Express care for his or her comfort and dignity, such as allowing a person to wear "street clothes" unless it is necessary to disrobe.
- Build rapport. This increases trust and may help patients share information more readily and honestly.
- Collaborate with the patient. Ask for his or her opinion. Attempt to engage patients in decision making even if they don't initially agree, and only make promises you can keep.
- Check in with the patient regularly to see how the ED visit is going. Provide information about what to expect during the visit and patient rights.
- When possible maintain provider continuity for patients experiencing suicidal ideation or notify the patient in advance when provider assignments change.
- With the patient's permission, involve trusted informal caregivers (e.g., family, friends) and outpatient providers in treatment decisions and discharge planning.
- Offer the support of a certified peer specialist for the patient during his or her visit.
- Keep in mind that in mind that some individuals may not be as forthcoming with suicidal ideation, depending on their background and situation. This could be due to religious reasons (e.g. believing those who die by suicide go to hell) or fears of confidentiality (e.g. living in a small inter-connected community). Reassure the individual that help is available, and they are not alone.
- Throughout all healthcare settings, it is vital to reinforce resources like the National Suicide Prevention Lifeline (Call 1-800-273-8255 [TALK] or text "IN" to 741-741).

What are the steps after the plan is developed?

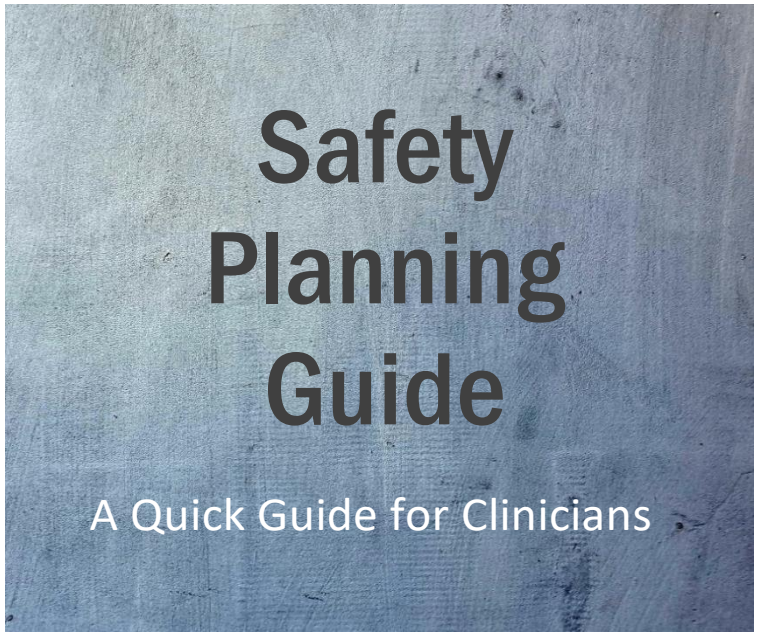
ASSESS the likelihood that the overall safety plan will be used, and problem solve with the patient to identify barriers or obstacles to using the plan.

DISCUSS where the patient will keep the safety plan and how it will be located during a crisis.

EVALUATE if the format is appropriate for patient's capacity and circumstances. Consider if there should be any social media element protection included, if this is a sensitive point for the patient.

REVIEW the plan periodically when patient's circumstances or needs change.

This tool was originally developed by the WICHE Center for Rural Mental Health Research and the Suicide Prevention Research Center. The original document can be found here:
http://www.sprc.org/sites/default/files/SafetyPlanningGuide%20Quick%20Guide%20for%20Clinicians.pdf



WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicide crisis. The plan is brief, is in the patient's own words, and is easy to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicide crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use. While this is a clinical process, anyone can create safety plan as this is a vital step in suicide prevention. Individuals do not need to be mental health professionals.

DEVELOPING AND IMPLEMENTING THE SAFETY PLAN

The following section outlines the six steps in building and putting into action a safety plan.

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Developing and Implementing the Safety Plan: A Six Step Process

Warning Signs

*Ask: **"How will you know when the safety plan should be used?"**
*Ask: **"What do you experience when you start to think about suicide or feel extremely depressed?"**
*List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patient's own words.

Internal Coping Strategies

*Ask: **"What can you do, on your own, if you experience suicidal ideation again, to help yourself not to act on your thoughts?"**
*Assess likelihood of use: Ask: **"How likely do you think you would be able to do this step during a time of crisis?"**
*If doubt about use is expressed, ask: **"What might stand in the way of you thinking of these activities or doing them?"**
*Use a collaborative, problem solving approach to address potential roadblocks and identify alternative coping strategies.

Social Contacts Who May Distract from the Crisis

*Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
*Ask: **"Who or what social settings help you take your mind off your problems at least for a little while?" "Who helps you feel better when you socialize with them?"**
*Ask for safe places they can go to be around people (i.e. coffee shop).
*Ask patient to list several people and social settings in case the first option is unavailable. Keep in mind the potential for online supports.
*Remember, in this step, the goal is distraction from suicidal ideation.
*Assess likelihood that patient will engage in this step; identify potential obstacles, and problem solve, as appropriate.

Family Members or Friends Who May Offer Help

*Instruct patients to use Step 4 if Step 3 does not resolve crisis
*Ask: **"Among your family or friends, who do you think you could contact for help during a crisis?"** or **"Who is supportive of you and who do you feel that you can talk with when you're under stress?"**
*Ask patients to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
*Assess likelihood patient will engage in this step; identify potential obstacles, and problem solve.
Role play and rehearsal can be very useful in this step.

Professionals and Agencies to Contact for Help

*Instruct the patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
*Ask: **"Who are the mental health professionals that we should identify to be on your safety plan?"** and **"Are there other health care providers?"**
*List names, numbers of clinicians and urgent care services.
*Assess likelihood patient will engage in this step; identify potential obstacles, and problem solve.
*Role play and rehearsal can be very useful in this step.

Making the Environment Safe

*Ask patients which means they would consider using during a suicidal crisis.
*Ask: **"Do you own a firearm, such as a gun or rifle?"** and **"What other means do you have access to and may use to attempt to kill yourself?"**
*Collaboratively identify ways to secure or limit access to lethal means: Ask: "How can we go about developing a plan to limit your access to these means?"
*For low lethality methods, clinicians may ask patients to remove or limit their access to these methods.
*Restricting the patient's access to a **highly lethal method**.

SUICIDE SAFETY PLANNING TEMPLATE

Step 1: Recognizing warning signs that signal that you need to find help: Identify specific thoughts, feelings, situations and behaviours that may predict a crisis. Examples include feeling that emotional pain will never end, having persistent thoughts that others would be better off without you.

Step 2: What can you do by yourself to take your mind off the problem? What obstacles might there be to using these coping skills? List activities that may take your mind off thoughts related to suicidal ideation. This allows time to pass and for the impulses to subside. Simple, engrossing activities can be surprisingly helpful. Examples include listening to calming music, exercising, going for a walk or playing a musical instrument.

Step 3: If you are unable to deal with your distressed mood alone, contact trusted family or friends, and think of social settings that offer support as well as distraction from the crisis.

Name:_____ Phone number:_____
Name:_____ Phone number:_____
Name:_____ Phone number:_____
Name:_____ Phone number:_____

Place that provides distraction: _____
Place that provides distraction: _____

Step 4: Contact local health professionals or emergency services if you continue to have thoughts of suicide. Create a list of names, phone numbers and locations that can be contacted during a suicide emergency. A crisis is no time to begin searching for this type of information.

Clinician Name: Phone number:
Clinician Name: Phone number:
Local Urgent Care Services:_____ Phone number:_____
Suicide Prevention Lifeline Phone: 1-800-273-8255 or text “HELLO” to 741741

This plan has been developed using information from Reach Out and ‘Safety Planning Intervention’ by Barbara Stanley and Gregory Brown from National Suicide Prevention Lifeline. A copy of this plan can be found here: https://www.template.net/business/plan-templates/plan-sample/

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Step 5: Make sure that access to any deadly means of self-harm are minimized. For example, limiting the number of pills available at any one time and removing any potentially harmful implements considered in plans. It is a myth that if someone wants to die by suicide, they will, no matter what. In fact, limiting access to deadly means makes a real difference. The strongest of feelings tied to suicidal ideation typically last only a brief period. If it is more difficult to act during these periods, there is a good chance that the feelings will subside.

Step 6: What is most important to me and worth living for:

DISCHARGE PROTOCOL

The emerging standard in suicide care requires innovative approaches to creating smooth and uninterrupted care transitions from one setting to another with support and contact provided throughout by the behavioral health provider, physician, or other designated staff from the organization. Keep in mind that if the patent has Medicaid, they can be connected to their managed care company in this process. Specifically, the referring staff member should do the following:

Talk with the patient about the risk of suicide during the post-discharge timeframe, including warning signs of a worsening condition, what to do, and when to return to the hospital.

Encourage family participation and engage all community supports such as schools to ensure a smooth transition for the patient. Possible partners could include schools, workplaces, etc.

Provide every patient with crisis center information upon discharge from treatment with their safety plan, explaining the purpose, utility, and services offered by the crisis center.

Ensure the patient has spoken over the phone with the new provider. Consider innovative approaches for connecting the two such as meeting in person or bridging the therapy through a case manager.

Schedule the first outpatient session before the patient is discharged, optimally scheduling 24-72 hours after discharge. Call the new provider and share patient records before the first appointment.

Contact the patient within 24–48 hours after they have transitioned to the next care provider. Provide ongoing caring contacts within seven days of discharge and for at least 12 months or more.

One of the most important things healthcare professionals can do for a patient or family member after having been in a healthcare facility is to **offer hope.** Patients and families will look to healthcare professionals to determine the prognosis and for some assurance that this will not happen again.

If a patient does have a reoccurrence of suicidal ideation, as it can when people recover, it is not a sign that the treatment is not working. This is a sign that the brain is still healing and that the individual needs to use the plan that was built and reach out. Assure the patient that they are not alone, and that help is available.

This was adapted from the Action Alliance's "Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care," which can be found here: https://theactionalliance.org/sites/default/files/report_-_best_practices_in_care_transitions_final.pdf. It was also adapted from SAMHSA's "After an Attempt: A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors," which can be found here: https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4359.pdf

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AFTER AN ATTEMPT: What Family Members Need to Know

Suicide is a traumatic experience for both the individual who attempted and the family. As the family member, you may feel numb and lost, not knowing where to turn. Experiencing a range of emotions is completely normal. When it comes time for that individual to come home, it can be good to start thinking about safety. Research shows that when an individual has a previous attempted, they do have higher risk of later dying by suicide. As a family member, you can help your loved by reducing risk.

Reduce the Risk at Home—To help reduce the risk of self-harm or suicide at home, here are some things to consider:

- Guns are high risk and the leading means of death for individuals experiencing suicidal ideation —they should be taken out of the home and secured.
- Overdoses are common and can be lethal—if it is necessary to keep pain relievers such as aspirin, Advil, and Tylenol in the home, only keep small quantities or consider keeping medications in a locked container. Remove unused or expired medicine from the home.
- Alcohol use or abuse can decrease inhibitions and cause people to act more freely on their feelings. As with pain relievers, keep only small quantities of alcohol in the home, or none.

Create a Safety Plan—Following a suicide attempt, a safety plan should be created to help prevent another attempt. The plan should be a joint effort between your relative and his or her doctor, therapist, or the emergency department staff, and you. As a family member, you should know your relative's safety plan and understand your role in it, including:

- Knowing your family member's "triggers," such as an anniversary of a loss, alcohol, or stress from relationships.
- Building supports for your family member with mental health professionals, family, friends, and community resources.
- Working with your family member's strengths to promote his or her safety.
- Promoting communication and honesty in your relationship with your family member.

Remember that safety cannot be guaranteed by anyone—the goal is to reduce the risks and build supports for everyone in the family. However, it is important for you to believe that the safety plan can help keep your relative safe. If you do not feel that it can, let the emergency department staff know before you leave.

Maintain Hope and Self-Care—Families commonly provide a safety net and a vision of hope for their relative experiencing suicidal ideation, and that can be emotionally exhausting. Never try to handle this situation alone—get support from friends, relatives, and organizations such as the National Alliance on Mental Illness (NAMI), and get professional input whenever possible. Use the resources on the back pages of this brochure, the Internet, family, and friends to help you create a support network. You do not have to travel this road alone.

This was adapted from "After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department." This can be found here: https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4357eng.pdf. The graphics are from Noun Project (Check Mark by P.J. Onori, US)

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AFTER A SUICIDE LOSS: What Family Members Need to Know

Life as you know it has changed forever. You may feel numb and lost, not knowing where to turn. Experiencing a range of emotions is common: fear, anger, relief, abandonment, guilt, shame, and perhaps even responsibility for your loved one's death. These can change rapidly, and family members may have different reactions at different times which sometimes can lead to conflict.

Know that others have walked this difficult path before you. Reach out to those who have survived a suicide loss. Move forward step by step at your own pace and do not allow anyone to rush or criticize your grieving process. YOU ARE NOT ALONE. There are many ways to connect to others—staying in contact with others can help you through your grief.

Reach out for support:

- Attend a support group for suicide loss survivors (in person or online)
- Talk to a professional grief counselor
- Seek a licensed mental health provider, if needed
- Talk with those you trust (family, friends, faith leader, neighbors) to share your loss and pain
- Continue to ask the "why?" questions if you need to

Grieving can take over your life, so taking care of yourself is important:

- Try to get plenty of sleep, rest, and be gentle with yourself
- Eat healthy food and drink water
- Keep yourself busy by doing something you enjoy
- Continue your exercise routine

When a loved one passes away, it can be a very difficult time. Trying to remember all the details that must be taken care of related to a person's death is hard. In the next few pages, there are a list of items marked as things to do immediately, within a few days, and within a few weeks.

This was adapted from "Health & Hope: For Survivors of Suicide Loss." This can be found here: http://www.sprc.org/sites/default/files/resource-program/Help-and-Hope-For-Survivors-of-Suicide-Loss.pdf. This was also adapted from Ever Loved's "What to Do When Someone Dies: A Checklist," which can be found here: https://everloved.com/articles/end-of-life-affairs/what-to-do-when-someone-dies-checklist/

What to do immediately

1. **Get a death certificate.** If your loved one died in a hospital, a doctor can take care of this for you. However, if your loved one passed at home or in another location, you'll need to know who to call. If your family member wasn't at a hospital, call 911.

2. **Arrange for organ donation, if applicable.** Check your loved one's driver's license and/or advance directive (living will or health care proxy) to see if he or she was an organ donor. If so, let hospital staff know immediately (or call a nearby hospital if your loved one died at home).

3. **Contact immediate family.** Every family is different, and there's no one right way to do this. For some families, sharing the news in-person or over the phone is critical. For others an email or text message may be alright.

4. **Enlist help from family and friends.** There are a number of ways family and friends can help you, such as: answering the phone; collecting mail; caring for pets; finding important items (such as keys, insurance policies, claims forms, addresses for magazine subscriptions, etc.); staying at the home during the wake, funeral, and/or memorial services to guard against break-ins; organizing food for family and friends after the services.

5. **Notify the individual's religious leader, if applicable.** Contact the deceased's Pastor, Rabbi, Priest or other religious leader if there is one. He or she can help with counseling for surviving family and friends. They can also help you make funeral arrangements or services.

6. **Decide what you'd like to do with your loved one's body and arrange transportation.** First, check to see if your loved one expressed any wishes about final disposition or had made prepayments to a funeral home or cemetery. Ideally, there will be documentation with other medical documents. If no wishes or plans have been stated, you have three main options:
    - *Call a funeral home.* A funeral home can help you arrange either a burial or cremation. Check reviews and prices for a few different funeral homes before making a decision.
    - *Call a crematory.* While you can arrange a cremation through a funeral home, there are also crematories that will work with you directly if you aren't interested in the added services of a funeral director.
    - *Call a full-body donation organization.* Your loved one may have already registered to be a body donor, so check for paperwork. If he or she hasn't, there are still many programs that accept donations from next of kin.

7. **Arrange care for any pets or dependents.** If your loved one was responsible for caring for one or more people or pets, quickly find someone who can care for them temporarily.

8. **Secure major property.** If your loved one lived on their own, make sure his or her home and any vehicles are locked up. If it will sit vacant for some time, consider notifying the landlord and/or the police, so they can help to keep an eye on it.

9. **Notify the person's employer.** If the deceased was employed (or actively volunteering), call to let them know that your loved one has passed away. This is also a good time to ask about pay owed, benefits and life insurance.

What to do within a few days

1. **Decide on funeral plans.** If you decided to work with a funeral home, meet with the funeral director to go through your options. If you opted for an immediate burial (burial without any ceremonies), cremation or donation to science, you may also choose to hold a memorial service or celebration of life at a later date.

2. **Order a casket or urn.** You may choose to purchase a casket or urn directly through the funeral home. However, you can often find caskets online for hundreds (even thousands) of dollars less, and some websites even offer free overnight delivery.

3. **For a veteran, ask about special arrangements.** A range of benefits can help tailor a veteran's service. You may be able to get assistance with the funeral, burial plot or other benefits. You can find many details about options as well as potential survivor benefits at the U.S. Department of Veterans Affairs website.

4. **Consider whether you need or want other financial assistance for the funeral and burial.** Help might be available from a number of sources, including a church, a union or a fraternal organization that the deceased belonged to.

5. **Ask the post office to forward mail.** If the person lived alone, this will prevent mail from piling up and showing that no one is living in the home. The mail may also help you identify bills that need to be paid and accounts that should be closed. You'll need to file a request at the post office, show proof that you are an appointed executor, and authorized to manage his/her mail.

6. **Perform a check of the person's home.** Throw out any food that will expire, water plants, and look for anything else that may need regular care.

7. **Update the utilities.** Tell local utilities (telephone, gas, electricity, cable) about the death, only if someone else wants to be put on the accounts. Otherwise wait until you decide whether or not and when the utilities are to be turned off.

8. **Prepare an obituary.** The funeral home might offer the service, or you might want to write an obituary yourself. If you want to publish it in a newspaper, check on rates, deadlines and submission guidelines.

What to do within a few weeks

1. **Order a headstone.** Since headstones are rarely ready in time for a burial, you can save this until after the funeral when you have some more time. You can order a headstone through the cemetery, but you'll have more options (and often lower prices) if you look online.

2. **Order several copies of the death certificate.** You will likely need anywhere between 5 and 10 copies (but possibly more), depending on the accounts that your loved one had open. Your funeral director may be able to help you order them, or you can order them yourself from city hall or another local records office. Your certified copies should say display an official seal and say, *"This is an exact copy of the death certificate received for filing in_____ County*."

3. **Start the probate process with the will.** If the estate is relatively small, doesn't contain unusual assets and isn't likely to be disputed by family members you may be able to handle it yourself.

4. **Contact the Social Security office.** Your funeral director may have already done this, so find out if this is the case. If you need to contact social security yourself, you can reach them by phone at 1-800-772-1213. Through Social Security you may be able to apply for survivor benefits.

5. **Handle Medicare.** If your loved one received Medicare, Social Security will inform the program of the death. If the deceased had been enrolled in Medicare Prescription Drug Coverage (Part D), Medicare Advantage plan or had a Medigap policy, contact these plans at the phone numbers provided on each plan membership card to cancel the insurance.

6. **Notify any banks or mortgage companies.** If you're unsure of what accounts your loved one held, use their mail and any online accounts you have access to in order to identify what accounts may be open. Then, take copies of the death certificate to each bank and change ownership of the accounts.

7. **Reach out to any financial advisors or brokers.** Try to identify any additional financial and investment accounts that your loved one held. Work with each one to transfer ownership. You'll likely need a death certificate for each account.

8. **Contact a tax accountant.** You'll need to file a return for both the individual and the estate.

9. **Notify life insurance companies.** Fill out the claim form for any life insurance policies that the deceased had. Also, suggest that friends and family who may have listed your loved one on their own life insurance policies update theirs.

10. **Cancel insurance policies.** This could include health insurance, car insurance, homeowner's insurance or anything else. Depending on the policy, reach out to either the insurance company or your loved one's employer to stop coverage.

11. **Determine any employment benefits.** If your loved one was working at the time of their death, contact their employer to find out about union death benefits, pension plans and credit unions.

12. **Identify and pay important bills.** Make a list of bills that are likely to be due (e.g. mortgage, car payments, electricity), tracking them down via the person's mail and online accounts.

13. **Close credit card accounts.** Leverage your loved one's mail, wallet and any online accounts you have access to in order to identify open credit card accounts. For each one, you'll likely need to call customer service and then email or mail a copy of the death certificate.

14. **Notify credit reporting agencies.** Provide copies of the death certificate to Experian, Equifax and TransUnion in order to reduce the chances of identity theft. It's also a good idea to check your loved one's credit history in another month to confirm that no new accounts have been opened.

15. **Creditors.** Letters should be sent to all creditors informing them of the person's death. If any life insurance coverage can pay off the balances, a copy of the death certificate will be needed. Do not tell any of them you will be paying the balances with your own money. The estate needs to pay these, not family members, no matter what the creditors tell you. If nothing is left in the estate to pay off debts, then tell the creditors this.

16. **Contact a tax preparer.** A return will need to be filed for the individual, as well as for an estate return. Keep monthly bank statements on all individual and joint accounts that show the account balance on the day of death.

17. **Cancel the person's driver's license.** Go online or call your state's DMV for instructions, having a copy of the death certificate ready. Additionally, notify the local election board. This will help to prevent identity theft and voter fraud.

18. **Memorialize your loved one's Facebook account.** If your loved one was on Facebook, you can memorialize their account. This will let current friends continue to post and share memories but will keep anyone from logging into it in the future.

19. **Close email accounts.** Once you feel confident that you have necessary information on other accounts, it's a good idea to permanently close your loved one's email accounts as an additional step to prevent fraud and identity theft.

20. **Dispose of Personal Items and Clothing.** It is hard, but as soon as possible, you should try to dispose items which will no longer be used by the survivors. Everyone does this at a different time. Ask for help with this, if you need it. No items should be moved, sold, or given away if they have been identified in the person's will to be given out to survivors.

21. **Find Important Documents.** There are some documents that may be needed or at least helpful in settling the estate of the deceased. Documents might include: *safe deposit rental agreement and keys; trust agreements; nuptial agreements/marriage licenses/prenuptial agreements/divorce papers; life insurance policies or statements; pension, IRA, retirement statements; income tax returns for the past three years/W-2 form; loan and installment payment books and contracts; gift tax returns; birth and death certificates; social security card; military records and discharge papers; budgets; bank statements, checkbooks, check registers, certificates of deposits; deeds, deeds of trust, mortgages and mortgage releases, title policies, leases; motor vehicle titles and registration papers; stock and bond certificates and account statements; unpaid bills; health/accident and sickness policies; bankruptcy papers.*

PROVIDER SELF-CARE CHECKLIST

Each provider may have a different way of coping with work-related stress. Below is a checklist of some warning signs of immediate stress responses and long-term effects. If you or someone you know is displaying some of these symptoms, seek professional help or follow the listed self-care strategies.

Warning Signs Checklist

Physical reactions

- ☐ Fatigue
- ☐ Sleep disturbances
- ☐ Changes in appetite
- ☐ Headaches
- ☐ Upset stomach
- ☐ Chronic muscle tension
- ☐ Sexual dysfunction

Emotional Reactions

- ☐ Feeling overwhelmed/ emotionally spent
- ☐ Feeling helpless
- ☐ Feeling inadequate
- ☐ Sense of vulnerability
- ☐ Increased mood swings
- ☐ Irritability
- ☐ Crying more easily or frequently
- ☐ Suicidal or violent thoughts or urges

Behavioral Reactions

- ☐ Isolation, withdrawal
- ☐ Restlessness
- ☐ Changes in alcohol or drug consumption
- ☐ Changes in relationships with others, personally & professionally

Cognitive Reactions

- ☐ Disbelief, sense of numbing
- ☐ Replaying events in one's mind over & over
- ☐ Decreased concentration
- ☐ Confusion or Impaired memory
- ☐ Difficulty making decisions or problem-solving
- ☐ Distressing dreams or fantasies

This was adapted the Healthcare Toolbox's page "Self-Care for Providers," which can be found here: https://healthcaretoolbox.org/self-care-for-providers.html.

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Self-Care Strategies Checklist

Preventing Secondary Traumatic Stress: In one's daily routine

- ☐ Eat sensibly and regularly every day
- ☐ Get adequate sleep each night
- ☐ Exercise regularly
- ☐ Be aware of stress levels; take precautions against exceeding personal limits
- ☐ Acknowledge reactions to stressful circumstances; allow oneself time to cope with these emotions

Preventing Secondary Traumatic Stress: At work

- ☐ Try to diversify tasks at work, or vary caseloads
- ☐ Take breaks during your workday
- ☐ Take vacation days
- ☐ Use relaxation techniques (e.g., deep breathing) as needed
- ☐ Talk with colleagues about how your work affects you
- ☐ Seek out, or establish, a professional support group
- ☐ Recognize one's personal limitations; set limits with patients and colleagues

Preventing Secondary Traumatic Stress: Outside of work

- ☐ Spend time with family and friends
- ☐ Stay connected with others through community events, religious groups, etc.
- ☐ Engage in pleasurable activities unrelated to work, especially those that allow for creative expression (writing, art, music, sports, etc.)
- ☐ Be mindful of one's own thoughts (especially cynicism) and feelings; seek out the positives in difficult situations
- ☐ Engage in rejuvenating activities such as meditation, prayer, or relaxation to renew energy
- ☐ Seek therapy if work is negatively impacting self-esteem, quality of life

First Responders

Introduction

First responders are first on scene and address various types of situations, including suicide. Depending on one's definition, this group can involve Firefighters, Law Enforcement, EMS professionals, Paramedics, Dispatch and Emergency Department personnel. It is vital that first responders know the best practices when it comes to suicide intervention and postvention as they are often the first to interact with the individual or the family. Each responder needs to understand how suicide prevention fits into their role and learn how to best address it.

Beyond their role in responding, it is also critical for first responders to embrace suicide prevention within their units. In a recent study examining Law Enforcement and Firefighters specifically, it was found that Law Enforcement officers and Firefighters are more likely to die by suicide than in the line of duty.[8] When looking at Law Enforcement agencies, it was estimated that only 3-5% had established suicide prevention training programs.[8] Given the trauma that first responders are exposed to on a regular basis, it is vital that they (1) know how to respond to a suicide event and (2) are supported in their own mental health.

First Responder Resources:

- First Responders Scene Protocol
- Involuntary Detention Policies
- Resource "Tuck" Cards Template
- After an Attempt: What Family Members Need to Know
- After a Suicide Loss: What Family Members Need to Know
    - *Also included in the Family and Healthcare sections of the toolkit
- Suicide-Proofing your Home
- First Responder Mental Health Resources
- First Responder Care Checklist
- Suicide Training: First Responders (p. 209-210)

FIRST RESPONDER SCENE PROTOCOL

Before responding to a suicide-related incident, the first responders should:

1. **Review the protocols and standard operating procedures** required by the first responder's agency and in the state and local area for responding to a person with suicide-related situation.
2. **Meet with the local first responder partners** to discuss how to work together to help persons who have attempted or are having thoughts of suicide, including those who refuse to be transported.
3. If the community has a **crisis intervention team (CIT) or if the agency works closely with mental health providers, meet with them** regularly to discuss strategies.

When responding to any type of suicide-related incident, the first responder should:

Suicidal Ideation

Establish rapport with the person

- Follow local established protocols. Some examples include clearing the scene and eliminating access to lethal means (i.e. firearms, toxic substances)

Assess the person for need of medical treatment

- Address any serious medical needs
- Ask direct questions such as, "Are you thinking about killing yourself?" and "Do you have a plan?"
- Contact Law Enforcement trained in suicide prevention or call the National Suicide Prevention Lifeline at 1-800-273-8255 (TALK)

Determine next steps

- Connect the individual with the appropriate level of care
- Engage family members and friends at the scene. Talk openly about this distress and suicide attempt and ensure they have resources and understand the need for means safety after discharge

This was adapted from SPRC's "The Role of Law Enforcement Officers in Preventing Suicide," which can be found here: sprc.org/resources-programs/role-law-enforcement-officers-preventing-suicide-sprc-customized-information. This information was also adapted from OJP Diagnostic Center's "First Do No Harm" Model Practices for Law Enforcement Agencies When Arresting Parents in the Presence of Children," which can be found here: https://strategiesforyouth.org/sfysite/wp-content/uploads/2012/09/First_Do_No_Harm_Report.pdf.

Suicide Attempt

Check the individual's vital signs

- Contact emergency healthcare
- Apply resuscitation, if needed

Establish communication with the individual

- Ask open ended questions such as, "where does it hurt?" or "how can I help?"
- Avoid guilt-invoking or criticizing statements

Determine next steps

- If transfer to a medical facility is needed, identify drugs or toxic substances used and bring empty bottles to the hospital
- If transfer to a medical facility is not needed, remove lethal means and ensure that the individual has a family or close friend to help with next steps.

Establish communication with close contacts

- Talk with the individual present at the scene to determine what happened
- Be sure to exercise tact, compassion, sensitivity and support

Suicide Death

Establish contact with the family and friends

- Express empathy by saying, "I'm sorry for your loss," and explain first responders are here to help
- Allow the loss survivors to express their thoughts and feelings

Discuss the investigation process

- Explain the investigation process that occurs with any unnatural death
- Discuss what will happen with the body and why personal items may need to be held until the investigation is complete

Determine next steps

- Provide written information about community resources they can contact for mental health support or survivors groups. The "Help & Hope for Survivors of a Suicide Loss" guide is designed for survivors of suicide loss and can be found here: https://www.sprc.org/sites/default/files/resource-program/Help-and-Hope-For-Survivors-of-Suicide-Loss.pdf
- Refer the family to a bereavement team, if the community has one

Follow up

- Take care of first responders leaving the scene
- Offer additional support to debrief, if needed

In situations where children are present at the scene of a suicide attempt or completion, it is vital for first responders to engage with the children. Below are a few steps that first responders can go through when interacting with children on the scene.

1. **When first responders arrive on the scene, first responders should:**
   - account for and locate all children, anticipating that some children may hide;
   - avoid exposing the children to traumatic situations; and
   - ask whether other children may return later to the home and arrange for their care in the absence of the parent.

2. **When children are present and there are multiple first responders, one responder should:**
   - talk with children present in a separate area;
   - speak to any children present using developmentally informed and age-appropriate language and conversation styles;
   - reduce children's anxiety by discussing what will happen next; and
   - help children calm themselves by providing distractions and, when appropriate, an item to hold (e.g., a teddy bear).

3. **When an alternate caregiver is available, first responders should:**
   - inform the remaining caregiver that children are often traumatized by observing or hearing about the parent's suicide-related incident;
   - where possible, provide referrals to child, family and youth services to address the trauma of the experience and help mitigate its effects; and
   - help physically transfer the child to another location, if necessary, while giving the child the opportunity to bring comforting objects from home.

4. **When the parent is a sole caregiver, responders should:**
   - follow local protocol for transferring custody of children to a state agency and
   - ensure the transfer of custody occurred as required.

5. **After a situation is resolved, departments should:**
   - where possible and appropriate, enable an responder to return to the home and visit children affected to demonstrate concern for their safety and well-being;
   - follow up with service providers; and
   - confer with the interagency team about outcomes.

If first responders are interested in expanding communication between agencies in events when a child is present, those agencies my want to research the **Handle with Care** program. This program is designed to increase communication between responding agencies and the child's school, in the case of a traumatic event. More information can be found here: http://handlewithcarewv.org/handle-with-care.php.

Police officer intervention policies can be modeled after this document:
httpss://www.michigan.gov/documents/mcoles/Model_Policy_MH_344418_7.pdf
Firefighter intervention policies can be modeled after this document:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4784501.

INVOLUNTARY DETENTION POLICIES

After a suicide attempt or ideation, individuals in Law Enforcement will often have to decide whether or not to transport someone to receive a higher level of care. There are two primary ways that people become admitted to a mental health facility: voluntary and involuntary commitment. There are four types of involuntary admissions:

1. Immediate detention,
2. Emergency detention,
3. Temporary commitment, and
4. Regular commitment.

It is important to know that an immediate or emergency detention can become a temporary or regular commitment after the person has seen a judge. Based on the information given at a hearing, the judge may decide that it would be best to issue the individual a temporary or regular commitment. With that in mind, more detailed explanations of each involuntary admission type of commitment are below.

Immediate Detention (Indiana Code sec. 12-26-4) This type of involuntary admission happens if a person with a mental illness is believed by Law Enforcement to be in need of hospitalization. A person can be held for 24 hours if a Law Enforcement officer has reasonable grounds to believe that the person is:

- Mentally ill
- Dangerous to self or others or gravely disabled, and
- In immediate need of hospitalization and treatment.

The officer may take the person into custody and transport him or her to the nearest appropriate facility that is not a state institution.

The officer must submit a written statement to the facility containing the reasons for immediate detention. This statement will be filed in the individual's records at the facility.

Either the superintendent of the facility or a physician may provide emergency treatment necessary to preserve the health and safety of the person.

A person cannot be held under immediate detention for more than 24 hours from the time of admission without further action. However, if the superintendent or attending physician believes the person should be held longer, an application for emergency detention can be sought. The application must be filed immediately upon the availability of a judge, or within 72 hours of admission to the facility, whichever is earlier.

This was adapted from Indiana Disability Right's document, "Right of Adults Receiving Treatment in an Indiana Mental Health Facility," which can be found here: in.gov/idr/files/IDR108-PurpleBook-2017-09-25-V05-Small.pdf

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Emergency Detention (Indiana Code sec. 12-26-5-1) A person can be kept in a facility for up to 72 hours (excluding weekends and legal holidays) if a written application is made to the facility stating the belief that the person is:

- Mentally ill
- Either dangerous or gravely disabled, and
- In need of immediate restraint.

The application must include a written statement by at least one physician that, based on either an examination or information given by that physician, the person meets the above criteria.

Temporary Commitment (Indiana Code sec. 12-26-6) A person can be temporarily committed to an appropriate facility or outpatient treatment program for up to 90 days if he/she is found by a court to be:

- Mentally ill, and
- Either dangerous or gravely disabled.

Prior to the end of the temporary commitment, proceedings for an extension can be filed with the court. The extension, if granted, cannot exceed 90 days. (Indiana Code sec. 12-26-6-10).

Regular Commitment (Indiana Code sec. 12-26-7) Regular commitment may apply to a person:

- Alleged to be mentally ill,
- Either dangerous or gravely disabled, and
- Whose commitment is reasonably expected to require custody, care or treatment in a facility for more than 90 days.

These conditions must be included in the written statement of a physician who has examined the individual within the past 30 days. This statement must explain why the physician believes the individual meets the above criteria.

If the person is committed to a state institution, a community mental health center must have first evaluated the individual and reported that the commitment is appropriate. The court may order the individual's custody, care, or treatment in an appropriate mental health facility until that person has been discharged or the court terminates the commitment.

Mental illness (Indiana Code 12-7-2-130 (1)) - A psychiatric disorder that substantially disturbs an individual's thinking, feeling, or behavior and impairs the person's ability to function. In this case, the term mental illness includes intellectual disability, alcoholism, and addiction to narcotics or other drugs.

Dangerous (Indiana Code 12-7-2-53) - A condition in which an individual, as a result of mental illness, presents a substantial risk that the individual will harm him/herself or others.

Gravely disabled (Indiana Code 12-7-2-96) - A condition in which an individual, as a result of mental illness, is in danger of coming to harm because he/she: Is unable to provide for his/her food, clothing, shelter, or other essential human needs; or has a substantial impairment or an obvious decline of his/her judgment, reasoning or behavior that results in an inability to function independently.

RESOURCE "TUCK" CARDS TEMPLATE

If first responders are responding to a scene, but are not providing any additional transportation, it can be helpful to provide a resource list to affected individuals. Not a multi-page resource list that is difficult to read, instead a "tuck" card where the handout is small enough to fit inside the individual's pocket. Below is a sample template that communities can use to create their own "tuck" cards (the grey portions indicate customizable sections).

(Front of card)

Help is available if you or someone that someone you care about it at risk of suicide.

[*Lead organization name*]

State and Local Resources

In case of Emergency:
- Call 911 or visit the emergency room

Local Resource
- *Phone number*

Local Resource
- *Phone number*

Remedy Live Text Line (mental health line):
- Text "REMEDY" to 494949

Indiana 211/Be Well Crisis Line (Indiana-specific resources and mental health line):
- Call 211
- Press 3 for the Be Well Crisis Line

(Back of card)

You are not alone.

National Resources

National Suicide Prevention Hotline:
- Call 1-800-273-8255
- Text "IN" to 741741

Veterans Crisis Line
- Call (800)273-TALK (8255)
- Text anything to 838255

Trevor Project (LGBTQ+ youth line)
- Call (866)488-7386
- Text "TREVOR" to (202)304-1200

Trans Lifeline
- Call (877)565-8860

Crisis Line for Individuals Deaf and Hard of Hearing
- Call (800) 273-8255, video relay service or voice/caption phone
- Call (800)799-4889, TTY

Ayuda En Español
- Llama al número (888)628-9454

National Teen Dating Abuse Helpline
- Call (866)331-9474

RAINN National Sexual Assault Hotline
- Call (800)656-HOPE (4673)

AFTER AN ATTEMPT: What Family Members Need to Know

Suicide is a traumatic experience for both the individual who attempted and the family. As the family member, you may feel numb and lost, not knowing where to turn. Experiencing a range of emotions is completely normal. When it comes time for that individual to come home, it can be good to start thinking about safety. Research shows that when an individual has a previous attempted, they do have higher risk of later dying by suicide. As a family member, you can help your loved by reducing risk.

Reduce the Risk at Home—To help reduce the risk of self-harm or suicide at home, here are some things to consider:

- Guns are high risk and the leading means of death for individuals who die by suicide—they should be taken out of the home and secured.
- Overdoses are common and can be lethal—if it is necessary to keep pain relievers such as aspirin, Advil, and Tylenol in the home, only keep small quantities or consider keeping medications in a locked container. Remove unused or expired medicine from the home.
- Alcohol use or abuse can decrease inhibitions and cause people to act more freely on their feelings. As with pain relievers, keep only small quantities of alcohol in the home, or none at all.

Create a Safety Plan—Following a suicide attempt, a safety plan should be created to help prevent another attempt. The plan should be a joint effort between your relative and his or her doctor, therapist, or the emergency department staff, and you. As a family member, you should know your relative's safety plan and understand your role in it, including:

- Knowing your family member's "triggers," such as an anniversary of a loss, alcohol, or stress from relationships.
- Building supports for your family member with mental health professionals, family, friends, and community resources.
- Working with your family member's strengths to promote his or her safety.
- Promoting communication and honesty in your relationship with your family member.

Remember that safety cannot be guaranteed by anyone—the goal is to reduce the risks and build supports for everyone in the family. However, it is important for you to believe that the safety plan can help keep your relative safe. If you do not feel that it can, let the emergency department staff know before you leave.

Maintain Hope and Self-Care—Families commonly provide a safety net and a vision of hope for their relative experiencing suicidal ideation, and that can be emotionally exhausting. Never try to handle this situation alone—get support from friends, relatives, and organizations such as the National Alliance on Mental Illness (NAMI), and get professional input whenever possible. Use the resources on the back pages of this brochure, the Internet, family, and friends to help you create a support network. You do not have to travel this road alone.

This was adapted from "After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department." This can be found here: https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4357eng.pdf. The graphics are from Noun Project (Check Mark by P.J. Onori, US)

AFTER A SUICIDE LOSS: What Family Members Need to Know

Life as you know it has changed forever. You may feel numb and lost, not knowing where to turn. Experiencing a range of emotions is common: fear, anger, relief, abandonment, guilt, shame, and perhaps even responsibility for your loved one's death. These can change rapidly, and family members may have different reactions at different times which sometimes can lead to conflict.

Know that others have walked this difficult path before you. Reach out to those who have survived a suicide loss. Move forward step by step at your own pace and do not allow anyone to rush or criticize your grieving process. YOU ARE NOT ALONE. There are many ways to connect to others—staying in contact with others can help you through your grief.

Reach out for support:

- Attend a support group for suicide loss survivors (in person or online)
- Talk to a professional grief counselor
- Seek a licensed mental health provider, if needed
- Talk with those you trust (family, friends, faith leader, neighbors) to share your loss and pain
- Continue to ask the "why?" questions as long as you need to

Grieving can take over your life, so taking care of yourself is important:

- Try to get plenty of sleep, rest, and be gentle with yourself
- Eat healthy food and drink water
- Keep yourself busy by doing something you enjoy
- Continue your exercise routine

When a loved one passes away, it can be a very difficult time. Trying to remember all of the details that must be taken care of related to a person's death is hard. In the next few pages, there are a list of items marked as things to do immediately, within a few days, and within a few weeks.

This was adapted from "Health & Hope: For Survivors of Suicide Loss." This can be found here: http://www.sprc.org/sites/default/files/resource-program/Help-and-Hope-For-Survivors-of-Suicide-Loss.pdf. This was also adapted from Ever Loved's "What to Do When Someone Dies: A Checklist," which can be found here: https://everloved.com/articles/end-of-life-affairs/what-to-do-when-someone-dies-checklist/

What to do immediately

10. **Get a death certificate.** If your loved one died in a hospital, a doctor can take care of this for you. However, if your loved one passed at home or in another location, you'll need to know who to call. If your family member wasn't at a hospital, call 911.

11. **Arrange for organ donation, if applicable.** Check your loved one's driver's license and/or advance directive (living will or health care proxy) to see if he or she was an organ donor. If so, let hospital staff know immediately (or call a nearby hospital if your loved one died at home).

12. **Contact immediate family.** Every family is different, and there's no one right way to do this. For some families, sharing the news in-person or over the phone is critical. For others an email or text message may be alright.

13. **Enlist help from family and friends.** There are a number of ways family and friends can help you, such as: answering the phone; collecting mail; caring for pets; finding important items (such as keys, insurance policies, claims forms, addresses for magazine subscriptions, etc.); staying at the home during the wake, funeral, and/or memorial services to guard against break-ins; organizing food for family and friends after the services.

14. **Notify the individual's religious leader, if applicable.** Contact the deceased's Pastor, Rabbi, Priest or other religious leader if there is one. He or she can help with counseling for surviving family and friends. They can also help you make funeral arrangements or services.

15. **Decide what you'd like to do with your loved one's body and arrange transportation.** First, check to see if your loved one expressed any wishes about final disposition or had made prepayments to a funeral home or cemetery. Ideally, there will be documentation with other medical documents. If no wishes or plans have been stated, you have three main options:
    - *Call a funeral home.* A funeral home can help you arrange either a burial or cremation. Check reviews and prices for a few different funeral homes before making a decision.
    - *Call a crematory.* While you can arrange a cremation through a funeral home, there are also crematories that will work with you directly if you aren't interested in the added services of a funeral director.
    - *Call a full-body donation organization.* Your loved one may have already registered to be a body donor, so check for paperwork. If he or she hasn't, there are still many programs that accept donations from next of kin.

16. **Arrange care for any pets or dependents.** If your loved one was responsible for caring for one or more people or pets, quickly find someone who can care for them temporarily.

17. **Secure major property.** If your loved one lived on their own, make sure his or her home and any vehicles are locked up. If it will sit vacant for some time, consider notifying the landlord and/or the police, so they can help to keep an eye on it.

18. **Notify the person's employer.** If the deceased was employed (or actively volunteering), call to let them know that your loved one has passed away. This is also a good time to ask about pay owed, benefits and life insurance.

What to do within a few days

9. **Decide on funeral plans.** If you decided to work with a funeral home, meet with the funeral director to go through your options. If you opted for an immediate burial (burial without any ceremonies), cremation or donation to science, you may also choose to hold a memorial service or celebration of life at a later date.

10. **Order a casket or urn.** You may choose to purchase a casket or urn directly through the funeral home. However, you can often find caskets online for hundreds (even thousands) of dollars less, and some websites even offer free overnight delivery.

11. **For a veteran, ask about special arrangements.** A range of benefits can help tailor a veteran's service. You may be able to get assistance with the funeral, burial plot or other benefits. You can find many details about options as well as potential survivor benefits at the U.S. Department of Veterans Affairs website.

12. **Consider whether you need or want other financial assistance for the funeral and burial.** Help might be available from a number of sources, including a church, a union or a fraternal organization that the deceased belonged to.

13. **Ask the post office to forward mail.** If the person lived alone, this will prevent mail from piling up and showing that no one is living in the home. The mail may also help you identify bills that need to be paid and accounts that should be closed. You'll need to file a request at the post office, show proof that you are an appointed executor, and authorized to manage his/her mail.

14. **Perform a check of the person's home.** Throw out any food that will expire, water plants, and look for anything else that may need regular care.

15. **Update the utilities.** Tell local utilities (telephone, gas, electricity, cable) about the death, only if someone else wants to be put on the accounts. Otherwise wait until you decide whether or not and when the utilities are to be turned off.

16. **Prepare an obituary.** The funeral home might offer the service, or you might want write an obituary yourself. If you want to publish it in a newspaper, check on rates, deadlines and submission guidelines.

What to do within a few weeks

22. **Order a headstone.** Since headstones are rarely ready in time for a burial, you can save this until after the funeral when you have some more time. You can order a headstone through the cemetery, but you'll have more options (and often lower prices) if you look online.

23. **Order several copies of the death certificate.** You will likely need anywhere between 5 and 10 copies (but possibly more), depending on the accounts that your loved one had open. Your funeral director may be able to help you order them, or you can order them yourself from city hall or another local records office. Your certified copies should say display an official seal and say, *"This is an exact copy of the death certificate received for filing in_____ County*."

24. **Start the probate process with the will.** If the estate is relatively small, doesn't contain unusual assets and isn't likely to be disputed by family members you may be able to handle it yourself.

25. **Contact the Social Security office.** Your funeral director may have already done this, so find out if this is the case. If you need to contact social security yourself, you can reach them by phone at 1-800-772-1213. Through Social Security you may be able to apply for survivor benefits.

26. **Handle Medicare.** If your loved one received Medicare, Social Security will inform the program of the death. If the deceased had been enrolled in Medicare Prescription Drug Coverage (Part D), Medicare Advantage plan or had a Medigap policy, contact these plans at the phone numbers provided on each plan membership card to cancel the insurance.

27. **Notify any banks or mortgage companies.** If you're unsure of what accounts your loved one held, use their mail and any online accounts you have access to in order to identify what accounts may be open. Then, take copies of the death certificate to each bank and change ownership of the accounts.

28. **Reach out to any financial advisors or brokers.** Try to identify any additional financial and investment accounts that your loved one held. Work with each one to transfer ownership. You'll likely need a death certificate for each account.

29. **Contact a tax accountant.** You'll need to file a return for both the individual and the estate.

30. **Notify life insurance companies.** Fill out the claim form for any life insurance policies that the deceased had. Also, suggest that friends and family who may have listed your loved one on their own life insurance policies update theirs.

31. **Cancel insurance policies.** This could include health insurance, car insurance, homeowner's insurance or anything else. Depending on the policy, reach out to either the insurance company or your loved one's employer to stop coverage.

32. **Determine any employment benefits.** If your loved one was working at the time of their death, contact their employer to find out about union death benefits, pension plans and credit unions.

33. **Identify and pay important bills.** Make a list of bills that are likely to be due (e.g. mortgage, car payments, electricity), tracking them down via the person's mail and online accounts.

34. **Close credit card accounts.** Leverage your loved one's mail, wallet and any online accounts you have access to in order to identify open credit card accounts. For each one, you'll likely need to call customer service and then email or mail a copy of the death certificate.

35. **Notify credit reporting agencies.** Provide copies of the death certificate to Experian, Equifax and TransUnion in order to reduce the chances of identity theft. It's also a good idea to check your loved one's credit history in another month to confirm that no new accounts have been opened.

36. **Creditors.** Letters should be sent to all creditors informing them of the person's death. If any life insurance coverage can pay off the balances, a copy of the death certificate will be needed. Do not tell any of them you will be paying the balances with your own money. The estate needs to pay these, not family members, no matter what the creditors tell you. If nothing is left in the estate to pay off debts, then tell the creditors this.

37. **Contact a tax preparer.** A return will need to be filed for the individual, as well as for an estate return. Keep monthly bank statements on all individual and joint accounts that show the account balance on the day of death.

38. **Cancel the person's driver's license.** Go online or call your state's DMV for instructions, having a copy of the death certificate ready. Additionally, notify the local election board. This will help to prevent identity theft and voter fraud.

39. **Memorialize your loved one's Facebook account.** If your loved one was on Facebook, you can memorialize their account. This will let current friends continue to post and share memories but will keep anyone from logging into it in the future.

40. **Close email accounts.** Once you feel confident that you have necessary information on other accounts, it's a good idea to permanently close your loved one's email accounts as an additional step to prevent fraud and identity theft.

41. **Dispose of Personal Items and Clothing.** It is hard, but as soon as possible, you should try to dispose items which will no longer be used by the survivors. Everyone does this at a different time. Ask for help with this, if you need it. No items should be moved, sold, or given away if they have been identified in the person's will to be given out to survivors.

42. **Find Important Documents.** There are some documents that may be needed or at least helpful in settling the estate of the deceased. Documents might include: *safe deposit rental agreement and keys; trust agreements; nuptial agreements/marriage licenses/prenuptial agreements/divorce papers; life insurance policies or statements; pension, IRA, retirement statements; income tax returns for the past three years/W-2 form; loan and installment payment books and contracts; gift tax returns; birth and death certificates; social security card; military records and discharge papers; budgets; bank statements, checkbooks, check registers, certificates of deposits; deeds, deeds of trust, mortgages and mortgage releases, title policies, leases; motor vehicle titles and registration papers; stock and bond certificates and account statements; unpaid bills; health/accident and sickness policies; bankruptcy papers.*

Suicide in Indiana

Death rates for suicide have continued to rise both nationally and in Indiana, despite efforts to curtail these trends. Suicide is the 10th leading cause of death in Indiana for people ages 10-64 and was the 11th overall leading cause of death for all ages.

Suicide prevention efforts must be diverse and draw on a varied set of resources and tools. While each suicide attempt is different, there are multiple ways to address the factors involved. One evidence-based suicide prevention strategy that an individual can use to prevent suicide is safety-proofing their own home.

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Further Information

To find out more about suicide prevention in Indiana and nationally, please visit:

In.gov/issp
In.gov/isdh/21838.htm
Indianasuicideprevention.org
afsp.org
sprc.org

Safety-Proofing Your Home

A guide to keeping families safe

IS YOUR HOME SUICIDE PROOF?

Even if you think your loved is not at risk for suicide, why take chances?
These simples steps can help you suicide-proof your home and possibly save a life.

SUPPORT

Listen and ask.

FACT: Millions of kids and teens seriously consider attempting suicide every year.

- The warning signs of suicide are not always obvious.
- Pay attention to your teen's moods and behavior.
- If you notice significant changes, ask them if they're thinking about suicide.

FIREARMS

Remove. Lock.

FACT: Firearms are used in two thirds of teen suicide deaths.

- Ask a trusted friend or family member to keep it temporarily.
- Your local police precinct or shooting club might offer temporary storage.
- At the very least, lock them securely away from ammunition.

MEDICATIONS

Lock and limit.

FACT: Teens who attempt suicide use medication more than any other method.

- Don't keep lethal doses on hand and dispose of any unneeded medications.
- Consider locking up medications.
- Call the National Poison Control Hotline which runs 24/7 and is free/confidential: 1-800-222-1222.

Help is available if you're concerned that someone you care about it at risk of suicide.

National Suicide Prevention Hotline:
1-800-273-8255 (TALK)
In case of Emergency:
Call 911 or visit your local emergency room.

First Responder Mental Health Resources

Safe Call Now – 1(206)459-3020
A 24/7 help line staffed by first responders for first responders and their family members. They can assist with treatment options for responders who are suffering from mental health, substance use disorder, and other personal issues.

Fire/EMS Helpline – 1(888)731-3473
A 24/7 confidential hotline specifically for Firefighters, EMS professionals, and their families. This helpline is designed to address behavioral health issues, including stress, depression, PTSD, substance use disorder, and more.

Copline (Law Enforcement Only) – 1(800)267-5463
A 24/7 confidential helpline staffed by retired trained officers. This Law Enforcement-specific helpline can assist with various stressors Law Enforcement careers encounter both on and off the job.

Frontline Helpline – 1(866)676-7500
A 24/7 confidential helpline is staffed by first responders. This helpline can help with the following issues: substance use disorder, anger management, depression, anxiety, sleep deprivation, PTSD, psychological stress, divorce & family issues.

You are not alone.

This was adapted from Code Green's Help and Resources page, which can be found here: https://codegreencampaign.org/resources/.
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FIRST RESPONDER CARE CHECKLIST

First responders are exposed to hazards inherent in the nature of their jobs. Examples include exposure (direct or indirect) to death, grief, injury, pain, or loss as well as direct exposure to threats to personal safety, long hours of work, frequent shifts and longer shift hours, poor sleep, physical hardships, and other negative experiences. In fact, PTSD and depression rates among Firefighters and Law Enforcement officers are nearly five times higher than the civilian population. Here are a few suggestions first responder leaders and personnel could follow before, during, and after an incident:

Leaders can take these steps to support their teams before an incident:

- ☐ **Plan in advance of incidents and develop clear written protocols and strategic plans.** This is important for the behavioral health of first responders because the feeling of being well-prepared and the sense of doing a job well serve as protective factors against behavioral health issues and conditions.
- ☐ **Include all the team members in the development of the protocol**, and ensure they are all adequately trained. Teamwork and sense of community serve as major protective factors. High sense of team accomplishment and assurance of personal and team capabilities were associated with reduced stress levels.
- ☐ **Develop a clearly defined leadership cadre**, establish sub-teams, and determine factors that could prevent some of the team members from participating. Organizations should put the welfare of their team at the forefront and move toward a more supportive attitude.
- ☐ **Ask potential responders before the incident** to be aware of the stress they are dealing with and to assess whether they have the capacity to deal with the additional stress the situation will involve. Recognize good work during incidents, empower staff, and assign responsibility to staff to have a protective effect.

First responders can take these steps to support themselves before an incident:

- ☐ **Be aware of personal vulnerability** and signs of burnout and compassion fatigue, or profound psychological pain observed in therapists working for long periods with people who have been directly traumatized.
- ☐ **Make plans for self-care** and plan on taking breaks, sleeping adequately, and eating nutritious meals and exercising during relief work.

This was adapted from SAMHSA's "Disaster Technical Assistance Center Supplemental Research Bulletin First Responders: Behavioral Health Concerns, Emergency Response, and Trauma," which can be found here: https://www.samhsa.gov/sites/default/files/dtac/supplementalresearchbulletin-firstresponders-may2018.pdf and "Preventing Suicide Among First Responders," which can be found here: https://www.usfa.fema.gov/operations/infograms/080819.html#:~:text=The%20Ruderman%20White%20Paper%20on,line%2Dof%2Dduty%20death.&text=PTSD%20and%20depression%20rates%20among,higher%20than%20the%20civilian%20population.

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Leaders can take these steps to support their teams during and after an incident:

- **Assess the welfare of the team**, resolve any conflicts between team members, and rotate assignments. The role of leadership is crucial in maintaining the mental health of their team.
- **Encourage workers to pair up in a "buddy system"** to support each other and monitor each other's stress reactions and provide support to them if needed in doing so.
    - There are new models of this type of system happening across the country. Chicago implemented a peer support program in April 2020. More information about Chicago's program can be found here: https://home.chicagopolice.org/information/employee-assistance-program-eap/peer-support/.
- **Provide mental health and resilience training,** and promote counseling and debriefing following stressful situations.
- **Provide team group sessions** upon return to home base, as well as staff support services. No further assignments should be given before workers have had sufficient time to recover; relief workers need some time to adjust, ease back into personal life, and take some time before returning to work.

Additional resources addressing suicide prevention in Law Enforcement can be found on Suicide Awareness Voices of Education's (SAVE) Law Enforcement safety guide education page on Facebook, found here: https://www.facebook.com/securityguides/lesafety.

Government

Introduction

Government agencies and elected leaders have a vital role in addressing the behavioral health needs of their communities. Important programs such as social services, homelessness programs, and criminal justice system services, if operated well, can serve to address various behavioral health issues.

Based on 2018 data outlined in the data section of this toolkit, it was calculated that one person dies by suicide every eight hours in the state of Indiana. Overtime, this has totaled 23,559 years of potential life lost (YPLL) in Indiana.[9] This is all to say that there is clear space for societal, community, and governmental engagement in suicide prevention work.

Government Resources:

- Suicide Prevention Quick Start Guide
- After Suicide: Community Response Plan
- Guidance: Considerations for Community Meetings
- Warning Signs of Suicide
- Mental Wellness Posters
- 5 Action Steps for Helping Someone in Emotional Pain Brochure
- Suicide Training: Government (p. 211-212)

SUICIDE PREVENTION QUICK START GUIDE

In order to start suicide prevention initiatives in a community, it is vital to assess the community's current landscape. For example, asking questions such as "what is the treatment infrastructure?" and "what is the city's history with suicides?" can be key to identifying potential prevention initiatives.

Context Questions

- Is there an existing suicide prevention coalition in the area? If so, is it better to join forces across groups?
- Have there been suicide and suicide attempts in the community? If yes, how many? Which ages, which sex? What are the risk factors, and what are the protective factors relevant to your community? Which methods of suicide are most used in your community?
- Is there good access to quality health and mental health services in your community? Have health workers been trained in suicide prevention? Has there been gatekeeper training for first responders?
- What is the quality of services for persons who made a suicide attempt or who are bereaved by suicide (e.g. in-patient care), and to what extent can persons access these services (e.g. 24/7)? Are there any existing programs in place? If there are, have the service providers received training (e.g. type of training, number of hours)? Are there any efforts to coordinate services in order to make a continuity of care?
- Describe the communication infrastructure and the resources of your community. What are the most prominent channels of communication? Which are the most prominent media outlets? Are there guidelines for responsible reporting of suicide by the media and have media professionals been trained?
- Describe your community's resources for suicide prevention. What could be barriers and facilitating factors for your activities? Are there policies and procedures that are inhibiting people from getting care? How can we mitigate those challenges?

Future-focused Questions

- What do you think are the most urgent needs for suicide prevention in your community?
- Describe the population you wish to serve in suicide prevention (i.e. location, population, ethnicity, age groups)
- Write down activities that could be undertaken in your community to foster a supportive environment (i.e. have champions speak out about suicide, build partnerships, explore social/cultural/political/ethnic/economic tensions in the community).

This was adapted from WHO's "Suicide Prevention: Toolkit for engaging communities," which can be found here: https://www.who.int/mental_health/suicide-prevention/engaging_communities_toolkit/en/.

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Community Readiness Assessment – Once groups have gone through the task of answering all of these questions, it is vital to assess community readiness. While a score will be assigned, there is no rigid rubric. Instead, communities should assess based on their conversations. The assessment serves to jumpstart conversations.

Dimension	Score (5 – excellent, 4 – good, 3 – average, 2- below average, 1-poor)
Degree of community readiness and community knowledge *How much does the community know about the current suicide prevention programs and activities?*	
Leadership *What is the leadership's attitude towards addressing suicide prevention?*	
Community climate *What is the community's attitude towards addressing suicide prevention?*	
Community knowledge of the issue *How much does the community know about suicide prevention?*	
Resources *What resources (i.e. human, financial, infrastructure) are being used or could be used to address suicide prevention?*	

Form a Steering Committee – At this point, organizers may want to be thinking about key stakeholders to engage. This chart below can serve as an information gathering tool.

Name	Organization	Nature of the Collaboration (How do your organizations work together?)	Resources Shared (Knowledge, skills, access to priority populations)	Level of Involvement (networking, cooperating, coordinating, leading)

Next Steps – Develop a strategic plan moving forward for the group. Utilize existing tools such as the Indiana Suicide Prevention Network's suicide prevention planning tool, found here: https://indianasuicideprevention.org/. For a strategic planning framework in this toolkit, utilize the "Strategic Planning with Suicide Prevention Initiatives Guide" found on page 65.

AFTER SUICIDE: COMMUNITY RESPONSE PLAN

As the community, it important to have a coordinated plan in place before a suicide death occurs. This will help to mobilize support in a timely manner and ensure that the situation is appropriately addressed. The first step is determining which entity/agency in the community should coordinate a postvention response. Once the agency is determined, they should consider doing the following:

Task	Actions	Who	Notes
1	**Establish, confirm and document facts and circumstances.** Ideally determine name, age, gender, method, location of death, contact information for loss survivors/witnesses. Also useful are race/ethnicity, marital status, family information, employment, veteran/military status, and health history. This information can be captured in a psychological autopsy.		
2	Designated team member **contacts other team members** to share information and coordinate responses.		
3	**Mobilize support** to those directly affected.		
	Verify that loss survivors are followed up with.		
	Talk to first responders to determine if loss survivors and witnesses agreed to being contacted and to learn any other information about survivor needs.		
	Two weeks or more after the death ensure that survivors have been **reached out to** by bereavement teams (if those are in place).		
	If a broader community response is planned within a year of the death, **reach out** to immediate survivors to inform them.		
	Offer support to affected entities (businesses, schools, workplaces, etc.) about planning for anniversaries or other events.		
4	**Identify** if there are agencies or organizations that should be prepared to provide support.		
5	**Monitor** news and social media and respond as needed via public communications.		
6	**Reach out** to community groups, agencies, schools to which the deceased belonged. Work with them to assess and monitor contagion risk.		
7	**Assess and monitor** contagion risk.		
8	Identify and implement **broader community response** options, as needed.		
	Notify the suicide prevention coalition.		
	Advise and/or issue a **public statement**.		
	Host and participate in a **community memorial**, if appropriate.		
	Meet with groups of potentially affected individuals to provide education, healing, and support.		
	Identify training needs or requests.		
	Provide support for obituaries, services, or memorials.		

This was adapted from "After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department." This can be found here: https://www.sprc.org/resources-programs/after-rural-suicide-guide-coordinated-community-postvention-response.

GUIDANCE: CONSIDERATIONS FOR COMMUNITY MEETINGS

After a suicide in a community, there may be movement to hold some kind of community meeting. Given the sensitivity of the situation, it is important to keep the following in mind:

Be clear about the goal. The goal of a community meeting is to promote healing. To many survivors who have recently lost a loved one, discussion of prevention can feel like an accusation, when they may already be feeling like they should have seen the signs. Whenever the meeting is held, it is important to acknowledge the loss(es) that have occurred and to reassure the community that no one is to blame for a suicide death.

Set the agenda with the purpose in mind. The purpose of a community meeting is to facilitate a community conversation about suicide or suicide prevention (e.g., promote healing, alleviate anxiety, gather input on what is needed). If a meeting is convened, it is vital to invite a skilled facilitator to lead the meeting. Develop a set of specific questions that will shape the conversation. In either case, make sure notes are taken during the meeting so follow-up can be provided, and information is gathered that can feed back into prevention planning with the suicide prevention coalition.

Any community meeting should include information about the help that is available, including the Suicide Prevention Lifeline (1-800-273-8255) or local accredited crisis center. It should also avoid discussing details of any particular incident. Consider inviting a loss or attempt survivor whose loss or suicidality is several years behind them to share a story of hope.

Reach out to recent loss survivors. When first planning the meeting, contact recent survivors to let them know about the plans and help them prepare for any issues may arise as a result. Talk with them about how they are coping with the death and remind them of available services and supports. Ensure they understand the goal of the meeting is to promote healing. It is not recommended that these individuals play an active role in the meeting as their loss is recent.

Identify meeting personnel. Assign a skilled facilitator and one or two greeters. Determine who will take notes on the issues raised or questions that arise during the meeting to facilitate follow-through, and to compile information for prevention planning. Include a trained counselor or other mental health professional that will be on hand to offer support to anyone showing distress and/or offer professional input to the meeting. If the meeting is smaller and part of a targeted response to those directly impacted, this person may take a lead role in discussing complicated grief, how to know when professional help is needed, and what services are available locally.

This was adapted from CIBHS's "After Rural Suicide: A Guide for Coordinated Community Postvention Response," which can be found here: https://www.cibhs.org/pod/after-rural-suicide.

Identify an appropriate location and meeting space. Offer a "neutral" meeting space, such as in community centers, park buildings, libraries, or senior center. In most cases, neutral spaces do not include places such as churches, mental health or crisis centers, or hospitals, where some individuals may have negative/painful memories or associations. Within the meeting space, have an ancillary quiet space available for anyone who needs it. Identify this space with a welcoming indication of some kind, such as flowers, rather than a sign.

During the meeting. Open the meeting with a clear statement of the purpose and what will be achieved, as well as what will not be addressed. Assure participants that they can leave the meeting at any time if their feelings overwhelm them and can rejoin when they are able. Make clear how people can find the ancillary quiet space set aside for this purpose. Ask the counselor to be sure and check in on anyone who spends a lot of time there to see if they would like to talk. The facilitator may choose to offer an acknowledgment of the person(s) who have died and/or to hold a moment of silence.

Be sure to include resources on how help is available, such as the resources listed below. This box below can be included as a slide in a rotating screen or a presentation. Resources are vital to highlight as these gatherings can be difficult for attendees. Also, as mentioned above, it is vital to have counselors present during the event for individuals immediately seeking or needing help.

Help is available.

National Suicide Prevention Hotline
- Call 1-800-273-8255
- Text "IN" to 741741

Be Well Indiana Crisis Line
- Call 211 and Press 4

Trevor Project (LGBTQIA+ youth line)
- Call 1-866-488-7386
- Text "TREVOR" to 202-304-1200

Trans Lifeline
- Call 877-565-8860

Warning Signs of Suicide

Changing behavior, such as:

- Making a plan or researching ways to die
- Withdrawing from friends, saying goodbye, giving away important items, or making a will
- Taking dangerous risks such as driving very fast
- Displaying extreme mood swings
- Eating or sleeping more or less
- Using drugs or alcohol more often

Feeling

- Empty, hopeless, trapped, or having no reason to live
- Extremely sad, more anxious, agitated, or full of rage
- Unbearable emotional or physical pain

Talking about

- Wanting to die
- Great guilt or shame
- Being a burden to others

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Adapted from nimh.nih.gov/health/publications/warning-signs-of-suicide/index.shtml, Graphics from Noun Project (talking by Aneeque Ahmed, Broken Heart by ending firmansyah, Change by Allice Design)

Help is available if you're concerned that someone you care about it at risk of suicide.

National Suicide Prevention Hotline:
1-800-273-8255
In case of Emergency:
Call 911 or visit your local emergency room.

It’s okay not to be okay.

There is help.

Bewellindiana.com
Indiana 211

Indiana Department of Health

You are not alone.

There is help.

Bewellindiana.com
Indiana 211

Indiana Department of Health

Indiana Department of Health

5 Action Steps for Helping Someone in Emotional Pain

Further Information

To find out more about suicide prevention in Indiana and nationally, please visit:

In.gov/issp
In.gov/isdh/21838.htm
Indianasuicideprevention.org
afsp.org
sprc.org

This information was adapted from the National Institute of Mental Health's "5 Action Steps for Helping Someone in Emotional Pain." The original content can be found here: nimh.nih.gov/health/publications/5-action-steps-for-helping-someone-in-emotional-pain/index.shtml.

In 2018, suicide claimed the lives of more than 48,000 people in the United States, according to the Centers for Disease Control and Prevention. Suicide affects people of all ages, genders, races, and ethnicities.

For every person who dies by suicide annually, there are another 280 people who have thought seriously about suicide who don't kill themselves, and nearly 60 who have survived a suicide attempt. The overwhelming majority of these individuals will go on to live out their lives.

Suicide is complicated and tragic, but it can be preventable. Knowing the warning signs for suicide and how to help can help to save lives. For helping someone in emotional pain, consider the following:

1

ASK:

"Are you thinking about killing yourself?" It's not an easy question but studies show that asking at-risk individuals if they are experiencing suicidal ideation does not increase suicide attempts or suicidal thoughts.

2

KEEP THEM SAFE:

Reducing a person experiencing suicidal ideation's access to highly lethal items or places is an important part of suicide prevention. While this is not always easy, asking if the at-risk person has a plan and removing or disabling the lethal means can make a difference.

3

Be There:

Listen carefully and learn what the individual is thinking and feeling. Research suggests acknowledging and talking about suicide may in fact reduce rather than increase suicidal ideation.

4

Help Them Connect:

Save the National Suicide Prevention Lifeline's number in your phone so it's there when you need it: 1-800-273-TALK (8255). You can also use the Crisis Text Line by texting "HELLO" to 741741. Additionally, it always helps to make a connection with a trusted individual like a family member, friend, spiritual advisor, or mental health professional.

5

Stay Connected:

Staying in touch after a crisis or after being discharged from care can make a difference. Studies have shown the number of suicide deaths goes down when someone follows up with the at-risk person.

Help is available if you're concerned that someone you care about it at risk of suicide.

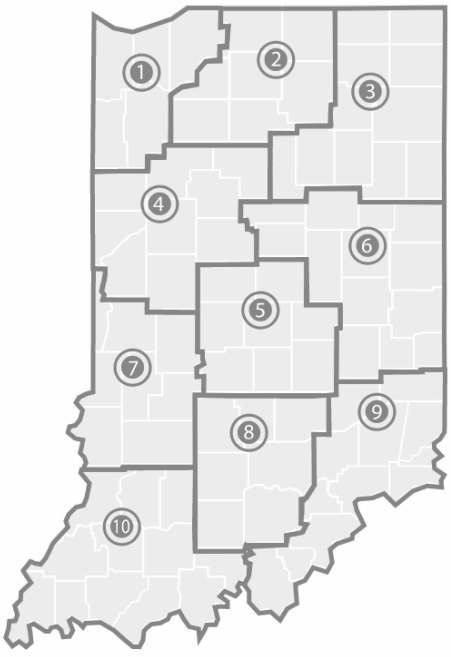
National Suicide Prevention Hotline:
1-800-273-8255 (TALK)
In case of Emergency:
Call 911 or visit your local emergency room.

Stakeholder Groups

Introduction

A community coalition or stakeholder group is formed if enough people recognize the need for change and action in a community, regardless of the issue. A stakeholder group is a multi-disciplinary diverse group focused on examining a certain issue and creating/implementing actionable steps to bring about change.

In Indiana, suicide coalitions across the state are organized into ten regions. One can find out more information about the suicide coalitions here: https://www.in.gov/issp/2377.htm. Beyond suicide coalitions in Indiana, there are many other groups focused on similar topics. For example, Systems of Care groups are focused on improving the access to and quality of behavioral and mental health services for youth and families and Local Coordinating Councils are focused on planning and coordinating body for addressing alcohol and other drug problems. These groups help to implement prevention, intervention, and postvention initiatives across the state of Indiana and all have similar aims when it comes to coalition work and community change.



Stakeholder Group Resources:

- Identifying Stakeholders Guide
- Strategic Planning with Suicide Prevention Initiatives Guide
- Logic Model Template
- Managing Coalition Dynamics
- Ensuring Culturally Competent Collaboration
- Worksheet: Creating a Memorandum of Agreement
- Braiding and Blending Funding
- Coalition Annual Report Template
- National Suicide Prevention Resources
- Working with Suicide Loss and Attempt Survivors
- Suicide Training: Evidence-Based Program Repositories for Stakeholder Groups (p. 213)

IDENTIFYING STAKEHOLDERS GUIDE

Very few stakeholder groups happen spontaneously. More often, individuals need to actively persuade, or recruit, potential partners to work with them. Although recruitment can be as simple as placing a phone call or sending an email, successful recruitment takes time and intentionality if you are looking to build a more long-term, sustainable collaboration. Below are a few steps to go through when thinking through which partners to engage.

Phase 1: Do Your Homework

Before reaching out, learn everything you can about your potential partner. The more you know about your potential partner, the more likely you will be to reach out to the right person and make a case for collaboration that resonates with your partner's priorities and experiences.

- Be judicious about with whom you connect first. Start with someone who can help you get the lay of the land, who has decision-making authority, or who has positive experiences collaborating in the past.
- Review the organization's past media presence as this can help you figure out which issues matters most to them and who their key players are. Has the organization recently experienced a change in leadership? Has the group expressed a need that your collaboration could address?

Phase 2: Establish a Relationship

People are more likely to work with people they know and trust. Plus, collaborations built on existing relationships are more likely to be sustained over time. So, take the time to build a relationship before moving in for the "ask." Whenever you can, make a personal connection.

- Find a mutual contact who can introduce you to the person with whom you want to connect.
- "Break bread" with your potential partner by asking him to coffee or lunch.
- Connect with your potential partner's organization on social media and share or retweet the organization's posts.
- Ask if you can begin attending meetings at your potential partner's organization or invite them to attend yours.

Phase 3: Develop your pitch

Develop a short, convincing message that clearly describes what you want from your potential partner, and how you will both benefit. Will working together provide the partner with access to needed resources? Help access hard-to-reach populations? Prevent duplication of efforts?

- Be concrete. What will collaboration look like?
- Remember that one size does not fit all when it comes to making a pitch. Your reasons for collaborating with one partner will not be the same as your reasons for partnering with another, nor will their reasons for wanting to partner with you.

Phase 4: Choose a Delivery Approach

When it finally comes time to ask your potential partner to do something, how will you do so (i.e. send an email)? When choosing an approach, consider your existing relationship with the person and what you know about their communication style.

- Although face-to-face meetings are a nice way to add a personal touch, calling or writing potential partners can be effective if you are short on time or need to engage a number of partners.
- Consider using a combination of delivery methods. For example, begin by providing background information via email, then follow up with an in-person meeting.

This was adapted from Prevention Solutions @ EDC's "Growing Your Collaboration: Preparing for Recruitment," which can be found here: https://pscollaboration.edc.org/sites/default/files/attachments/Growing-Your-Collaboration-Preparing-for-Recruitment_508compliant_0.pdf

Indiana Department of Health

STRATEGIC PLANNING WITH SUICIDE PREVENTION INITIATIVES GUIDE

When convening a stakeholder group, it is important to keep in mind a strategic planning approach that incorporates long-term goals and evaluates outcomes.

In the subsequent pages, there are step-by-step instructions on how to utilize a strategic planning approach to suicide prevention. These sections follow the outline on the left, with six steps in total. At the end of the document, there is a health equity evaluation tool so teams can check whether their interventions are designed with an anti-racism health equity lens.

This framework was largely adapted from the Suicide Prevention Resource Center's (SPRC) online training "A Strategic Planning Approach to Suicide Prevention." For individuals interested, SPRC offers this free two- to three-hour training online, here: https://training.sprc.org/enrol/index.php?id=31.

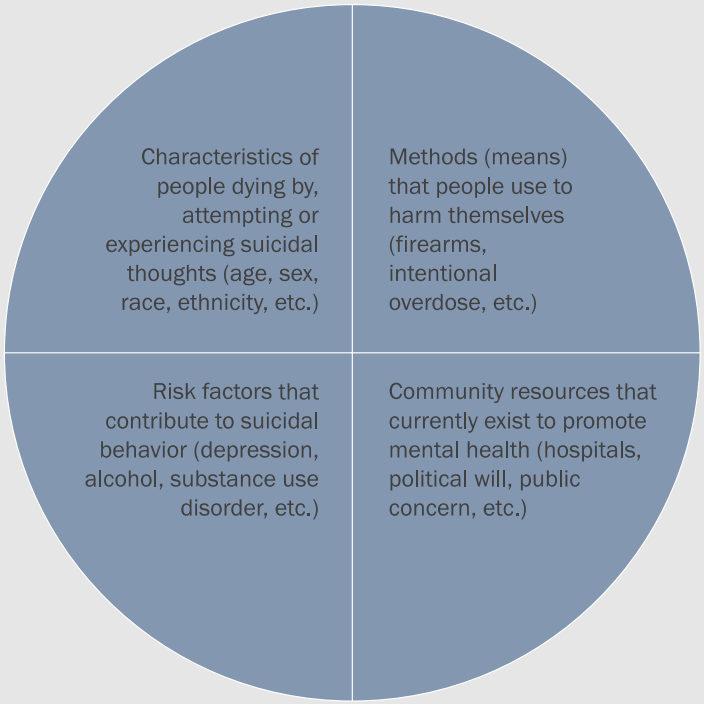
The equity tool was adapted from the National Farm to School Network's "Racial and Social Equity Assessment" which can be found here: http://www.farmtoschool.org/resources-main/nfsn-programs-and-policy-racial-and-social-equity-assessment-tool.

Indiana Department of Health

1. Describe the problem and its context

It is vital to get an accurate picture of suicide in one's community if the goal is to create effective, lasting, and purposeful prevention strategies. For example, if one thought there were only veteran suicides in a community when there were actuality teen suicides, how would one create effective prevention strategies?

Below are the various information and facts a community would want to gather before implementing a suicide prevention initiative. This information can be gleaned by reviewing research/data and talking with citizens.



2. Choose long-term goals

Without long-term goals, ideas, and strategies, groups can lose direction and not address the ultimate goal. That is why it is vital to choose a long-term strategy initially before choosing prevention strategies. As stated below, this long term goal should be specific and actionable. If one chooses too broad a goal, it may be difficult to implement the goal. For example, between the two sentences below, the first sentence is a better long term goal as it targets a specific group of people and a specific circumstance or setting.

✓ "Reduce suicidal behavior in LGBTQIA+ youth in our county." *

✗ "Reduce suicide deaths in our county."

Long term goals should surround reduction in suicidal behavior in a…

- specific **group of people**, associated with a specific risk factor
- specific **circumstance or setting**

Additionally, does this long-term goal answer the questions listed below.

- Extent – How widespread is the problem?
- Disparity – Does the problem represent a health disparity?
- Capacity – Are there resources that can be directed at the problem?
- Understanding – Is enough known about the problem to take action?

*LGBTQIA+ refers to lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual or allied.

3. Identify key risk and protective factors

Shared risk and protective factors are key to getting an accurate picture of a group's characteristics. These factors are defined as:

- RISK FACTORS - Characteristics of people or environments that are associated with an increase in a health-related condition, such as suicidal behavior.
- PROTECTIVE FACTORS - Characteristics of people or environments that reduce the effects of risk factors and thus 'protect' people from risk.

With both risk and protective factors, no one factor is responsible for suicidal ideation, attempts or deaths. Below, is a chart of a few risk and protective factors specific to suicide prevention.

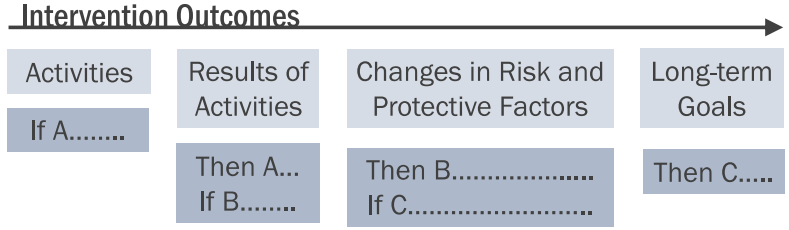
Risk Factors	Protective Factors
Mood/anxiety or substance use disorders	Effective and accessible healthcare options
Prior suicide attempt(s)	Connectedness to others
History of trauma	Problem solving/coping skills
Access to lethal means	Early treatment or detection

When choosing risk and protective factors, choose factors that would best reduce suicide ideation and attempts in the specific identified population. It is helpful to ask questions listed below.

- Which factor would have the most impact in reducing suicidal behavior?
- What efforts has the research literature documented that address specific risk and protective factors, and were effective?

4. Select or develop interventions

When choosing the activities a group wants to implement to prevent suicide, it is important to determine whether the activity addresses the specific risk and protective factors and the long-term goal, previously identified

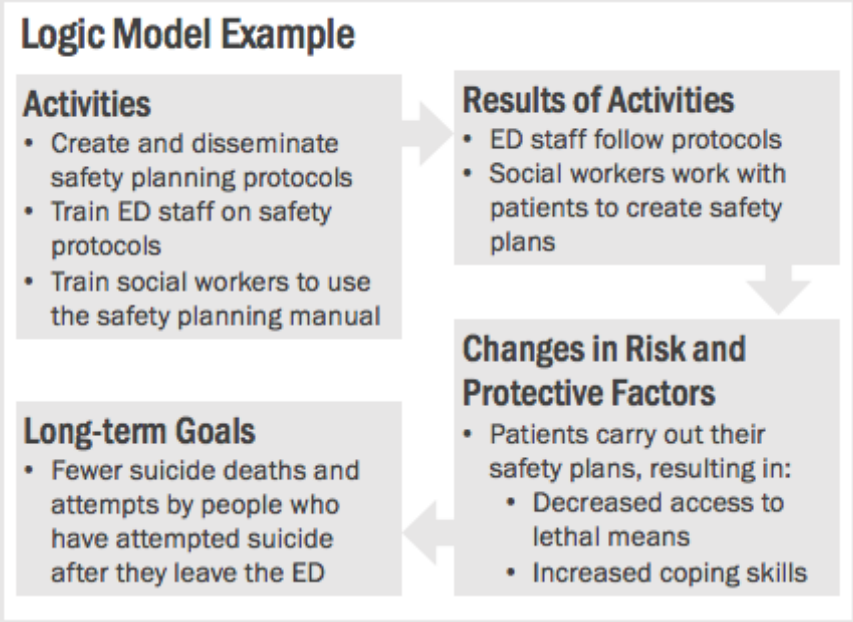


To determine whether this intervention is the best for a particular community, one can use a logic model, like the one above. Per SPRC's description, a logic model, "is a systematic and visual way to show the relationship between your intervention and the change you hope to achieve in the risk and protective factors, which will then lead to achieving your long-term goals." Logic models work as a series of "if-then" statements to assess intervention outcomes; an example of these statements are below.

"If protocols are created specifying that ED staff contact a hospital social worker after treating a patient for a suicide attempt or crisis, ED staff are taught these protocols, and social workers are trained to work with patients to create safety plans...."

"Then ED staff will follow protocols by contacting a social worker after treating a patient for a suicide attempt, and social workers will work with patients to create safety plans...."

Logic Model Example



After creating a logic model, it is helpful to create an action plan to clarify what tasks need and who is responsible for what. An list of what one may want to include is listed below. After creating the action plan, revisit the original goal. Does it capture what the group wants to implement?

Action Plan		
Task	People	Timeline
A list of tasks and subtasks in the order in which they must be completed	Who has primary responsibility for overseeing each task?	Timelines and target dates for each task
*Additional helpful information could include; objectives for each task, who else will be involved in each task, what resources will be needed for each task, who should be informed about each task (even though they may not be involved)		

5. Plan the evaluation

Evaluation is vital to validate an activity's efficacy. It helps determine what data needs to be collected, changes that need to be made to the project, and potential interventions to pursue in the future. Individuals charged with planning the evaluation need to consider a few key questions.

Who should be involved in the evaluation?

- Agencies, organizations, and people who will be expected to collect or provide data
- Groups that will be interested in the evaluation results

Where will the data come from?

- Accessing existing data
- Revising existing systems
- Creating a new data system

What should be evaluated?

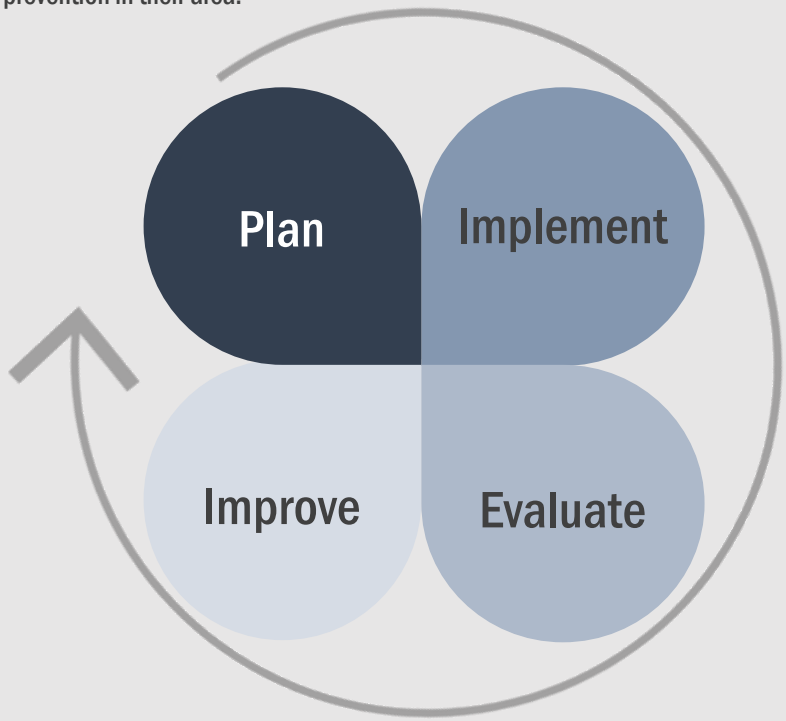
- Have the activities been implemented as expected?
- What were the results of the implemented activities?
- What changes were seen in the aforementioned risk and protective factors?
- Did the results of the implemented activities align with the long-term goals

Does the project need an evaluation specialist?

6. Implement, evaluate, and improve

Finally, getting to the implementation stage, the group implements all they have planned. Once the implementation begins, it is vital to simultaneously start evaluation efforts to determine whether goals are being met. Once all of this is completed, the process can start over again and the group can outline new goals and strategies.

Regardless of the interventions chosen, it is vital that communities begin having these conversations and determining what can be done with suicide prevention in their area.



Health Equity Evaluation Tool

Question	Yes	No	How or Why?
Could this program lead to greater access to health resources in communities of color or socially disadvantaged* communities?			
Could this program lead to increased engagement in healthy behavior or practices in communities of color or socially disadvantaged communities?			
Do people of color or socially disadvantaged individuals have greater control over community resources as a result of this program?			
Will this program work towards reducing racial health disparities in Indiana?			
Does the program have targeted impacts for a specific community of color or socially disadvantaged community?			
Are targeted communities of color or socially disadvantaged communities engaged in the development and implementation of this program?			
Does the program explicitly include a strategy for direct representation of community stakeholders?			
Are there components of this program that may unintentionally further racial and social inequities?			
If this program is created, could it create immediate change for communities of color or socially disadvantaged communities?			
If this program is created, could it create systemic change for communities of color or socially disadvantaged communities?			
Does this program directly address the needs and desires expressed by community stakeholders?			
Does this program support local leadership from socially disadvantaged communities?			
Does this program allow communities of color and socially disadvantaged communities to adapt implementation to local needs and desires?			

*The deficit-based term "socially disadvantaged" was used intentionally to align with federal classifications. Socially disadvantaged individuals are those who have been subjected to racial or ethnic prejudice or cultural bias because of their identities as members of groups without regard to their individual qualities. Small Business Act (15 USC 637).

LOGIC MODEL TEMPLATE

As mentioned in the previous pages, it is important to have a logic model when strategically planning initiatives and programs. Below is an example of a completed logic model and on the next page is the same logic model, but blank.

Program Name: Fictional Crisis Hotline **Date:** 6/1/13

Target Population: In-crisis residents in the metropolitan areas of Baltimore, Maryland (zip codes 21201, 21202, and 21210)

Resources	Activities	Outputs	Outcomes	Evaluation	Needs
The capacities and resources available to the program	The program activities conducted with the resources	The direct products of the program activities	What your program expects to change as a result of the activities	How your program addresses outcomes	Needs in the community that the outcomes address
Three psychologists on staff trained annually in ASIST A large volunteer base from the local suicide prevention coalition that can be leveraged as needed Enough funding to run the program for one year ($50,000) Donated space to run the program at the local department of health Hotline equipment (phones, phone lines, answering service, etc.) An MOU with the sheriff's department to conduct house calls when hotline staff identify a caller as high-risk	Operate a 24-hour hotline for individuals in Baltimore	616 in-crisis callers served in the past year	**Short term:** None **Long term:** Decrease in suicide rate in Baltimore by 20% over the first 3 years	Assess changes in suicide rates before and after hotline initiation using hospital data	Mayor's Task Force Report indicated Baltimore has high rates of suicide compared with U.S. average
	Screen callers for mental health problems using the PHQ-9	550 in-crisis callers screened for mental health problems in the past year	**Short term:** Increase the identification of callers at risk for suicide by 15% in the first 6 months **Long term:** None	Assess changes in the number of callers screened for risk of suicide	An assessment conducted by the state health department identified a lack of support for in-crisis Baltimore residents

This was adapted from RAND's "Suicide Prevention Program Evaluation Toolkit" which can originally be found here: https://www.rand.org/pubs/tools/TL111.html..

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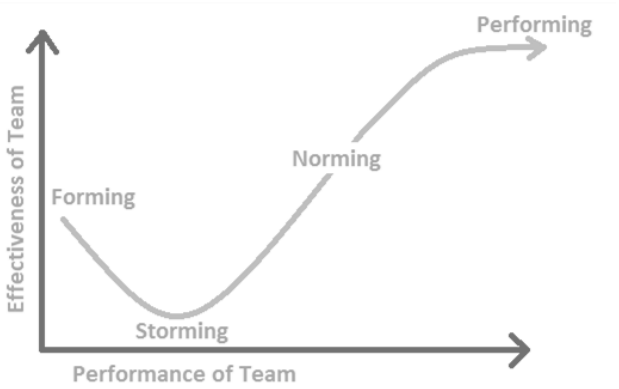
Program Name: _____ **Date:** _____

Target Population: _____

Resources	Activities	Outputs	Outcomes	Evaluation	Needs
The capacities and resources available to the program	The program activities conducted with the resources	The direct products of the program activities	What your program expects to change as a result of the activities	How your program addresses outcomes	Needs in the community that the outcomes address
	Activity 1:	Outcome 1:	Short Term: Long Term:	Measure 1:	Need 1:
	Activity 2:	Outcome 2:	Short Term: Long Term:	Measure 2:	Need 2:
	Activity 3:	Outcome 3:	Short Term: Long Term:	Measure 3:	Need 3:
	Activity 4:	Outcome 4:	Short Term: Long Term:	Measure 4:	Need 4:
	Activity 5:	Outcome 5:	Short Term: Long Term:	Measure 5:	Need 5:

MANAGING COALITION DYNAMICS

In a perfect world, every prevention collaboration would come together effortlessly: members would agree right away on goals and processes, then work together harmoniously and efficiently to produce lasting change. But as anyone who has started or managed a coalition knows, the reality of group functioning is often a whole lot messier. This tool offers an overview of four stages (originally from the *Stages of Development Team Theory*) of team development, accompanied by tips for maximizing productivity and cohesion, reducing conflict, and steering group members toward long-term success.



Stage 1: Forming

When new groups first come together, members are likely to feel both excited and anxious: eager to get started but also unsure of what will be expected of them and/or how they might contribute. To support group functioning at this stage, leaders should focus on guiding members toward ownership and investment in the newly formed group. Tips for doing this include the following:

- **Define the group's mission and goals.** The fastest way to give members a voice and reason for participating is to have them help define the direction of the group. Having a clear mission and goals will also help to allay the anxiety of members who are unclear about the group's direction.
- **Focus on creating group identity and a sense of belonging, rather than accomplishments.** Until members develop a sense of shared ownership, any accomplishments will feel false and may be attributed to the leader rather than to the efficacy of the group as a whole.
- **Build trust.** Prevention-focused collaborations often bring the same players to the table. These groups often hold deeply held opinions about one another, and may or may not feel comfortable working together. Recognizing potential "turf" issues early on, and then working collaboratively to build an atmosphere of respect and trust, will lay the foundation for open dialogue and productivity over time.

Stage 2: Storming

Groups in the Storming stage are figuring out how to meet their goals and define their processes. For some members—especially those who are uncomfortable with ambiguity—this phase can generate some frustration. They may vocalize concerned about the direction the group is heading and/or have doubts that identified goals will be met. For leaders, successfully managing the Storming stage and addressing member concerns s crucial to the longevity of the collaboration. Some tips for managing dynamics during this stage include the following:

This was adapted from Prevention Solutions @ EDC's "Managing Coalition Dynamics" document, found here: https://pscollaboration.edc.org/sites/default/files/attachments/Managing-Coalition-Dynamics_508Compliant_0.pdf.

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- **Break down larger goals into smaller, achievable steps.** This will help members identify clear opportunities for participation and concrete ways to contribute, and realize immediate, short-term success.
- **Redefine goals with concrete, measurable outcomes.** Members who are uncomfortable with vague processes will rejoice at knowing exactly how success is defined. It's also helpful to begin creating the evaluation design in this phase—and to involve interested members in this process.
- **Invite members to voice their concerns openly and honestly**. Let members know that their feedback is important, and that the input of all members is valued equally. Work together to develop a process for sharing ideas and concerns.

Stage 3: Norming

In Norming, members begin working independently and/or in small, task-oriented groups, clarifying processes and objectives along the way. Groups in this phase welcome constructive criticism: members feel like they can say what they're thinking, have a sense of belonging to the group, and are realistically optimistic about meeting the group's overarching goals. Though it may appear that the group is now functioning autonomously, groups in the Norming phase benefit enormously from smart leadership. Tips for success at this stage include the following:

- **Delegate responsibility.** The Norming phase is a great time to identify and build potential leaders. One way to do so (and increase productivity at the same time) is to delegate tasks to subgroups headed by the collaboration's rising stars.
- **Refine processes (as needed).** While leaders may feel good about the swell of productivity that often marks the beginning of the Norming phase, be vigilant about identifying and reviewing processes that may hamper workflow or cause frustration for members.
- **Encourage members to get feedback and support.** Much of the leadership work of Norming is establishing a culture of positive support. Creating a space for sharing and soliciting feedback as members move toward goals is a great way to do this.

Stage 4: Performing

Groups in the Performing phase are working steadily toward their long-term goals and have a solid number of "wins" under their belt. Members are enthusiastic about both their work, feel confident about the group's abilities, and are able to anticipate and effectively address potential roadblocks. Leaders may be tempted to take a hands-off approach; instead, leaders should ensure that members remain engaged and prepared for potential changes in focus, direction, or leadership. Tips for managing group dynamics in the Performing phase include the following:

- **Allow group members to assume new roles organically—especially those related to leadership.** This will not only help members continue to grow and remain engaged but is also critical to the group's long-term sustainability.
- **Provide opportunities for professional or personal development.** Share information about relevant conferences and trainings and invite speakers in to share their expertise. Encouraging professional and personal development not only builds the capacity of your group but also shows members that you are invested in their continued growth and learning.
- **Celebrate coalition successes and wins.** Devote dedicated time to praising hard work and letting members know how much they are valued and appreciated.
- **Identify and tackle new prevention challenges.** Collaborations with a proven track record of success are ideally suited to taking on new projects and shifting their focus to address issues.

ENSURING CULTURALLY COMPETENT COLLABORATION

Cultural competence describes the ability of an individual or organization to interact effectively with people of different cultures. It also means being respectful and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse population groups. Effective collaboration depends on cultural competence. Although cultural competence isn't a quick fix and can't be accomplished simply by following a set of culturally sensitive rules and recommendations, here are some tips for increasing the cultural competence of your collaborative efforts:

Make sure that all printed, digital, and audiovisual materials reflect the culture, preferred language, and background of the populations they are meant to serve. For example, in tribal communities, symbols have language; therefore, some terms and their uses can vary depending on the audience's country of origin. Understanding and using the most appropriate terms and phrases for your intended audience helps to ensure that materials are welcomed and not deemed offensive.

Connect with culturally relevant organizations to be your outreach ambassadors. For example, if an organization focused on suicide prevention among college students and it would like to reach Latino college students, partner with a Latino organization on campus to help reach these students. The Latino organization will know the best ways to communicate to Latino college students and help outreach.

Invite a member from the community to co-present. This will help to ensure that your audience feels like they are being heard and represented in a discussion and conveys the message that the knowledge and experiences of community members are respected. For example, if the presenter was speaking about suicide prevention at a church made up of largely Spanish-speaking congregants, it may be helpful to have a Spanish-speaking individual with lived experience speak as well.

If making a presentation, practice remarks with an interpreter (if using one) to rehearse pacing and translation pauses—that is, the time it takes for the interpreter to translate content from one language to another. For example, Spanish uses more words than other languages. As a result, when translating from one language to Spanish, there is a median duration pause of 100 milliseconds longer than for other languages. This helps to reduce confusion among individuals.

This was adapted from Prevention Solutions @ EDC's "Tips for Ensuring a Culturally Collaborative Collaboration" document, found here: pscollaboration.edc.org/sites/default/files/attachments/Tips-for-Ensuring-a-Culturally-Competent-Collaboration_508compliant.pdf. The graphics are from Noun Project (Languages by supalerk laipawat, shake hands by fajar hasyim, presentation by Gregor Cresnar, Language by the Icon Z)

WORKSHEET: CREATING A MEMORANDUM OF AGREEMENT

A memorandum of agreement (MOA) is a written document that describes how two parties will work together to meet a common objective. MOAs help partners specify the purpose of their collaboration, as well as the roles and responsibilities of each partner in achieving articulated goals. MOAs can range from informal (a firm handshake) to formal (a binding legal document that holds parties responsible to their commitment). The terms memorandum of agreement and memorandum of understanding (MOU) are often used interchangeably. This tool presents the major sections of a standard MOA, accompanied by a template that can be adapted.

- **Purpose and Scope.** This section conveys the "big picture" of why and how all parties will work together. It typically includes a clear mission or vision statement that defines the primary purpose of the collaboration and how it will benefit the community. It may also include the goals and objectives that the collaboration hopes to achieve. Other components may include name of all parties involved in the collaboration; brief description of the scope of work and desired outcomes; financial obligations of each party, if applicable; dates that the agreement is in effect; key contacts for each party.

- **Background.** This section contains a brief description of the agencies participating in the collaboration, as well as any current or historical ties between partners.

- **Responsibilities under this MOA.** This section contains a brief description of how partners will work together (i.e., what they will be doing), as well as individual partner responsibilities. It can also describe expectations for meetings and communication (e.g., frequency and approach), and the types of management and decision-making processes that will be used. It may also include descriptions of:

    - How information will be shared across agencies, including any policies or procedures that inform and/or dictate the selected approach.
    - Partner responsibilities related to evaluation, data collection, data sharing, and reporting.
    - Who has decision-making authority? Some MOAs may benefit from a delineation of decision-making authority.

- **Funding.** This section describes each partner's fiscal duties, if any, ensuring that these are consistent with the stated goals and planned activities.

- **Effective Date and Signature, including:**
    - *Duration of the Agreement*—the effective date that the agreement begins and how long it will be in effect, as well as circumstances under which the agreement can be modified or terminated.
    - *Signatures*—the MOA is not considered in effect until all parties have signed. Each party should keep an original signed copy.

This was adapted from Prevention Solutions @ EDC's "Worksheet: Creating a Memorandum of Agreement" document, found here: pscollaboration.edc.org/sites/default/files/attachments/Worksheet-Creating-A-Memorandum-of-Agreement_508Compliant.pdf

Memorandum of Agreement Template

MEMORANDUM OF AGREEMENT (MOA)

Between

_____
(insert legal name of Party A)

And

_____
(insert legal name of Party B)

This is an agreement between "Party A," hereinafter called

_____
(insert commonly called name or acronym of Party A)

And "Party B," hereinafter called

_____
(insert commonly called name or acronym of Party A)

I. PURPOSE AND SCOPE

The purpose of this MOA is to clearly describe the roles and responsibilities of each party as they relate to:

In particular, this MOA is intended to:

II. BACKGROUND

III. RESPONSIBILITIES UNDER THIS MOA

(Party A) shall undertake the following activities:

(Party B) shall undertake the following activities:

IV. FUNDING

This MOA does (does not) include the reimbursement of funds between the two parties (clearly describe details of funding agreement/reimbursement).

V. EFFECTIVE DATE AND SIGNATURE

This MOA shall be effective upon the signature of Parties A and B authorized officials. It shall be in force from _____ to _____.

Parties A and B indicate agreement with this MOA by their signatures.

Name	Name
_____	_____
Title	Title
_____	_____
Party A	Party B
_____	_____
Date	Date
_____	_____

BRAIDING AND BLENDING FUNDING

With numerous grants and funding opportunities these days, it can be difficult to know how to coordinate all the funding. That is why it is vital to blend and braid funding. Blending funding involves co-mingling the funds into one "pot" whereas braiding funding involves using multiple streams to pay for different things. The subsequent templates help to navigate these complex funding frameworks.

Step 1: Prior to developing the funding model, your group must identify what you hope to accomplish by blending and braiding funding. Fiscal coordination strategies are only a means to an end, and to be successful, the end needs to be well defined. Regardless of the scope of your goals, you need to clearly define them and outline what you will be funding. Fill out the questions below.

- What population do we need to serve?
  - Demographics of the population (age, income, race/ethnicity)
  - Needs of the population (health, mental health, housing, etc.)
  - Strengths/protective factors of the population
  - Other resources/systems likely to be serving the population

- What are the services or interventions that are part of our program?
  - Services we will provide, including case management
  - Services we will refer out
  - Services we will purchase
  - Priority of services we're planning – which ones must be provided versus preferred, but not critical
  - Length of services we expect to provide on average

- Evidence-based of the services we're planning What will our services accomplish and how will we know?
  - Desired outcomes from the services
  - Plan for monitoring, evaluation, and quality assurance

- Where are we delivering the services?
  - Whether home-based services will be included
  - Whether school-based services will be included
  - Other locations where services will be provided
  - Staff and client transportation needs to access service sites

- Who will deliver the services?
  - Qualifications of providers who will implement services
  - Number of providers needed to implement the array of services
  - Qualifications of supervisors

- What infrastructure is needed to support the program?
  - Indirect expenses (phones, supplies, physical space, etc.)
  - Daily direct expenses (staff, equipment, transportation, etc.)
  - Other direct expenses (supervision, training, evaluation, etc.)

This was adapted from the Spark Policy Institute's Colorado Guide 1: Blending and Braiding: A step by step instructions to develop and expand fiscal coordination.

Step 2: Fill in the "population" column with the answers to the questions. In the example below, based on a homeless services program, the population includes two age ranges and two types of need – at risk and already homeless. They also noted that their population is likely to be lower income and some of the youth would be runaways without families.

Step 3: Collect information about your funding streams from your fiscal staff, the funder's documentation sent to your organization, the funder's website, or by talking to the funder directly. Review the information and start to enter the specific information that tells you what is allowed and not allowed in the context of your program design. Write that information in the "funding stream" columns.

EXAMPLE:

Population	Funding Stream 1	Funding Stream 2
What population do we need to serve?		
Youth ages 12-18	Eligible if parent/guardian is income eligible	Yes, if homeless
At risk of losing their housing	Yes, provided the risk of losing housing is leading to risk related to self-sufficiency, out-of-wedlock pregnancy, or keeping a two-parent family together	Not eligible, must be homeless

TEMPLATE:

Population	Funding Stream 1	Funding Stream 2
What population do we need to serve?		
What are the services or interventions that are part of our program?		
What will our services accomplish and how will we know?		
Where are we delivering the services?		
Who will deliver the services?		
What infrastructure is needed to support the program?		
What is the time frame for our funding streams? (including allowability of no-cost extensions)		

Step 4: Create a list that breaks out into distinct subgroups all of the populations and services you want to fund. The goal is to have non-overlapping groups. In the example below, based on a homeless services program, the population includes two age ranges (youth ages 12 - 18, young adults ages 19 - 24), two types of need (at risk of being homeless, homeless), and three demographic factors (low-income, runaway, have children).

Step 5: Using the template below, place an X for what is allowable by each funding stream. You should end up with a grid that clearly shows what each funding stream can and cannot fund.

EXAMPLE:

Population	Funding Stream 1	Funding Stream 2
What population do we need to serve?		
Ages 12-18, at risk of losing housing, low-income families		X
Ages 12-18, at risk of losing housing, non-low-income families	X	
Ages 12-18, at risk of losing housing, runaway (no family income known)		X
Ages 12-18, homeless, low-income families		X
Ages 12-18, homeless, non-low-income family	X	X
Ages 12-18, homeless, runaway (no family income known)	X	

TEMPLATE:

Population	Funding Stream 1	Funding Stream 2
What population do we need to serve?		

Step 5: Using the previous templates, to complete the plan. Make sure to engage the fiscal and programmatic staff in the design of the plan, as they will be responsible for implementing it.

COORDINATED FINANCING PLAN

_____(*enter program/organization name*)_____
_____(*date created*)_____

PROGRAM DESIGN

- Provide a short overview of the program design, including eligible populations, direct services, and nonservice delivery activities.

FUNDING SOURCES

- Briefly list each funding source, the contact information, the amount, duration, and any critical information to understand the purpose of the funding stream in supporting the program. For example, one funding stream might be comprehensive, supporting all components, while another funding stream is for primary health care services only.

PROGRAM BUDGET

- Briefly describe the Program Budget.
- Indicate any key decisions made that relate to the budget, such as the total population served.

COST ALLOCATION

- Briefly describe your overall cost allocation model.
- Indicate whether you are blending or braiding.
- Include a list of all the sources of financial information and how to access them.

TRACKING AND REPORTING

- Include a timetable for your reports to your funders, including fiscal and programmatic reporting.
- Include your tracking and reporting tools. These tools should capture all of the information needed for all of your funders. They must include a timesheet to track personnel time spent on specific clients and on non-client-based activities.
- Include your protocol for completion of reports using the information collected. You will want to indicate how frequently programmatic staff must complete the tracking tools and the process for inputting data into various funders' databases or reporting templates.

FINANCIAL SYSTEMS

- Include a brief description of how your Coordinated Financing Plan aligns with existing financial practices and systems.
- Indicate where the Coordinated Financing Plan requires additional practices or systems and include protocols for those.
- Address potential need for segregating your funding in your accounting systems. This is critical for many public funding streams, and particularly important if you are a faith-based organization.

CONTRACTING

- Include an explanation of your contracting system (pre-approved providers, fixed price contracts, capitated contracts, case-rate contracts for multiple services).
- Include an explanation of your reporting requirements to ensure contractors provide sufficient information to meet reporting needs.

COALITION ANNUAL REPORT TEMPLATE

An annual report is a great way for groups to report out on outcomes. This report can begin with a review of the group's missions, goals, and structure and then summarize the various activities – usually task forces objectives, activities, and outcomes for the year. Below is an example of a coalition annual report and on the subsequent pages is a blank annual report template.

Coalition Annual Report Example

Mission
The Happy Valley Community Coalition is a community-wide alliance committed to improving the quality of life for all those living in Happy Valley.

Goals
To increase access to health care, especially for the uninsured, to advocate for local, state, and Federal health policy changes that increase access, and advocate for quality patient care through every stage of medical treatment.

2000-2001 Objectives
- *To increase Happy Valley residents' usage of the Community Dental Center to 25% of the total participants.*
- *Identify town health needs and resources and advocate for coordinated responses with Happy Valley Health Care and other providers.*
- *Implement, track, and evaluate the effectiveness of the coordinated outreach plan for enrollment in MassHealth.*
- *Involve consumers in the evaluation of the Happy Valley Community Dental Center.*
- *Implement a preventative educational dental program in Happy Valley.*

Task Force Activities
- *Distributed 25,000 pink business cards with phone numbers to call for health insurance enrollment assistance.*
- *Dental Center evaluation completed by patients.*
- *Provided informational luncheons for 50 medical office managers on community health center.*
- *8 people attended and 3 people testified at the public hearing on May 10 for the Health Now! Legislation*
- *Participated in the Community Health Access Project (CHAP).*

Outcomes
- *53.5% of total users of the Dental Care Center are from Happy Valley.*
- *Identified and advocated for health needs of Happy Valley residents.*
- *690 people enrolled in MassHealth and CMSP*
- *CHAP efforts brought #1,279,000 in resources to the valley.*

This was adapted from *Evaluating Community Collaboration*'s, "Coalition Annual Report" document, found here: tomwolff.com/resources/baker.pdf

Coalition Annual Report Template

Mission:

Goals:

Year's Objectives:

1.
2.
3.
4.
5.

Task Force Activities:

-
-
-
-

Outcomes:

-
-
-

NATIONAL SUICIDE PREVENTION RESOURCES

As a coalition, the group may be asked to help connect individuals with care or to direct individuals to national resources. Listed below are several contact lines.

The National Suicide Prevention Lifeline: Call 1-800-273-TALK (8255)
A free, 24/7 confidential service that can provide people in suicidal crisis or emotional distress, or those around them, with support, information, and local resources.

Crisis Text Line: Text "IN" to 741-741
This free text-message service provides 24/7 support to those in crisis. Text 741-741 to connect with a trained crisis counselor right away.

Additional Phone Resources:

- **The Veterans Crisis Line and Military Crisis Line:** Call 1-800-273-TALK (8255) Press 1, Text 838255
- **Trevor Project (LGBTQ+ Youth):** Call 1-866-488-7386, Text "TREVOR" to 202-304-1200
- **Trans Lifeline:** Call (877)565-8860
- **Crisis Line for Individuals Deaf and Hard of Hearing:** Call 1-800-273-8255 (video relay service or voice/caption phone), Call 1-800-799-4889 (TTY)
- **Ayuda en Español:** Llama al número 1-888-628-9454

National Websites:

- **American Association of Suicidology:** https://www.suicidology.org
- **American Foundation for Suicide Prevention:** https://www.afsp.org
- **Mental Health America:** https://www.mhanational.org/
- **Mental Health.gov:** https://www.mentalhealth.gov/get-help
- **Suicide Prevention Resource Center:** https://www.sprc.org

This was adapted from Reporting on suicide's "Get and Share Support" webpage which can be found here: https://reportingonsuicide.org/onlinemedia/. The graphic is from Noun Project (phone by monkik).

WORKING WITH SUICIDE LOSS AND ATTEMPT SURVIVORS

Supporting someone who has lost a loved one (suicide loss survivors) and individuals with lived experience (suicide attempt survivors) can feel overwhelming and complex. There are ways to help.

Suicide Loss Survivors

Accept their feelings: Loss survivors grapple with complex feelings after the death of a loved one by suicide, such as fear, grief, shame, and anger. Accept their feelings and be compassionate and patient and provide support without criticism.

Use sensitivity during holidays and anniversaries: Events may bring forth memories of the lost loved one and emphasize this loved one's absence.

Use the lost loved one's name: Use the name of the person who has died when talking to survivors. This shows that you have not forgotten this important person and can make it easier to discuss a subject that is often stigmatized.

There are numerous postvention resources available to suicide loss survivors. A few are listed below.

- Survivors of Suicide Loss Support Groups - https://afsp.org/find-a-support-group/
- LOSS (Local Outreach to Suicide Survivor) Teams - https://lossteam.com/
- Alliance of Hope - https://allianceofhope.org/
- American Foundation for Suicide Prevention - https://afsp.org/ive-lost-someone

Suicide Attempt Survivors

Ask and listen: Be an active part of your loved ones' support systems and check in with them often. If they show any warning signs for suicide, be direct. Tell them it's OK to talk about suicidal ideation. Practice active listening techniques and let them talk without judgment.

Be understanding: Do not make them feel guilty. Don't make it about you. Listen and be as understanding as possible.

Give a hug: Let them know that they are still loved and that you still want them in your life. Sometimes, a hug can say more than a thousand words.

Get them help and take care of yourself: Don't be afraid to get your loved one the help they might need. The Lifeline is always here to talk or chat, both for crisis intervention and to support allies. Helping a loved one through a crisis is never easy. You might want to talk about your feelings with another friend or a counselor.

This was adapted from Suicide Prevention Lifeline's webpages on Loss Survivors and Attempt Survivors, found here: https://suicidepreventionlifeline.org/help-yourself/loss-survivors/

Justice

Introduction

The justice system is a vital partner in bringing about change with suicide deaths in Indiana. In fact, suicide is a leading cause of death in state and federal prisons as well as local jails. Throughout all correctional facilities, the suicide rate is higher than that of the general population. In state and federal prisons across the US, the suicide rate is 17 and 13 per 100,000 for males and females, respectively.[10] In comparison, jails are 45 and 29 per 100,000 for males and females, respectively.[11] This trend of suicide rates being higher for those in jail compared with those in prison is a consistent trend.

When looking at the correctional facilities, individuals with justice system involvement often have histories of mental health and substance use. While it is estimated that approximately 5 percent of people living in the community have a serious mental illness, comparable figures in state prisons and jails are 16 percent and 17 percent, respectively.[12] The prevalence of substance use disorders is notably more disparate, with estimates of 8.5 percent in the general public (aged 18 or older) but 53 percent in state prisons and 68 percent in jails.[12] All of that said, it is clear there is both need and ample opportunity for intervention within both jails and prisons.

Justice Resources:

- Suicide Prevention Frameworks for Correctional Facilities
- Strategies for Primary Prevention of Suicide
- Suicide Prevention is Everyone's Business
- Creating a Supportive Physical Environment for the Mental Wellness of Individuals who are Justice-Involved
- High Risk Times for Suicide: Individuals who are Justice-Involved
- Correctional Officer Care Checklist
- Suicide Training: Individuals Who Work in Correctional Facilities (p. 214-215)

SUICIDE PREVENTION FRAMEWORKS FOR CORRECTIONAL FACILITIES

There are numerous suicide prevention frameworks that have been developed for justice-related settings. In the next few pages, two are outlined. The first is the **National Commission on Correctional Health Care's** (NCCHC) standards for both jails and prisons. Listed below are the key components that every suicide prevention program should have, per the NCCHC.

Training. All staff members who work with individuals with justice involvement are trained to recognize verbal and behavioral cues that indicate potential suicide and how to respond appropriately. Initial and at least annual training is provided.

Identification. The receiving screening form contains observation and interview items related to potential suicide risk. If a staff member identifies someone who is experiencing suicidal ideation, the individual is placed on suicide precautions and is referred immediately to mental health staff.

Referral. There are procedures for referring individuals experiencing suicidal ideation and those who have experienced a suicide attempt to qualified mental health professionals or facilities. The procedures specify a time frame for response to the referral.

Evaluation. An evaluation, conducted by a qualified mental health professional, determines the level of suicide risk, level of supervision needed, and need for transfer to an inpatient mental health facility or program. Patients are reassessed regularly to identify any change in condition indicating a need for a change in supervision level or required transfer or commitment. The evaluation includes procedures for periodic follow-up assessment after the individual's discharge from suicide precautions.

Treatment. Strategies and services to address the underlying reasons (e.g., depression, auditory commands) for individual's suicidal ideation are to be considered. The strategies include treatment needs when the patient is at heightened risk for suicide as well as follow-up treatment interventions and monitoring strategies to reduce the likelihood of relapse.

Housing. Unless constant supervision is maintained, an individual experiencing suicidal ideation is not isolated but is housed in the general population, mental health unit, or medical infirmary and located in close proximity to staff. All cells or rooms housing individuals experiencing suicidal

The first framework was adapted from NCCHC's frameworks for jails and prisons, found here: NCCHC's webpage on suicide prevention https://www.ncchc.org/suicide-prevention-resources. The second framework was adapted from SAMHSA's, "Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide" document, found here: store.samhsa.gov/product/Guidelines-for-Successful-Transition-of-People-with-Mental-or-Substance-Use-Disorders-from-Jail-and-Prison-Implementation-Guide/SMA16-4998

ideation are as suicide resistant as possible (e.g., without protrusions that would enable hanging).

Monitoring. There are procedures for monitoring an individual identified as "non-acutely suicidal." Unpredictable, documented supervision is maintained, with National Commission on Correctional Health Care 40 irregular intervals no more than 15 minutes apart. Although several protocols exist for monitoring individuals experiencing suicidal ideation, when an individual experiencing suicidal ideation is housed alone in a room, continuous monitoring by staff should be maintained. Other supervision aids (e.g., closed circuit television, companions or watchers) can supplement, but never substitute for, direct staff monitoring.

Communication. Procedures for communication between mental health, medical, and correctional personnel are in place to provide clear and current information. These procedures include communication between transferring authorities (e.g., county facility, medical/psychiatric facility) and facility correctional personnel.

Intervention. There are procedures addressing how to handle a suicide attempt in progress, including appropriate first-aid measures.

Notification. Procedures state when correctional administrators, outside authorities, and family members are notified when an individual has attempted suicide or has died by suicide.

Reporting. Procedures for documenting the identification and monitoring of situations involving suicide attempts are detailed, as are procedures for reporting a death by suicide.

Review. There are procedures for mental health, medical, and administrative review, including a psychological autopsy, for deaths by suicide.

Debriefing. There are procedures for offering timely debriefing to all affected individuals. Debriefing is a process whereby individuals are given an opportunity to express their thoughts and feelings about an incident (e.g., suicide or attempt), develop an understanding of stress symptoms resulting from the incident, and develop ways to deal with those symptoms. Debriefing can be done by an in-house response team or outside consultants prepared to handle these highly stressful situations.

To find out more, explore NCCHC's webpage on suicide prevention (https://www.ncchc.org/suicide-prevention-resources) and the documents on suicide prevention for jails (https://www.ncchc.org/filebin/Resources/Standard_J-B-05.pdf) and prisons (https://www.ncchc.org/filebin/Resources/Standard_P-B-05.pdf).

The second is the Assess, Plan, Identify, and Coordinate (APIC) framework developed by **SAMHSA's GAINS Center's Re-Entry Initiative** to provide procedural guidelines for recidivism reduction, successful reentry, and individual recovery. The APIC framework is outlined below.

ASSESS individual clinical and social needs and public safety risk

- **Guideline 1:** Conduct universal screening as early in the booking/intake process as feasible and throughout the criminal justice continuum to detect substance use disorders, mental disorders, suicidal ideation, co-occurring substance use and mental disorders, and criminogenic risk. Valid, reliable, and evidence-based screening instruments for the target population should be used (e.g. Columbia Suicide Severity Rating Scale, Suicide Behaviors Questionnaire)
- **Guideline 2:** For individuals with positive screens, follow up with comprehensive assessments to guide appropriate program placement and service delivery. The assessment process should involve obtaining information on the following:
    - Basic demographics and pathways to criminal involvement
    - Clinical needs (e.g., identification of probable or identified diagnoses, severity of associated impairments, and motivation for change)
    - Strengths and protective factors
    - Social and community support needs (e.g., housing, education, employment, and transportation)
    - Public safety risks and needs, including changeable (dynamic) and unchangeable (static) risk factors, or behaviors and attitudes that research indicates are related to criminal behavior.

PLAN for the treatment and services required to address the individual's needs, both in custody and upon reentry.

- **Guideline 3:** Develop individualized treatment and service plans using information obtained from the risk and needs screening/assessment process.
    - Determine the appropriate level of treatment and intensity of supervision for individuals with behavioral health needs.
    - Identify and target individuals' multiple criminogenic needs in order to have the most impact on recidivism
    - Address the aspects of individuals' disorders that affect function to promote effectiveness of interventions.
    - Develop strategies for integrating appropriate recovery support services into service delivery models.
    - Acknowledge dosage of treatment as an important factor in recidivism reduction, requiring the proper planning and identification of what, where, and how intensive services provided to individuals will be.

- **Guideline 4:** Develop collaborative responses between behavioral health and criminal justice that match individuals' levels of risk and behavioral health need with the appropriate levels of supervision and treatment.

IDENTIFY required community and correctional programs responsible for post-release services.

- **Guideline 5:** Anticipate that the periods following release (the first hours, days, and weeks) are critical and identify appropriate interventions as part of transition planning practices for individuals with co-occurring mental and substance use disorders leaving correctional settings. Take into account the individual's support system and access to social capital.
- **Guideline 6:** Develop policies and practices that facilitate continuity of care through the implementation of strategies that promote direct linkages for post-release treatment and supervision agencies.

COORDINATE the transition plan to ensure implementation and avoid gaps in care with community-based services.

- **Guideline 7:** Support adherence to treatment plans and supervision conditions through coordinated strategies.
    - Provide a system of incentives and graduated sanctions to promote participation in treatment; ensure that goals and decisions are made by the individual; and employ problem-solving strategies to encourage compliance, promote public safety, and improve treatment outcomes.
    - Establish clear protocols across systems on handling behaviors that constitute technical violations of community supervision conditions.
- **Guideline 8:** Develop mechanisms to share information, mindful of confidentiality, from assessments and treatment programs across different points in the criminal justice system to advance cross-system goals.
- **Guideline 9:** Encourage cross training to facilitate collaboration between workforces and agencies working with people with co-occurring mental and substance use disorders who are involved in the criminal justice system.
- **Guideline 10:** Collect and analyze data to evaluate program performance, identify gaps in performance and plan for long-term sustainability.

The third is the American Correctional Association's (ACA) standards. To find out more information about the ACA's framework visit their website at www.aca.org or complete their "Understanding and Preventing Suicides in Corrections" e-learning module here: http://www.aca.org/ACA_Prod_iMIS/ItemDetail?iProductCode=EL-UPSC&Category=E-LEARNING&WebsiteKey=139f6b09-e150-4c56-9c66-284b92f21e51.

STRATEGIES FOR PRIMARY PREVENTION OF SUICIDE

Primary prevention strategies reduce suicide risk for individuals who are justice involved. This impact occurs directly (such as increasing opportunities for individuals to connect with others) and indirectly (such as promoting hope). More information can be found about this through the University of Oklahoma's Hope Research Center, here: https://www.ou.edu/tulsa/hope.

Create a healthy correctional facility

- Each facility is like a "village behind walls."
- Encourage the following: provide safe housing, reduce emotional/physical trauma (e.g. celebrate the individual's strengths, define treatment options with individuals), promote gender and cultural awareness, and support healthy activities and daily routine

Promote connectedness

- Ensure that incarcerated persons, especially those housed alone, can maintain regular contact with family and other supports, regardless of administrative status or financial resources.
- Reduce isolation of individuals with justice involvement, given the negative psychological effects: https://www.euro.who.int/__data/assets/pdf_file/0011/249194/Prisons-and-Health,-5-Solitary-confinement-as-a-prison-health-issue.pdf?ua=1.

Lower barriers to seeking mental health care

- Embrace reducing stigma, ensuring confidentiality, and maintaining an effective referral system

Reduce access to the means of suicide

- Focus on locations where individuals with justice involvement are isolated

Reduce the harmful use of alcohol and drugs

- Provide addictions treatment that includes treatment options and follows NCCHC guidelines

Promote resilience

- Educate individuals with justice involvement about coping with stress and asking for help
    - Emphasize the opportunity for each individual to experience himself or herself as part of a community whose members can make a difference to others.
    - Promote peer-to-peer outreach such as, "Suicide is Forever: Recognizing & Preventing Suicide," produced by individuals with justice system involvement.
- Provide work skills development and opportunities, educating individuals with justice involvement about life skills, coping skills, and money management.

Promote general health

- Encourage healthy physical activities and healthy nutrition
- Ensure restorative sleep and control noise levels
- Lower barriers to primary care, ensuring access to effective management of chronic illness/pain

This was adapted from AFSP's, "Suicide Prevention Resource Guide: National Response Plan for Suicide Prevention in Corrections" document, found here: ncchc.org/filebin/Publications/NCCHC-AFSP_Suicide_Prevention_Resource_Guide.pdf

SUICIDE PREVENTION IS EVERYONE'S BUSINESS

All staff members who work with individuals with justice involvement must be trained in suicide prevention. Everyone should be provided at least a basic knowledge about risk factors, warning signs, what to do if they think someone may be at risk, and the overall suicide prevention plan. While some training needs overlap, each group has its own priorities and roles in suicide prevention.

Executive leadership

These individuals are responsible for creating regulations, policies, and procedures, need training focused on the public health dimensions of suicide prevention, including primary preventive measures that have the potential to reduce risk throughout an entire system.

Training should enable them to:

- Review risk factors and warning signs for suicide and institutional procedures for identification and intervention for individuals at risk
- Ensure that individuals have easy access to mental health care (including crisis/emergency care) to meet their needs in a safe manner

Qualified health care professionals

These individuals are on the front line of health care; individuals who die by suicide have often recently been treated for primary medical problems, including chronic disorders, substance use disorders, or pain conditions.

Training should enable them to:

- Screen for suicide risk in the course of providing primary care
- Recognize the warning signs of a mental health crisis, including risk of suicide or self-injury
- Recognize signs and symptoms of common mental health conditions
- Refer patients in need of mental health services in a timely and effective manner

Custody staff

These individuals are the eyes, ears, and leaders of every correctional and detention facility, the first to see and first to respond.

Training should enable them to:

- Recognize and respond effectively to warning signs of impending suicide or self-harm
- Intervene to interrupt a suicidal act in progress
- Recognize when an individual needs to be referred for mental health care and ensure the referral is made in a timely and effective manner

Qualified mental health professionals

These individuals need to possess up-to-date knowledge and skills necessary to assess and treat individuals experiencing suicidal ideation or displaying self-harming behaviors in a manner that ensures that appropriate safety precautions are in place.

Training should enable them to:

- Interview and build a therapeutic alliance with vulnerable individuals while eliciting the information necessary to determine if the individual is "acutely or non-acutely suicidal"
- Perform and document a thorough suicide risk assessment
- Formulate and implement a treatment plan that addresses safety and treatment needs using the least restrictive means consistent with clinical guidelines and institutional policies

This was adapted from AFSP's, "Suicide Prevention Resource Guide: National Response Plan for Suicide Prevention in Corrections" document, found here: ncchc.org/filebin/Publications/NCCHC-AFSP_Suicide_Prevention_Resource_Guide.pdf

Indiana Department of Health

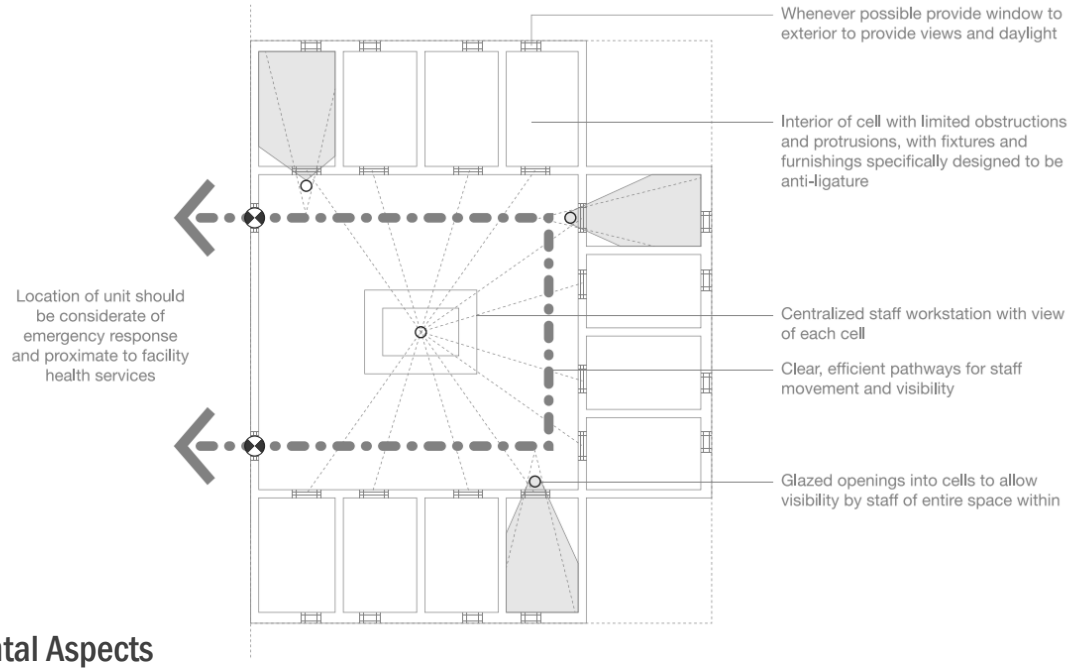
CREATING A SUPPORTIVE PHYSICAL ENVIRONMENT FOR INDIVIDUALS WHO ARE JUSTICE-INVOLVED

Planning Considerations

It is essential for staff to be able to perform their duties in a safe and efficient manner. Facilities should think through how staff will perform their rounds, respond to emergencies, and maintain visual and audial control of their surroundings. This may change things like location of staff and nurse workstations in relation to observed cells, corridor locations and connections, and glazed window openings.

Physical Characteristics

Facilities need to review the physical environment to identify items that could be used for a suicide attempt (e.g. bed sheets). Visibility is critical when monitoring individuals experiencing suicidal ideation. Cells should be glazed to the greatest extent possible, allowing trained supervisors to view the interior of a cell in its entirety (shown in the diagram below). Floor drains and air vents, plumbing and lighting fixtures, and furniture must be carefully selected to prevent any opportunity for an individual with justice involvement to attempt suicide. Where small gaps or voids may be present, tamper-resistant security-grade caulking or grout should be used.



Environmental Aspects

Environment has a profound impact on wellness. For example, excessive noise, which is prevalent in correctional institutions, can lead to sleep loss and fragmentation. Such noise should be mitigated through the strategic use of acoustical materials. Optimally, observation cells should have natural light and exterior views, as there is evidence that greater exposure to daylight can reduce stress and depression, and the absence of windows has been linked to higher rates of anxiety. Germany does an excellent job applying this model, learn more here: https://www.nytimes.com/2015/08/07/opinion/what-we-learned-from-german-prisons.html. By eliminating the features of a space that might be considered vulnerabilities with regard to safety, and including features that improve wellness, the design of a facility can meet the mission of health and safety.

This was adapted from AFSP's, "Suicide Prevention Resource Guide: National Response Plan for Suicide Prevention in Corrections" document, found here: ncchc.org/filebin/Publications/NCCHC-AFSP_Suicide_Prevention_Resource_Guide.pdf

Indiana Department of Health

High Risk Times for Suicide:
Justice-Involved Individuals

It is important to understand that suicide can occur at any time, so focusing too narrowly on the "typical" risks and times can be dangerous. However, certain times and situations are particularly high-risk for individuals with justice involvement who may be experiencing suicidal ideation.

- After the receipt of bad news regarding self or family
- Upon admission (e.g., 2 to 14 days following incarceration)
- Pending release after a long period of incarceration
- After admittance to segregation or single-cell housing
- After suffering humiliation (e.g., sexual assault) or rejection
- Following new legal problems (e.g., within 48 hours of a court appearance, new charges, additional sentences, institutional proceedings, denial of parole)

Other high-risk situations include: anniversary dates; decreased staff supervision; ending release from custody, especially if the inmate lacks a viable discharge plan due to lack of family, employment, housing, and other stabilizing resources.

This was adapted from AFSP's, "Suicide Prevention Resource Guide: National Response Plan for Suicide Prevention in Corrections" document, found here: ncchc.org/filebin/Publications/NCCHC-AFSP_Suicide_Prevention_Resource_Guide.pdf

Indiana Department of Health

CORRECTIONAL OFFICER CARE CHECKLIST

Given the many duties and stressors of the job, it is vital that correctional officers practice self-care. Below is a list that was originally developed for COVID but was adapted to fit all situations for the purpose of this toolkit. The first half of the document explains how officers can care for themselves and the second explains how officers can care for others on their team.

Take care of yourself as much as you possibly can:

- ☐ Prioritize your basic needs <u>while working</u>
  - Take breaks to eat, even snacks, and drink water or other healthy fluids
  - Pause and take a moment to mindfully deep breathe, especially after stressful situations
  - Check in with yourself about how you are doing/feeling at the beginning, middle, and end of each shift or at least every 6 hours when working an extended shift
  - Ask for help when you need it
    - Consider seeking support from spiritual care providers in your setting
    - Talk with allies/trusted co-workers and receive support from one another
  - Practice mindfulness
    - Set aside 5-10 minutes daily to process uncomfortable emotions
    - Use accept the things you cannot control
    - Acknowledge, accept and find time to process things that are not in your control
    - Accept your anxious, helpless, and hopeless thoughts and let them wash through you like a wave as you turn your attention to the present
    - Remind yourself that any stressful feelings you experience are understandable
    - Exercise self-compassion, saying I am doing the best I can in any given moment
  - Use "both/and" statements to promote self-compassion and clarify distressing contradictory feelings – e.g. "I'm both a dedicated healthcare worker or correctional officer expected to care for individuals with justice involvement no matter what, and I am an involved family member who wants to care for loved ones at home"
- ☐ Prioritize your basic needs <u>outside of work</u>
  - Make sleep a priority and make time to move or exercise
  - Engage in activities you find pleasurable and/or calming/relaxing
  - Spend time with people you care about and who understand/value your feelings
  - Limit your substance use
  - Ask for help when you need it (symptoms of critical stress include: struggling for meaning and purpose, ruminating over incident(s), loss of sleep or appetite, distancing from friends or family, inability to focus, finding no pleasure in hobbies/activities)
    - Seek out spiritual care support resources in the community
    - Seek individual therapy and/or medication if you feel too distressed

This was adapted from Caring Communities' "COVID-19 Psychological Wellness Guide: Staff at Correctional and Detention Facilities" document, found here: https://med.emory.edu/departments/psychiatry/_documents/tips.staffforensicfacilities.pdf. The symptoms of critical stress section was found here: https://www.lexipol.com/resources/blog/causes-of-stress-for-correctional-officers/

Take care of your team:

- ☐ Look out for each other
- ☐ Check-in regularly (informally and formally) with team members
  - Use huddle time to see how providers and staff are emotionally and physically coping with stress and demands
  - Talk informally with colleagues about things happening at work
  - Chat with colleagues about what they are doing to relax outside of work
- ☐ Be intentional about good communication
  - Respect differences and interact with tolerance, patience, and compassion
  - Take time to listen to others, talking clearly and calmly with colleagues
  - Address tensions, concerns, problems or conflicts and strive to resolve them
- ☐ Foster team unity
  - Prioritize collaboration
  - Try to help your colleagues to problem-solve
  - Step forward to help when you can and allow others to step forward when they can
  - Use humor when appropriate
  - Construct a gratitude box where team members can write small notes to each other
  - Be intentional, pause, debrief, and support one another after tough cases/ situations
  - Seek out peer and team consultation when needed
- ☐ Recognize and celebrate the helpful and/or creative contributions of colleagues
  - Encourage formal recognition by starting a sticky-note wall in a break room
  - End shifts with a huddle, having everyone thank team members for something they did
  - Thank team members throughout the shift for small and large ways they were helpful
  - Recognize formally people who go above and beyond the call of duty
- ☐ Develop mental health and trauma-informed practices
  - Request support and debriefings from a trained mental health provider
  - Have leadership set the example in self-care practices
  - Develop trauma-informed trainings so staff can understand their own triggers
- ☐ Continue developing skills for managing high-stress situations
  - Ensure you're up to date with information about how to handle high-risk situations
  - Stop, breathe, think, and then act when confronted with a high-risk situation
  - Take the extra time and effort to ensure your own safety
  - Recognize and manage anticipatory anxiety
    - Remember that you are not alone, and your reaction is understandable
    - Process your reactions
    - Visualize packaging up and throwing away the anxiety
    - Keep moving forward mentally
  - Be attuned to situations that raise moral concerns and discuss and address those with your colleagues and consultants
  - Say to yourself what you would tell a friend when they are most scared
  - Provide colleagues distressed about high risk situations
    - Your presence and listening ear
    - A genuine human and emotional response
    - Empathy
    - Positive regard

Employers

Introduction

Over 70% percentage of individuals who die by suicide in Indiana are within working ages of 25-64, based on the data section at the beginning of this toolkit. In the same way that we look to schools to enact youth-focused suicide prevention programs, employers can play a similar role for their employees.

Employers have the ability to reduce suicides in their workforce by becoming aware of the real threat of suicide to their workforce, creating policies to prevent suicides, and developing a protocol, should a suicide occur.
Business leaders also have significant leadership status in the community. It is a best practice in prevention spaces to include business leaders in the community in prevention work. That being said, it is easy to see why workplaces would need to be engaged in this work.

Employer Resources:

- Industries and Occupational Groups at High Risk
- Mental Health and the Workplace
- Six Key Areas for a Mentally Healthy Workplace
- Implementing a Workplace Mental Health Initiative Guide
- Employee Assistance Programs (EAPs)
- Hierarchy of Controls One-Pager
- Postvention Guide for Managers
- Internal Notification Memo Template

INDUSTRY AND OCCUPATIONAL GROUPS AT HIGH RISK

As an employer, it is vital to know the suicide risks of your company's sector. In a recent CDC study, suicide rates were found to be significantly higher in the following occupational groups:

1.  **Construction and Extraction** (males and females)
2.  **Installation, Maintenance, and Repair** (males)
3.  **Arts, Design, Entertainment, Sports, and Media** (males)
4.  **Transportation and Material Moving** (males and females)
5.  **Protective Service** (females)
6.  **Healthcare Support** (females)

Suicide rates were also significantly higher in five major industry groups:

1.  **Mining, Quarrying, and Oil and Gas Extraction** (males)
2.  **Construction** (males)
3.  **Other services (e.g., automotive repair)** (males)
4.  **Agriculture, Forestry, Fishing, and Hunting** (males)
5.  **Transportation and Warehousing** (males and females)

This was adapted from the CDC's "Suicide Rates by Industry and Occupation – National Violent Death Reporting System, 32 States, 2016." The original document can be found here: https://www.cdc.gov/mmwr/volumes/69/wr/mm6903a1.htm. The graphics are from Noun Project (hammer by supalerk laipawat, mining by nikita kozin, wrench by NTT, handshovel by debruder studio, oil can by Vectorstall, art by Vectorstall, security by Ester Se.Kim, healthcare by Eris Natansa)

Indiana Department of Health

Mental Health and the Workplace

Signs of a possible mental health issue in the workplace

What it feels like

- Loss of interest in work/social activities
- Energy loss or increased fatigue
- Lack of focus, slowed thoughts, and difficulty thinking
- Sadness, despair, and feelings of worthlessness
- Difficulty making decisions
- Irritability, anger, stressed out, elevated heart rate
- Change in sleep, weight or appetite

How it looks to co-workers

- Indifference, lack of engagement
- Low motivation, detached
- Missed deadlines, sloppy work, slow productivity, absentminded
- Emotional withdrawal, isolation, lack of confidence
- Procrastination, indecisiveness, inconsistent behavior
- Relationship issues, inappropriate reactions, frantic behavior
- Late to work frequent fatigue, large change in appearance

How you can help

Actionable strategies for management and staff:

1. Stay positive and reinforce the value that employees bring to the organization
2. Set a regular employee check-in to address job concerns and give/receive constructive feedback
3. Recognize and reward achievements
4. Provide explanation/rationale for decisions/changes in workplace practices
5. Create fair practices and an environment of inclusivity where employees feel acknowledged and concerns heard

Five common workplace factors that can negatively impact mental well-being:

1. High job demands (long hours, workload, time pressure, poor management)
2. Lack of role clarity, job responsibilities and expectations
3. Unsupportive job environment (low pay, lack of recognition and few career advancement opportunities, low job security)
4. Unfair workplace practices and lack of management transparency
5. Misalignment of job functions with skills and personal values

This was adapted from Right Direction's "Signs of a possible mental health issue in the workplace" document, which can be found here: https://www.rightdirectionforme.com/wp-content/uploads/2020/04/Right-Direction-Mental-Health-at-Work-Fact-Sheet.pdf.

Indiana Department of Health

Six Key Areas for a Mentally Healthy Workplace

Smarter Work Design: More flexibility, greater individual and team input into decision-making, harm and hazard reduction

Build Resilience: Training on stress management for high-risk jobs using evidence-based approaches, increasing physical activity, and providing opportunities for mentoring and coaching

Support Recovery: Helping employees reintegrate and get support during and after stressful life events and challenges with mental illness, having generous sick leave and accommodations

Build Better Work Culture: Senior leadership engagement, mental health education, zero tolerance for bullying or discrimination, a climate of safety, mental health education, and change management that has open and realistic communication

Early Intervention: Wellbeing checks, ability to seek help easily and early, evidence-based training for providers, and opportunities for peer support

Increase Awareness: Promoting mental health resources, trainings and programs, and participating in community and national events and campaigns

This was adapted from Suicide Prevention Australia's Work and Suicide Position Statement, which can be found on their website here: https://www.suicidepreventionaust.org/policy-advocacy/.

Indiana Department of Health

Implementing a Workplace Mental Health Initiative

As an employer, it can be overwhelming to think through a workplace mental health prevention initiative. Luckily, a lot of the work has already been done by the American Psychiatric Foundation's Center for Workplace Mental Health and Employers Health's Right Direction program, found here: https://www.rightdirectionforme.com/for-employers/. This website outlines, for employers, the steps that need to be taken to address depression and mental health in the workplace. To fully implement the Right Direction framework, the following steps need to be taken:

✓	Activity	Description	Rationale	Personnel
	Form the project team	Engage a diverse team of stakeholders	Broad representation creates ownership, customization, and consensus	Leadership, EAP, HR, marketing and communications, organizational development
	Set success measures	Establish project objectives and how you will measure results	Gain project team consensus on what will be measured and desired results to sustain team engagement	Leader (C-suite level, director, team leader, business owner)
	Develop communications plan	Create project name, branding graphics, and customized messages	Sustained and consistent promotion communicates commitment	Marketing, Communications
	Share roll-out plan	Engage key trusted leaders from the project team before launch on expectation of their roles	Employees will ask key trusted leaders about the project. Responses will greatly influence employee receptivity and engagement	Organizational development and/or EAP
	Launch	Hold "town hall" meetings, conference calls, electronic messages to promote education and train employees	Reinforce that leadership is fully supportive, a diverse team developed the initiative, and career opportunities will not be jeopardized by seeking help	All project team members
	Measure results	Collect data on a quarterly basis and share with the project team, including leaders	Data and positive results provide the basis for increased investment in growing the initiative, tools, resources, and more. Don't forget to celebrate success!	HR or another designated project team member

This was adapted from Right Direction's "Checklist for Planning the Implementation of Right Direction as Part of Your Workplace Mental Health initiative" document, which can be found here: https://www.rightdirectionforme.com/wp-content/uploads/2020/04/Mental-Health-Initiative-Checklist.pdf

Employee Assistance Programs (EAPs)

It is well known that not all EAPs are built the same. There are 1-800-EAPs, embedded EAPs, and full service or "top tier" EAPs. Employers should remember that they are customers of their EAP, and they should do the due diligence to ensure the best benefits.

Don't an EAP?

- Find an EAP that is right for your business
- Make sure the EAP is prepared to deal with situations involving suicidal ideation, suicide attempts, and deaths by suicide

Have an EAP?

- Evaluate the EAP's suicide prevention, intervention, and postvention capabilities
- Promote EAP services and evaluate impact
- Hold the EAPs accountable by asking the following questions

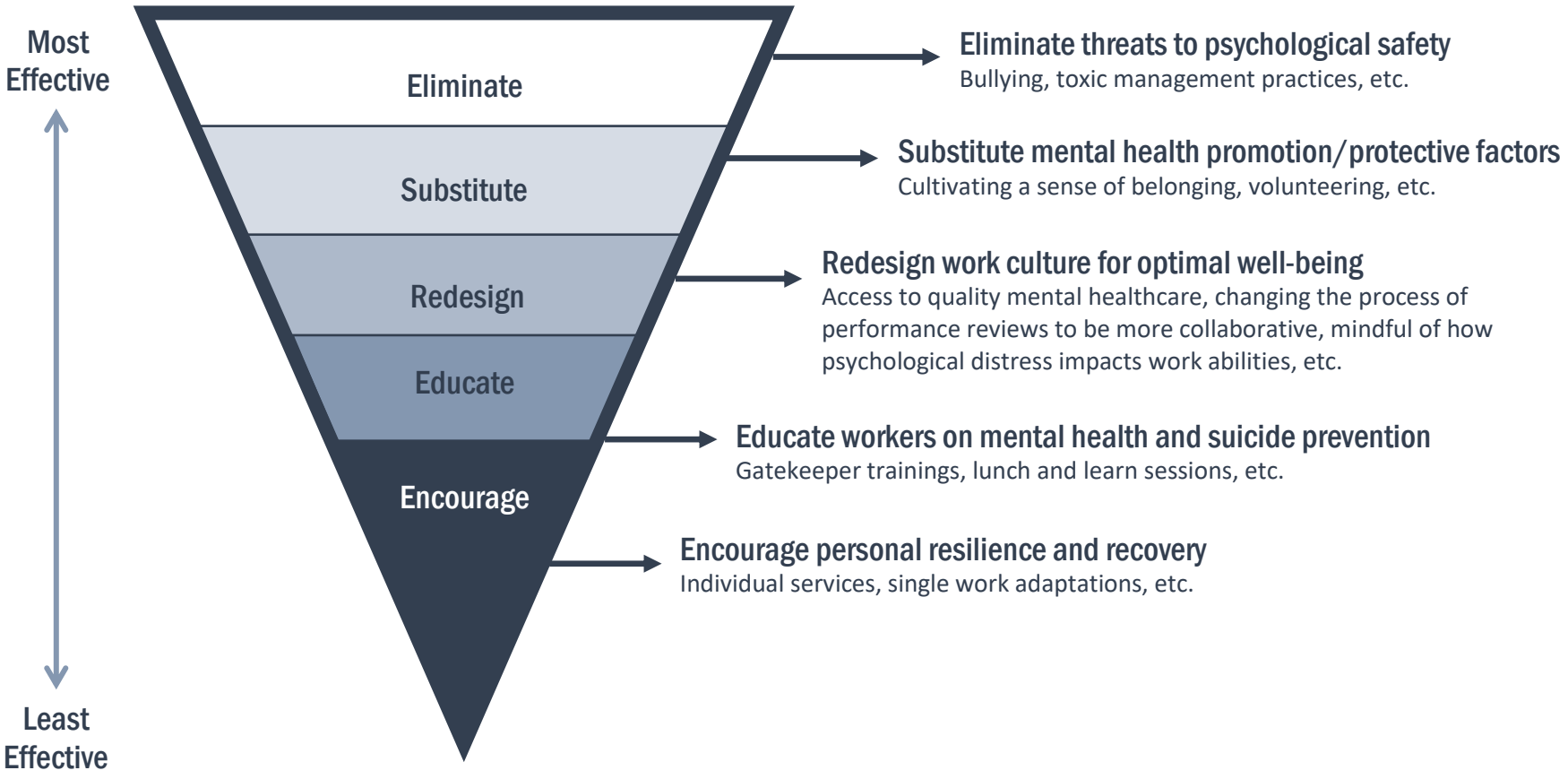
1. What services does your EAP cover? Are these services available 24/7?
2. Who answers the calls of the EAP and how are they trained and supervised? What professional education, preparation, and certifications do they have? Are they licensed?
3. How are counselors selected and trained? Are certain licenses and other credentials required to be a part of the EAP provider network?
4. What types of training have EAP providers received? Specifically, when was the last time they received training in suicide risk formation and treatment?
5. How is the EAP reporting utilization? How does your workplace's utilization rate compare to others in your industry and what can be done by the EAP and by you as the employer to encourage more utilization.
6. Do your employees know about your EAP services and how to access them?
7. For those who havve used the EAP, how satisfied were they with the services? Did the services have a positive impact on the problem for which they were seeking support?
8. Whenemployees completed EAP services, did the EAP follow-up (or attempt to follow-up) with the employee to make sure all needs were adequately met?
9. How does your EAP interact with health plans? Are EAP providers also providers of outpatient mental health and if not, are they well-versed in the benefits of employees to make effective and seemless referrals.
10. How is your EAP measuring outcomes? Can they also provide you with return-on-investment and other cost-benefit analysis?
11. How is the EAP promoting upstream mental health efforts like prevention, resilience, psitive psychology, and work-life integration?
12. Are there general mental health screening or other wellness tools the EAP can offer the workers to help them understand and monitor their mentla wellness? Does the organization also assess its own culture of system-level mental wellness?
13. Does the EAP have experience serving clients in your industry? If yes, what are some recommendations that they have to improve how EAP services are promoted and offered at our workplace?
14. Is the employer receiving regular reports (i.e. bi-annual, annual) from the EAP on utilization, presenting problems, satisfaction, and other workplace outcomes?
15. Does the EAP provider manager or HR offer a training on how to best support an employee experiencing a mental health or suicide crisis? Are there additional staff training on skills needed to idenitify and assist employees in distress?

This was adapted from Workplace Suicide Prevention's "Workplace Suicide Prevention & The Role and Potential of the Employee Assistance Program (EAP), found here: https://m.youtube.com/watch?v=vu_PYbr-AOk and https://www.sallyspencerthomas.com/dr-sally-speaks-blog/2019/3/19/kicking-the-tires-of-your-employee-assistance-program-eap-15-questions-workplaces-should-ask-to-strengthen-the-mental-health-safety-net

Indiana Department of Health

HIERARCHY OF CONTROLS ONE-PAGER

Organizations often can feel overwhelmed sorting through how to tackle suicide prevention in their organization. One way to think through different strategies is the number of people the intervention would impact and the effectiveness of the intervention. The chart below, adapted from NIOSH's Hierarchy of Controls, illustrates this thought process.



This was adapted from Workplace Suicide Prevention's "A Report of Findings to Direct the Development of National Guidelines for Workplace Suicide Prevention." The original document can be found here: https://workplacesuicideprevention.com/wp-content/uploads/2019/10/National-Guidelines-Report.pdf.

Indiana State Department of Health

POSTVENTION GUIDE FOR MANAGERS

After a suicide, it is vital for workplaces to act. Below is a 10-step postvention guide for managers after a suicide. There are three phases explained: immediate, short-term, and long-term.

IMMEDIATE: Acute Phase

- ☐ **Coordinate:** Contain the crisis.
  - Identify main point person to coordinate all postvention efforts and related communication
  - Contract for professional clean up (after the investigation is completed) if required by a suicide in the workplace.
  - Contact victims' assistance.
- ☐ **Notify:** Protect and respect the privacy rights of the deceased employee and their loved ones during death notification.
  - Distribute death notification memo to staff
- ☐ **Communicate:** Reduce the potential for additional suicide deaths.
  - Review safe messaging guidelines for external and internal communication strategies and media recommendations for reporting on suicide for help developing public communications plans.
  - Develop an internal communication plan to document what is and is not known and what to say if the family does not want the cause of death revealed
  - Develop an external communication plan that identifies a spokesperson and draft a statement for the media.
- ☐ **Support:** Offer practical assistance to family.
  - Bring easy-to-heat and nutritious frozen meals to grieving family.
  - Offer the family of the deceased assistance by packing up the personal belongings at the workplace and bringing them by the home. Always call ahead to be sure the family will be there when you deliver the items.
  - Ask the bereaved person or family what can be done to help and, when possible, make arrangements to provide the support. Some common supports that help are:
    - Keep a list of phone calls, visitors, and people who bring food and gifts
    - Organize the mail (e.g. bills, cards, newspaper notices)
    - Offer to make calls to people they wish to notify
    - Help with errands (e.g. childcare, house-sitting, lawn care, laundry)

This was adapted from the Workplace Postvention Task Force of the American Association of Suicidology and the Workplace Task Force of the National Action Alliance for Suicide Prevention's "A Manager's Guide to Suicide Postvention in the Workplace," which can be found here: https://theactionalliance.org/sites/default/files/managers-guidebook-to-suicide-postvention-web.pdf.

Indiana Department of Health

SHORT-TERM: Recovery Phase

- **Link:** Identify and link impacted employees to additional support resources and refer those most affected to professional mental health services.
    - Contact EAP to develop customized response (e.g., grief counseling, education, and community counseling resources).
    - Compile and promote a list of suicide bereavement-specific support resources.
- **Comfort:** Support, comfort, and promote healthy grieving of the employees who have been impacted by the loss.
    - Participate in mourning activities (e.g., funerals, memorial services, etc.).
    - Instead of enshrining the desk or other workspace, suggest to co-workers that they help create a memory album or quilt for the bereaved family or make a donation to a charity the appreciated by the deceased (or the deceased's family).
- **Restore:** Restore equilibrium and optimal functioning in the workplace.
    - Develop a return-to-work schedule for those most profoundly impacted. Conduct peer supervision with other managers to evaluate postvention process.
- **Lead:** Build and sustain trust and confidence in organizational leadership.
    - Leadership provides personalized, reassuring communication helping team transition from crisis to healing.

LONGER-TERM: Reconstructing Phase

- **Honor:** Prepare for anniversary reactions and other milestone dates.
    - Convene group most affected to see if honoring the loss around the anniversary or milestone event would be appreciated and follow safe memorialization practices supported by research.
- **Sustain:** Transition postvention to suicide prevention.
    - Review comprehensive approach to suicide prevention for next steps.
    - Investigate state and local suicide prevention efforts for volunteer opportunities.

If employers are interested in engaging with suicide prevention on-related work more, there are national resources such as the Employer Assistance and Resource Network's Mental Health Toolkit (https://askearn.org/mentalhealth/) and the Action Alliance for Suicide Prevention's Workplace page (https://theactionalliance.org/communities/workplace).

INTERNAL NOTIFICATION MEMO TEMPLATE

When companies experience a suicide death, it is vital to communicate with employees. Below are two templates that can be used, depending on whether the cause of death was revealed. The first can be used when the cause of death is revealed and the second when the cause of death is not revealed.

SAMPLE INTERNAL NOTIFICATION MEMO - **WHEN CAUSE OF DEATH REVEALED**

Date:
To: Staff
From: [Name of CEO]
Re: Death of [name of employee]

[Our workplace] is saddened to learn of the reported suicide of [employee]. The tragic and sudden circumstances of [employee's] death may cause a range of reactions among our workplace, so with the family's permission we are sharing the facts as we know them and are offering support for those who might need it.

[Employee] worked for [workplace] for the last [number] years. On [Saturday night] [s/he] died around [11:00PM] [DO NOT MENTION PLACE OR METHOD USED FOR SUICIDE]. We may never know all the factors leading to this tragedy; however, experts agree that in nearly all suicides there is no single cause or simple explanation.

[Employee's] memorial service will be held on [January 7 at 11:00AM], and all employees who wish to attend may be excused. The family would like to welcome all of [his/her] friends and colleagues who wish to share in the celebration of [his/her] life.

Some of you may be having difficulty coping with the sudden loss of one of our workplace family. We have arranged for the Employee Assistance Program (EAP) professionals to facilitate a debriefing on [January 8th at 5:00PM]. During this group meeting, counselors will be on hand to support us and answer any questions we may have. Others may prefer individual support at this time. If so, please contact our EAP program by calling [1-800-123-4567].

The family has requested that instead of flowers, those who wish to do so may donate to [a local suicide prevention center or other charity as shared by the family] in [employee's] memory.

For those who would like to talk about what has happened, our HR team is available to you.

Sincerely,
[Name of CEO]

This was adapted from the Workplace Postvention Task Force of the American Association of Suicidology and the Workplace Task Force of the National Action Alliance for Suicide Prevention's "A Manager's Guide to Suicide Postvention in the Workplace," which can be found here: https://theactionalliance.org/sites/default/files/managers-guidebook-to-suicide-postvention-web.pdf.

SAMPLE INTERNAL NOTIFICATION MEMO - **WHEN CAUSE OF DEATH WITHHELD BY FAMILY**

Date:
To: Staff
From: [Name of CEO]
Re: Death of [name of employee]

[Our workplace] is saddened to learn of the death of [employee]; the family has requested that the cause of death be withheld. The tragic and sudden circumstances of [employee's] death may cause a range of reactions among our colleagues, so with the family's permission we are sharing the following information and are offering support for those who might need it.

[Employee] worked for [workplace] for the last [number] years. On [Saturday night] [s/he] died around [11:00PM] [DO NOT MENTION PLACE OR METHOD USED FOR SUICIDE].

[Employee's] memorial service will be held on [January 7 at 11:00AM], and all employees who wish to attend may be excused. The family would like to welcome all of [his/her] friends and colleague who wish to share in the celebration of [his/her] life.

Some of you may be having difficulty coping with the sudden loss of one of our workplace family. We have arranged for the Employee Assistance Program (EAP) professionals to facilitate a crisis counseling session on [January 8 at 5:00PM]. During this group meeting, counselors will be on hand to support us and answer any questions we may have. Others may prefer individual support at this time. If so, please contact our EAP program by calling [1-800-123-4567].

The family has requested that instead of flowers, those who wish to do so may donate to [a local suicide prevention center or other charity as shared by the family] in the [employee's] memory.

For those who would like to talk about what has happened, our HR team is available to you.

Sincerely,
[Name of CEO]

Faith-based

Introduction

While faith-based entities have not historically been involved with suicide prevention work, they offer a unique opportunity for prevention. Faith-based entities often provide individuals with counseling and serve as central community-building entities. In fact, the research has shown that religion plays a protective factor in suicide prevention.[13]

As a faith-based entity, these organizations already have a lot on their plates so suicide prevention can seem like a lot on top of typical goals. However, the good news is that suicide prevention can be easily integrated into existing organizational efforts. Of course, the interventions may vary depending on the traditions of the particular faith.

Faith-based Resources:

- Quick Reference on Mental Illness for Faith Leaders
- Talking about Suicide Guide
- Model Faith-based Organization Prevention Policy
- Organization Mental Health Strategy: Crawl, Walk, Run
- Faith Leader Checklist to Prevention, Intervention, and Postvention
- Language for Public Messaging
- Writing an Obituary
- Self-Care Checklist for Faith Leaders

QUICK REFERENCE ON MENTAL ILLNESS FOR FAITH LEADERS

Given the vast amount of information around mental illness, it can be difficult know what is useful for faith leaders. Below is a quick reference guide on mental illness for faith leaders.

Mental Illness is Common

In the United States,

- 1 in 5 people have a mental illness
- 1 in 25 people have a serious mental illness
- 1 in 12 people have a substance use disorder

Suicide is the 10th leading cause of death in the U.S.

OBSERVABLE SIGNS: Some Signs that May Raise a Concern about Mental Illness

*These observations **may** help identify an individual with mental illness; they are not definitive signs of mental illness. Further mental health clinical assessment may be needed.*

Categories of Observation	Examples of Observation *Does something not make sense in context?*
Cognition: Understanding of Situation, memory, concentration	• Seems confused or disoriented to person, time, and place • Has gaps in memory, answers questions inappropriately
Affect/Mood: Eye contact, outbursts of emotion/indifference	• Appears sad/depressed or overly high-spirited • Overwhelmed by circumstances, switches emotions abruptly
Speech: Pace, continuity, vocabulary *(Is there difficulty with English language?)*	• Speaks too quickly or too slowly, misses words • Stutters or has long pauses in speech
Thought Patterns and Logic: Rationality, tempo, grasp of reality	• Expresses racing, disconnected thoughts • Expresses bizarre ideas, responds to unusual voices/visions
Appearance: Hygiene, attire, behavioral mannerisms	• Appears disheveled, poor hygiene, inappropriate attire • Trembles or shakes, is unable to sit or stand still (unexplained)

COMMUNICATION: When a Mental Health Condition is Affecting an Individual

- Speak slowly and clearly, express empathy and compassion
- Treat the individual with the respect you would give any other person
- Listen; remember that feelings and thoughts are real even if not based in reality
- Give praise to acknowledge/encourage progress, no matter how small; ignore flaws
- If you don't know the person, don't initiate any physical contact or touching

Examples of Common Observations	Recommendations for Responses
Loss of hope: Appears sad, desperate	• As appropriate, instill hope and establish personal connection
Loss of control: Appears angry, irritable	• Listen, defuse, deflect; ask why s/he is upset; avoid threats
Appears anxious, fearful, panicky	• Stay calm; reassure and calm the individual; try to understand
Has trouble concentrating	• Be brief; repeat if necessary; clarify what you are hearing
Is overstimulated	• Limit input and don't force discussion
Appears confused/disoriented; believes delusions (false beliefs, e.g., paranoia)	• Use simple language; empathize; don't argue • Ground individual in the here and now

This was adapted from the National Suicide Prevention Lifeline which can be found here: nmi.us/wp-content/uploads/2017/04/FaithToolKit-QuickRefGuide_rev2.pdf

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IMMEDIATE CONCERN: **Approaching a Person with an Urgent Mental Health Concern**

- Before interacting, consider **safety** for yourself, the individual, and others
- Is there a family member or friend who can help?
- Find a good, safe place (for both) to talk
- Express willingness to be there for the person
- **Seek immediate assistance if a person poses a danger to self or others; call 911**

SUICIDE: **Thoughts of suicide should always be taken seriously. A person who is experiencing suicidal ideation is a psychiatric emergency. Call 911.**

Warning Signs of Suicide	Risk Factors for Suicide
• Often talking or writing about death or suicide • Comments about being hopeless, helpless, or worthless, no reason for living • Withdrawal from friends, family, and community • Reckless behavior or engaging in risky activities • Dramatic mood changes	• Loss and other risk events (e.g., death, financial or legal difficulties, relationship breakup, bullying) • Previous suicide attempts • History of trauma or abuse • Having firearms in the home • Chronic physical illness, chronic pain • Exposure to the suicide-related behavior of others • History of suicide in family

REFERRAL: **Making a Referral to a Mental Health/Medical Professional**

When to Make a Referral	Dealing with Resistance to Help
Assessing the Person • **Level of distress** – How much distress, discomfort, or anguish is he/she feeling? How well is he/she able to tolerate, manage or cope? • **Level of functioning** – Is he/she capable of caring for self? Able to problem solve and make decisions? • **Possibility for danger** – danger to self or others, including thoughts of suicide or hurting others **Tips on making a mental health referral** • Identify a mental health professional, have a list • Communicate clearly about the need for referral • Make the referral a collaborative process between you and the person and/or family • Reassure person/family you will journey with them • Be clear about the difference between spiritual support and professional clinical care • Follow-up; remain connected; support reintegration • Offer community resources, support groups	Resistance to seeking help may come from stigma, not acknowledging a problem, past experience, hopelessness, cultural issues, or religious concepts. • **Learn about mental health** and treatments to help dispel misunderstandings • **Continue to journey** with the person/family; seek to understand barriers • **Use stories** of those who have come through similar situations; help the person realize he/she is not alone, and people can recover • **Reassure** that there are ways to feel better, to be connected, and to be functioning well • If a person of faith, **ask how faith** can give him or her strength to take steps toward healing

If you believe danger to self or others is imminent, call 911.

TALKING ABOUT SUICIDE GUIDE

When talking about suicide, there is a commonly held fear that talking about suicide might make matters worse by further upsetting the person or even putting the idea in their head. Research has consistently proven this theory wrong and has proven instead that talking about suicidal ideation can be a relief to a person experiencing suicidal ideation With that said, it can be helpful to keep the following in mind when talking to someone experiencing suicidal ideation.

1. **Ask the person directly about suicidal ideation,** such as, "Are you having thoughts of suicide" or "Are you thinking about killing yourself?" Asking the person about suicide-related thoughts will allow them the chance to talk about their problems and show them that someone cares. Avoid asking in leading or judgmental ways such as, "You're not thinking of doing anything stupid, are you?"

2. **Listen to the person's responses without judgement.** Let them talk about why they want to die. This can be a relief to the person. Don't try to convince the person that suicide is wrong or tell them how much they would hurt their family if they died. Such judgmental approaches will shut down communication and the opportunity for the person to get support.

3. **Tell the person at risk that you care and want to help.** Ask them how they would like to be supported and if there is anything you can do to help.

For further training in this area, please look into getting trained in QPR or SAFE TALK.

This was adapted from an article on the Conversation called "How to ask someone you're worried about if they're thinking of suicide," found here: https://theconversation.com/how-to-ask-someone-youre-worried-about-if-theyre-thinking-of-suicide-100237

Indiana Department of Health

MODEL FAITH-BASED ORGANIZATION PREVENTION POLICY

If an individual presents with suicidal ideation at a faith-based institution, it is vital that the institution have some sort of suicide prevention policy in place. A sample policy is listed below.

Model Suicide Prevention Policy

If a leader learns of an individual considering suicide or talking about self-harm, they are to contact _____(individual)_____ for instructions on how to proceed. If cannot be reached immediately or the concern appears to be an emergency, immediately contact 911.

Here are five things you must do before the individual leaves. If they do leave before you are able to have a full conversation with them, you must contact 911 immediately:

- **Ask them the tough questions.** Research shows you asking them if they are experiencing suicidal ideation will not "give them the idea" or "make them shy away from talking to you." Here are some ways you can ask it:
  - Do you ever wish you could go to sleep and never wake up?
  - Sometimes when people feel sad, they have thoughts of harming or killing themselves. Have you had such thoughts?
  - Are you thinking about killing yourself?

- **Recognize the limits of confidentiality.** There may be something you keep confidential, self-harm and suicide is not them. If they ask you to keep it secret, your response needs to be "I understand this is difficult for you to talk about, but I want to make sure you are safe. I can't make any promises about what we are about to talk about."

- **Start a support network with others**. Connect them with someone in their life at home who they feel safe to talk with about their suicidal ideation. If they are under the age of 18, you must inform their legal guardian(s). Use good judgment because not everyone is a good fit to be a support. Also, when you find someone, make sure they understand what you are asking of them and get their confirmation they are willing to do it.

- **Seek if they have professional counseling.** Ask if the individual is already in counseling and if they are, get the name and phone number of who they are seeing. If a person is talking about self-harm and/or suicidal ideation, there is a need for therapy. We encourage church leadership and congregation members to take the role of support and refer this person to licensed professional counseling to do mental health treatment. Counselors are bound to HIPPA, so make sure as the lead support from the church for this individual, you ask the parent or individual (if they are over the age of 18) to sign a release so you can check in how you can support the person. Offer transportation, mentorship, and any other resources that are available and communicate this to the counselor.

This was adapted from Church and Mental Health's "Church Suicide Prevention Policy," which can be found here: https://churchandmentalhealth.com/product/church-suicide-prevention-policy-free-digital-download/

- **Do not leave a person at imminent risk of suicide alone.** If you have any suspicions that a person is seriously considering harming himself or herself, let the person know that you care, that he or she is not alone, and that you are there to help. You may have to work with the person's family to ensure that he or she will be adequately supported until a mental health professional can provide an assessment. In some cases, you may have to accompany the person to the emergency room at an area hospital or crisis center. If the person is uncooperative, combative, or otherwise unwilling to seek help, and if you sense that the person is in acute danger, call 911 or (800) 273-TALK. Tell the dispatcher that you are concerned that the person with you "is a danger to [himself or herself]," or "cannot take care of [himself or herself]." These key phrases will alert the dispatcher to locate immediate care for this person with the help of police. Do not hesitate to make such a call if you suspect that someone may be a danger to himself or herself. It could save that person's life.

There are specific things you can do to help in the moment when someone talks about self-harm or suicide. Take these tips that come from the Suicide Prevention Lifeline:

- Take your loved one seriously: Some people feel that kids who say they are going to hurt or kill themselves are "just doing it for attention." But if your child, friend, or family member confides thoughts of suicide, believe them and get help.

- Listen with empathy and provide support: A fight or breakup might not seem like a big deal, but for a young person it can feel immense. Sympathize and listen. Minimizing what your child or friend is going through can increase his or her sense of hopelessness.

- Learn the warning signs: Friends sometimes let friends know if they are thinking about suicide or dying. Other times, changes in behavior may show that someone is struggling.

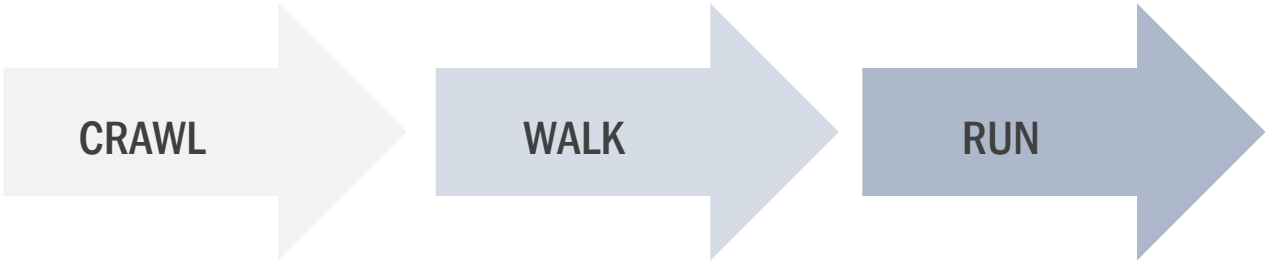
- Don't keep suicide a secret: If your friend is considering suicide, don't promise to keep it a secret. Tell him or her you can help, but you need to involve other people, like a trusted adult. Neither of you have to face this alone.

Make sure you have the following resources always available to give out to people who make inquire or you feel need to have them:

National Suicide Prevention Lifeline (available 24/7)
- Phone: 1-800-273-8255
- Text: The Lifeline (@800273TALK)
- Website: https://suicidepreventionlifeline.org
- Twitter: https://twitter.com/800273TALK

ORGANIZATION MENTAL HEALTH STRATEGY: Crawl, Walk, Run

A faith-based organization's mental health strategy can be built over time, adapting to address existing needs in the organization and community. It is recommended that entities start small and gradually expand, following these three stages: crawl, walk, and run.



Crawl

Crawl steps do not require money, training, resources, or paid staff. They are beginner steps for easing into creating your mental health ministry. All faith-based entities can implement crawl steps.

- Educate yourself on suicide prevention strategies for faith-based communities with resources such as "Mental Health: A Guide for Faith Leaders" from the American Psychiatric Association Foundation, found here: https://www.psychiatry.org/newsroom/news-releases/apa-releases-new-resources-on-mental-health-for-faith-leaders.
- Refer to mental illness within sermons or messages
- Within weekend services pray for people who are living with mental illness and their families
- Invite people who are living with mental illness to share their testimony in a service
- Give the members of the faith-based organization a survey that asks them questions related to mental health
- Provide a referral list of mental health resources available in your community and the National Suicide Prevention Lifeline (1-800-273-TALK)
- Educate and raise awareness in your organization by inviting mental health professionals to speak about mental illness
- Provide space for free NAMI (National Alliance on Mental Illness) support groups and substance use-related groups like Narcotics Anonymous (NA) or Alcoholics Anonymous (AA)
- Take a meal to someone newly diagnosed with mental illness
- Befriend someone living with mental illness - go to a movie together or get a cup of coffee
- Give hope to people who are mentally ill be providing encouraging connections: call, text, e-mails, letters, etc.

This was adapted from Kay Warren's site. The specific document was called "A Church-Initiated Mental Health Strategy," which can be found here: http://kaywarren.com/mentalhealthandthechurch/

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Walk

Walk steps require some training and minimal financial support. There is a greater level of commitment, but most faith-based entities can take these steps.

- Preach sermons or messages specifically about mental illness
- Start mental health-specific ministries such as support groups for adults and youth
- Start a Celebrate Recovery or other support group as a ministry
- Create care teams of three or four individuals who will commit to an on-going relationship with an individual or family to help with basic needs (helping with household tasks, transportation to doctor visits, basic home repairs, etc.)
- Train volunteers to be "companions" during a service to anyone appearing distressed, depressed, or lonely
- Regularly connect members of your faith-based organization with opportunities to serve
- Help connect people in your faith-based entity with individuals who have similar mental health challenges (with their permission)
- Build a mental health library with books and resources available
- Use local mental health professionals to offer frequent educational meetings for your staff, volunteers, and parents

Run

Run steps require a higher level of commitment, more extensive training, financial support, and trained staff. Some faith-based organizations can take these steps.

- Integrate mental health into existing ministries within the organization
- Develop a lay counseling ministry
- Hold mental health support groups for children
- Create a mental health safe place where people who are living with mental illness can come and find comfort and support
- Provide staff with more advanced mental health care training
- Create care teams of three or four individuals who will commit to an on-going relationship with an individual or family to help with mental health needs (assist in making connections to resources, programs and professionals who might be helpful to their specific needs - advocate for them in a holistic way)
- Establish serving opportunities for people living with severe mental illness
- Partner together with a mental health organization in your community to provide services such as a PEACE Center, mental health clinic, and therapeutic support groups
- Hold a mental health event; host a one-day mental health conference
- Build a team of volunteers who can help others in your community to become involved in caring for people living with mental illness and their families
- Become a model of what every faith-based entity can do about mental illness by being a reliable source of information about mental illness

FAITH LEADER CHECKLIST TO PREVENTION, INTERVENTION, AND POSTVENTION

It can be difficult for faith leaders to truly gauge whether they feel prepared to handle suicide prevention, intervention, and postvention. Below is a checklist for faith leaders to work through to determine whether they feel equipped.

Prevention

Attitudes

- ☐ I preach/teach my congregation about suicide with an awareness that some members may have suicide-related thoughts or experiences.
- ☐ When with someone who has been affected by suicide, I am aware of my attitudes about suicide that may help or hinder help-giving or help-seeking.

Theological reflection

- ☐ I have reflected on my theology as it relates to suicide and how it affects my attitudes when helping those with thoughts of suicide and those affected by suicide.
- ☐ I have reflected on my theology of life, death, and suffering and how it relates to suicide.

Establishing rapport to facilitate help-seeking and suicide prevention efforts

- ☐ I demonstrate genuine interest in others' well-being and trustworthiness in all my dealings with people.
- ☐ I participate in congregational events in order to build authentic community.

Reducing negative stereotypes and discrimination associated with help-seeking

- ☐ I actively promote the benefits of help-seeking and seek to reduce negative stereotypes.
- ☐ I network with other professionals to understand how their services can help reduce negative stereotypes and encourage help-seeking.

Community building

- ☐ I am intentional about connecting congregants with each other.
- ☐ I support efforts to build awareness about suicide prevention by supporting events such as the National Weekend of Prayer for Faith, Hope, & Life.

Prevention leadership

- ☐ I share a vision with other congregational leaders for the role of prevention activities in my congregation.

This was adapted from the National Action Alliance for Suicide Prevention's "Suicide Prevention Competencies for Faith Leaders: Supporting Life Before, During, and After a Suicidal Crisis," which can be found here: https://theactionalliance.org/sites/default/files/fhl_competencies_v8_interactive.pdf.

Intervention

Knowing my role

- When with a person experiencing suicidal ideation, I am clear about my role.
- When with a person experiencing suicidal ideation, I provide for spiritual needs while being informed of mental health and suicide prevention basics.

Culture

- When with a person experiencing suicidal ideation, I take the individual's culture into account and provide culturally relevant counsel, support, and referral.
- When with a person experiencing suicidal ideation, I am intentional about inviting the individual to talk about her/his/their culture.

Listening

- When with a person experiencing suicidal ideation, my goals are to first provide a safe place, listen, and fully understand the reasons the person is experiencing suicidal ideation before giving advice or safety planning.
- When with a person experiencing suicidal ideation, I know I don't have the answers.

Risk assessment and safety planning

- I have learned a best practice model for how to intervene with a person experiencing suicidal ideation, that includes recognizing warning signs, conducting a risk assessment, developing a safety plan and making referrals (e.g., ASIST, QPR, CSSRS).

Applying appropriate pastoral counseling skills to strengthen life-supporting resources

- I help the individual identify her/his/ their own unique resources and reasons for living (which may include purpose and meaning of life).
- I refer to teachings from relevant religious traditions or to the individual's worldview to emphasize the value of life itself.
- I continue to help the individual realize that she/he/they is/are not alone.

Collaborating with other caregivers

- When with a person experiencing suicidal ideation, I take an active role in connecting the individual with professional and/or lay help, as appropriate, and within the limits of confidentiality/privacy.
- When with a person experiencing suicidal ideation, I know when a referral is needed.
- When I refer a person experiencing suicidal ideation, to other caregivers, I collaboratively coordinate with these caregivers and continue to provide spiritual care.

Pastoral visitation and follow-up

- After meeting with a person experiencing suicidal ideation, I create a specific plan for follow-up with the individual.
- After meeting with a person experiencing suicidal ideation, I check in with the individual's family members and friends, as appropriate.
- In meetings with a person experiencing suicidal ideation, I help the individual consider and follow up on ways to form or strengthen connections within the community.

Postvention

Pastoral care skills

- ☐ After a suicide attempt happens, I know how to advise and support friends and family members.
- ☐ After a suicide attempt happens, I know how to advise leaders and key members within the congregation.
- ☐ When a suicide death happens, I know how to care for the friend(s)/family member(s).
- ☐ When a suicide death happens, I know how to care for the congregation.
- ☐ I ensure that the faith community reaches out to survivors the same way it would support family and loved ones after any death (e.g., casserole suppers, spiritual needs).
- ☐ When I talk to survivors, I watch for complicated grief, including guilt, anger, blame, and other mental health issues.
- ☐ When I talk to survivors, I allow them to ask difficult theological questions and avoid providing answers to unanswerable ones.
- ☐ I watch for people vulnerable to contagion—those closest to the decedent and youth who looked up to the individual.
- ☐ I reach out to survivors on anniversaries of events.

Skills to provide pastoral care with awareness of cultural differences

- ☐ When a suicide death happens, I take the culture of survivors into account— how they experience, display, and process emotions; beliefs about death and the after-life; rituals to address the death; and comfort level in speaking about the deceased.

Knowing and applying faith traditions to memorial ceremonies/services

- ☐ When a suicide death happens, I know how to conduct a memorial service or ceremony that is helpful to survivors and congregants, while seeking to prevent contagion and increased risk among those attending.
- ☐ I write a eulogy so that it follows guidelines on how to talk about suicide.

Pastoral communication with congregational leadership and members

- ☐ When a suicide death happens, if the family/loved ones are open, I communicate to my faith members that the death was a suicide.
- ☐ I serve as a liaison between survivors and the media, police, funeral directors, work supervisors, and others, as applicable.
- ☐ I balance sharing information and keeping confidentiality when I believe that an individual is a danger to herself/ himself/themselves or others.

Self-care

- ☐ I take care of myself to make sure that I'll be emotionally available when needed.
- ☐ When a suicide death happens, I am alert and sensitive to the risk of taking on guilt and take steps to avoid doing so.
- ☐ I reach out for support when needed.

*For additional information on steps after a suicide loss, click here.

LANGUAGE FOR PUBLIC MESSAGING

When crafting public announcements regarding suicide (sermons, bulletin announcements, emails, etc.), it is important to create effective and safe messaging. Utilizing safe messaging helps to mitigate the risk of suicide contagion. The following are some practical Do's and Don'ts when crafting public messaging.

DO'S – Helpful Practices for Public Messaging	DON'TS –Problematic Practices in Public Messaging
• DO use proper language. Use the phrase "died by suicide" rather than words like "committed" or "completed" suicide. • DO encourage help-seeking behavior. Make concrete recommendations to referral sources and offer steps that can be taken to seek out crisis service providers. One way to offer a concrete resource is to suggest the National Suicide Prevention Lifeline. • DO emphasis prevention. Emphasize that suicide is a preventable tragedy and steps can be taken to reduce the likelihood of suicide-related crisis in the community. • DO educate the community about warning signs, risk factors and protective factors about suicide. Share how people might be able to identify people experiencing a suicide-related crisis. • DO highlight effective treatments for mental health and mental illness. 90% of suicides can partially be linked to mental health conditions. Encourage stories of people who have sought out help. Discuss openly how the community can help to strengthen supports and help those in crisis.	• DON'T glorify or romanticize the stories and experiences of those who have died by suicide. People in vulnerable states (such as youth) may identify with the attention and sympathy attributed to the person who died by suicide. Caution needs to be exercised in minimizing the contagion effect of suicide, especially when describing an after-life destination or the current state of "peace" the deceased may have found through death. • DON'T normalize suicide by presenting it as common. It is important not to present suicide as a common or normal event that is depicted as acceptable. Instead, emphasize that an acceptable and normal action is to find constructive ways of dealing with suicidal ideation. • DON'T overly simplify the complex nature of suicide by concluding that one or two things caused the death or by saying that it is completely unexplainable. • DON'T discuss overly descriptive details of the method of suicide. Vulnerable individuals may be more likely to imitate the act if they are able to envision the methods previously used.

This was adapted from the Carson J Spencer Foundation's "The Role of Faith Communities in Suicide Prevention: A Guidebook for Faith Leaders." This document can be found here: http://15e50d5042f8867cff88-3b1d37bbed62ab73fc28b350df0f1686.r26.cf2.rackcdn.com/uploaded/s/0e8256734_1547665499_suicidefaithleadersguidebook.pdf

You've lost a loved one to suicide. You want people to know your loved one has died but you don't know how to tell them. The decision to include this information in an obituary is a personal one that only you and your family can make.

This pamphlet provides some basic guidelines and suggestions that can help you write an obituary that will honor your loved one, while protecting your family's privacy at this very difficult time.

WRITING AN OBITUARY

for a loved one who has died by suicide

Further Information

To find out more about suicide prevention in Indiana and nationally, please visit:

In.gov/issp
In.gov/isdh/21838.htm
Indianasuicideprevention.org
afsp.org
sprc.org

The information in this pamphlet was adapted from a brochure by the Ontario Funeral Service Association and the Warterloo Region Suicide Prevention Council. The original brochure can be found here: https://edmonton.cmha.ca/wp-content/uploads/2015/11/CMHAER_WAO_Trifold_PRESS.pdf.

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Where to Start

You first need to decide whether or not you want to use the word suicide. It is no longer "taboo" to mention suicide in an obituary. Some people choose to name suicide as the cause of death, others may not. There is no right or wrong way.

As an alternative to naming suicide as the cause of death, you might choose to suggest a donation to a suicide prevention program or support group. This can be a positive legacy to your loved one, as it can help increase public understanding and support others who have lost someone to suicide. We can help you identify an appropriate recipient.

Why you Might Choose to Acknowledge the Suicide

- Openly acknowledging the suicide in an obituary can help you and your family in the grieving process.
- Friends and family who have also lost someone to suicide may be better able to support you and your family during this difficult time.
- Using the word suicide in an obituary might be easier than telling others directly and can help end any rumors that might surround an unexpected death.
- When people openly acknowledge suicide in an obituary, it helps to reduce the stigma associated with suicide.

How to Include Suicide in an Obituary

Here are some examples of words you might use:

"John will always be remembered for his courage during difficult times. Unfortunately, this time the pain was too difficult, and John died by suicide on Saturday evening."

"After a courageous and long battle with depression, the pain became unbearable and Sarah took her life."

"Mary Lee, her life taken too soon by her own hand."

"John Horn, who we lost due to suicide on Wednesday, April 30."

"Jeff died by suicide on Thursday, November 10. He was no longer just sad; he was imprisoned in a powerful darkness."

"On August 22, Trevor was only 17 years old when he died by suicide. Trevor will be forever in our hearts."

Words or Information to Avoid

Mental health professionals encourage you to use non-judgmental words and phrases when writing an obituary. This can help reduce the stigma and discourage others from considering suicide.

Here are some suggestions:

- Use the phrase "died by suicide," rather than words like "committed" or "completed" suicide.
- Do not share specific details of the means and how to obtain them, as it may contribute to teenagers already at risk for acting on suicidal ideation.
- Do not try to offer simplistic reasons or explanations for the suicide.
- Avoid describing the suicide as unexplainable.
- Avoid words and phrases that "romanticize" suicide.

Help is available if you're concerned that someone you care about it at risk of suicide.

National Suicide Prevention Hotline:
1-800-273-TALK (8255)
In case of Emergency:
Call 911 or visit your local emergency room.

SELF-CARE CHECKLIST FOR FAITH LEADERS

It is vital that faith leaders stay on top of their own care; the list below is a usable self-care checklist.

Self-Care Checklist for Faith Leaders

- ☐ **Make Adequate Time for Yourself.** It's easy to be consumed by all the various demands in our lives. Regularly scheduling time for yourself can make a big difference.
- ☐ **Do Something you Enjoy.** Do something just for you. This can range from pleasure reading, to taking a class unrelated to our profession just because you have an interest in that area.
- ☐ **Take Care of Yourself Physically and Spiritually.** Take the time to undergo regular physical exams and dental care, exercise regularly, get adequate rest, maintain a healthy diet, get a massage, take a yoga class, or meditate, attend to your spiritual needs in some other more personal way. Keep in mind that self-care is a good thing. Self-care is not selfishness. The better job we do in taking care of ourselves, the better job we can do to take care of our communities.
- ☐ **Say NO!** Setting reasonable limits and having realistic expectations for yourself is of great importance. Have firm boundaries and limit the number of difficult individuals you counsel.
- ☐ **Don't Isolate.** Stay involved in outside organizations (e.g. local ministerial association) and community projects. Schedule regular lunch meetings with other faith community leaders in your area. Attend national conferences. Build a network of support outside the walls of your individual faith community. Consider peer supervision among pastoral care providers.
- ☐ **Watch Out for Warning Signs of Burnout.** These include violating boundaries, self-medicating, wishing those who are in need would not show up, finding it difficult to focus on the needs of your faith community, and being preoccupied with our own needs and issues.
- ☐ **Be your Brothers' and Sisters' Keeper.** Watch out for warning signs of distress, burnout, and impairment in colleagues. Don't overlook the signs or think they will work it out on their own.
- ☐ **Conduct Periodic Distress and Impairment Self-Assessments and Seek Help When Needed.** Be aware of your caregiver blind spot. We can see others' needs but often overlook our own. If assistance is needed consult with a trusted colleague.

Focus on Prevention. Stress is a part of our lives. Accept it, respond

This was adapted from the Carson J Spencer Foundation's "The Role of Faith Communities in Suicide Prevention: A Guidebook for Faith Leaders." This document can be found here: http://15e50d5042f8867cff88-3b1d37bbed62ab73fc28b350df0f1686.r26.cf2.rackcdn.com/uploaded/s/0e8256734_1547665499_suicidefaithleadersguidebook.pdf

Media

Introduction

Often when there is a suicide death, there is accompanying media coverage. Over the years, research worldwide has shown that unsafe media reporting can be correlated with an increase in suicide.[14] That is why it is vital for news organizations to follow safe reporting guidelines. Covering suicide carefully can change perceptions, dispel myths and inform the public on the complexities of the issue.

Contrary to popular opinion, a recent study found that when articles covered suicide correctly, the article was more likely to be shared and have positive engagement.[14] By utilizing this approach, the content is less sensationalized and individuals can be connected with care.

Media Resources:

- Best Practices and Recommendations for Reporting on Suicide
- Quick Checklist for Responsible Reporting on Suicide
- Tips for Online Media Coverage
- Resources for Connecting Individuals with Care
- Tips for Working with Media
- Staff Care Checklist for Editors

Best Practices and Recommendations for Reporting on Suicide

Describing or depicting the method and location of the suicide.	Report the death as a suicide; keep information about location general.
Sharing the content of a suicide note.	Report that a note was found and is under review.
Describing personal details about the person who died.	Keep information about the person general.
Presenting suicide as a common or acceptable response to hardship	Report that coping skills, support, and treatment work for most people who have thoughts about suicide.
Oversimplifying or speculating on the reason for the suicide.	Describe suicide warning signs and risk factors (e.g. mental illness, relationship problems) that give suicide context.
Sensationalizing details in the headline or story.	Report on the death using facts and language that are sensitive to a grieving family.
Glamorizing or romanticizing suicide.	Provide context and facts to counter perceptions that the suicide was tied to heroism, honor, or loyalty to an individual or group.
Overstating the problem of suicide by using descriptors like “epidemic” or “skyrocketing.”	Research the best available data and use words like “increase” or “rise.”
Prominent placement of stories related to a suicide death in print or in a newscast.	Place a print article inside the paper or magazine and later in a newscast.

This was adapted from Reporting on suicide’s “Best Practices and Recommendations for Reporting on Suicide” which can be found here: https://reportingonsuicide.org/wp-content/themes/ros2015/assets/images/Recommendations-eng.pdf.

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Quick Checklist for Responsible Reporting on Suicide

- **Report suicide as a public health issue.** Including stories on hope, healing, and recovery may reduce the risk of contagion.

- **Include Resources.** Provide information on warning signs of suicide risk as well as hotline and treatment resources. At a minimum, include the National Suicide Prevention Lifeline (1-800-273-TALK [8255]) and Crisis Text Line (text "IN" to 741741) or local crisis phone numbers.

- **Use Appropriate Language.** Certain phrases and words can further stigmatize suicide, spread myths, and undermine suicide prevention objectives such as "committed suicide" or referring to suicide as "successful," "unsuccessful" or a "failed attempt." Instead use, "died by suicide" or "completed" or "killed him/herself."

- **Emphasize Help and Hope.** Stories of recovery through help-seeking and positive coping skills are powerful, especially when they come from people who have experienced suicide risk.

- **Ask an Expert.** Interview suicide prevention or mental health experts to validate your facts on suicide risk and mental illness.

This was adapted from Reporting on suicide's "Checklist for Responsible Reporting" which can be found here: https://reportingonsuicide.org/wp-content/themes/ros2015/assets/images/Recommendations-eng.pdf.

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TIPS FOR ONLINE MEDIA COVERAGE

As online content is increasingly taking over the media market, it is vital that safe suicide messaging is considered. Online content can include anything from social media sites, blogs, and online content to traditional media organizations. Below are a few tips to follow when writing online content.

1. Include hyperlinks to resources, such as suicide warnings and risk factors, or to the National Suicide Prevention Lifeline to help inform readers and reduce the risk of suicide.

2. Think about reporting on suicide as a health issue, not just in response to a recent death. For example, you can report about:
    a. Effective suicide prevention programs
    b. New research on suicide prevention or mental illness
    c. Advocates working to reduce suicide
    d. Individual stories of people who have overcome suicidal ideations
    e. Stories on families bereaved by suicide loss who are helping others cope or working to prevent suicide in their community
    f. New treatments for depression or other mental illnesses that can lead to suicide
    g. Steps local/federal government agencies are taking to prevent suicide

3. Remember that most online stories also allow for public commentary. Websites and bloggers should develop policies and procedures for safe message board comments and monitor them for hurtful messages or comments from posters who may be in crisis. It might be helpful for webmasters, bloggers, or message board moderators to post the National Suicide Prevention Lifeline information in the first comment box in any story about suicide.

4. Traditional media journalists who also blog, either for their news organization or as an individual, should follow the media recommendations and be consistent. Try not to be sensational in your online coverage just because there is more space or less oversight.

This was adapted from Reporting on Suicide's "Online Media" webpage which can be found here: https://reportingonsuicide.org/onlinemedia/.

RESOURCES FOR CONNECTING INDIVIDUALS WITH CARE

When reporting on suicide, is vital that news organizations share resources. This can be simply including the numbers below at the end of an article or including, "If you or someone you know is in need of help, contact the National Suicide Prevention Lifeline." Regardless of the method of communication, these resources can be provided.

The National Suicide Prevention Lifeline: Call 1-800-273-TALK (8255)
A free, 24/7 confidential service that can provide people in suicidal crisis or emotional distress, or those around them, with support, information, and local resources.

Crisis Text Line: Text "IN" to 741-741
This free text-message service provides 24/7 support to those in crisis. Text 741-741 to connect with a trained crisis counselor right away.

Additional Phone Resources:

- **The Veterans Crisis Line and Military Crisis Line:** Call 1-800-273-TALK (8255) Press 1, Text 838255
- **Trevor Project (LGBTQ+ Youth):** Call 1-866-488-7386, Text "TREVOR" to 202-304-1200
- **Trans Lifeline:** Call (877)565-8860
- **Crisis Line for Individuals Deaf and Hard of Hearing:** Call 1-800-273-8255 (video relay service or voice/caption phone), Call 1-800-799-4889 (TTY)
- **Ayuda en Español:** Llama al número 1-888-628-9454

Mental Health Website Resources (these resources should not be the only resources provided; the National Suicide Prevention Lifeline should be included in any relevant story):

- **Mental Health America's "Where to Get Help":** https://www.mhanational.org/get-involved/b4stage4-where-get-help-0
- **Mental Health.gov's "How to Get Mental Health Help":** https://www.mentalhealth.gov/get-help

This was adapted from Reporting on suicide's "Get and Share Support" webpage which can be found here: https://reportingonsuicide.org/onlinemedia/. The graphic is from Noun Project (phone by monkik).

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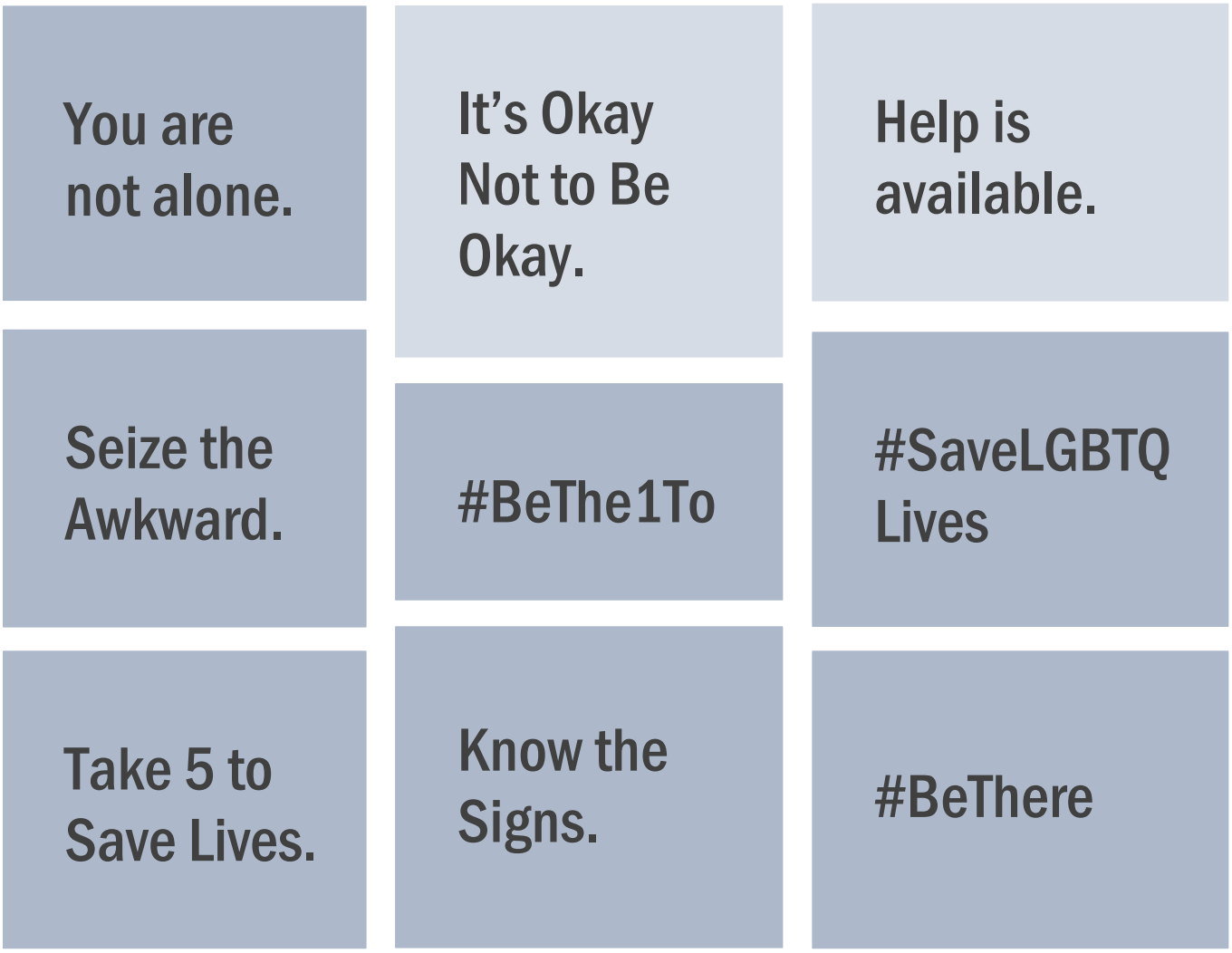
TIPS FOR WORKING WITH MEDIA

As a non-media organization, it can be confusing to navigate the multi-faceted world of media. The media play an important role in building public opinion and attitudes. Media interest can, at times, be very high, but the relationship can also be challenging. Below are some tips that organizations and coalitions can use on working successfully with media.

1. Work with the local media to develop media campaigns that inform about suicide and its prevention, promote mental health and reduce stigma. Strengthen health promotion messages on the link between stressors, mental health and physical health.
2. Encourage the local media to report responsibly about suicide, including the National Suicide Prevention Lifeline (1-800-273-8255 [TALK]) and text line (text "IN" to 741-741).
3. Invite the local media to participate in the community activities.
4. Encourage the local media to develop a communication strategy that includes the development and distribution of a press information kit that provides a resource for reporting responsibly on suicide and contact information for local spokespersons. Share available resources on suicide and the media.
5. Encourage the media to follow a code of ethics regarding suicide.
6. Implement a media monitoring process to collect information about appropriate coverage of suicide and provide constructive feedback on misleading or hurtful depictions of suicide.
7. Develop a process for nominating local media for existing media awards for excellence in reporting or collaborate to establish new awards to recognize journalists.
8. Involve media professionals in a workshop on the responsible reporting of suicide.
9. Develop a social media strategy to target certain demographics. For example, youth use Snapchat, Tik Tok and Instagram at the highest rates. Each platform has a different culture. Get to know it. As far as a few tips:
    a. Utilize a call to action
    b. Give a link with a snapshot of information
    c. Include an image as this will increase the number of views
    d. Use relevant hashtags to reach others looking for the same information.

This was adapted from Reporting on suicide's "Checklist for Responsible Reporting" which can be found here: https://reportingonsuicide.org/wp-content/themes/ros2015/assets/images/Recommendations-eng.pdf. Also, from SAMHSA's "Social Media Tips," which can be found here: https://www.samhsa.gov/childrens-awareness-day/resources/social-media.

When thinking about media messaging, it can be helpful to embrace a core message. Consider the following messages below. The ones in dark blue are actual campaigns (information included below) and the light blue boxes are helpful messages to include that do not necessarily have a campaign attached.



You are Not Alone - https://www.nami.org/Get-Involved/Awareness-Events/Mental-Health-Month
Seize the Awkward - https://seizetheawkward.org/?gclid=EAIaIQobChMI1a-Uwa-s6gIVCr3ACh0ZaQR-EAAYASAAEgKg-vD_BwE
#BeThe1To - https://www.bethe1to.com/
#SaveLGBTQLIVES - https://www.thetrevorproject.org/save-lgbtq-lives/
Take 5 to Save Lives - https://www.take5tosavelives.org/toolkit
Know the Signs - https://emmresourcecenter.org/initiatives/know-signs
#BeThere - https://www.veteranscrisisline.net/support/be-there#reach

STAFF CARE CHECKLIST FOR EDITORS

Reporters, photographers, videographers, designers, and other news staff may undergo traumatic stress during any news event, regardless of whether they are at the scene or behind the desk. It's important for editors to have specific care practices in place to help staff during these difficult moments.

Staff Care Checklist for Editors

- ☐ **Create an open newsroom culture.** To encourage trauma-informed self-care practices among your staff, your newsroom should nurture and reinforce an open and supportive newsroom culture. Encourage your staff to speak openly with you and with each other and to feel able to do so without sharp criticism or backlash.

- ☐ **Trauma awareness – educate.** Set aside time to educate your staff on trauma, traumatic stress, PTSD, and the effects of covering traumatic news events. By educating your staff and making them "trauma-aware," they will be better prepared to respond and cope when an event occurs.

- ☐ **Emergency Contact Lists.** Create an emergency contact tree for your newsroom. This emergency contact tree should lay out the protocol of who to call during a traumatic news event. This should be accessible to everyone on staff via print copy and digitally.

- ☐ **Check-in often.** Before any of your staff go out to cover a traumatic event, let them know that you appreciate and value their work. This will remind them that they have your support as they tackle challenges that lie ahead. Let them know that being in regular contact with you and others in the newsroom is encouraged. They should check in with you and other staff members while out reporting on the event so that you know they are safe.

- ☐ **Listening ear.** When your staff is out in the field covering a traumatic event, or even when they are behind the desk, make sure that they know that you are there for them and the newsroom is a supportive environment. Those who feel alone or lack other support networks are more likely to be at risk for traumatic stress than those who have other sources of support. Provide encouragement as they are working on a difficult story and let them know that they should not hide their stress, feelings or emotions in these moments. Let them know that it's important for them to acknowledge difficult feelings and to express them to you or others in the newsroom.

- ☐ **Encourage healthy self-care practices and be a role model.** Remind your staff before, during and after covering a traumatic event that they should do their best to take care of themselves: eat healthy food, get exercise, take breaks, and sleep. You should also encourage them to talk with family and friends about their experiences. Make sure that you are also practicing what you preach and serve as a role model who is following these same self-care practices.

This was adapted from the Dart Center for Journalism & Trauma's "Editor Perspective: Self-Care Practices and Peer Support for the Newsroom" webpage which can be found https://dartcenter.org/content/editor-perspective-self-care-practices-and-peer-support-for-newsroom.

- **Be on the lookout for trouble signs.** Pay attention to any trouble signs your staff members may be showing while covering a traumatic event or afterwards. Some examples are:
    - **S**leeplessness
    - Upsetting dreams
    - Intrusive images or thoughts of the event
    - Avoidance of reminders of the trauma or feeling numb
    - Feeling that bad things are about to happen
    - Being jumpy and easily startled**, a**nger
    - Difficulty concentrating**; f**eeling "hyper"
    - Physical reactions such as sweating, rapid heartbeat, dizziness or nausea when reminded of a traumatic event

  If your staff members show any of these signs, find a way to have a conversation and offer a listening ear. Keep an eye on them and monitor their wellbeing. If they are showing any of these signs for several weeks or months after covering a traumatic event, you might want to refer them to a trauma specialist. Teach your staff members to look out for these signs among their peers – the more people on your staff who are educated about signs of distress, the easier it will be to ensure they get the help they need.

- **Remind your staff of the impact of trauma.** Remind your staff that the adrenaline of the chaos can impair their judgment and they must try to remain centered throughout the experience. They should be reminded that the way they cover the story, how they interview sources, and the way the story is presented to the public can all have an impact on those affected by the event as well as the general public. It is essential to convey the importance of reporting in an ethical, humane and respectful way.

Coroners

Introduction

Coroners frequently respond to cases where an individual has died by suicide. Though these are often some of the most difficult cases, the Coroner is a vital and valued part of the investigation process. Once a Coroner arrives on the scene, they are the highest authority and are in control of the scene. The only situation where this is not the case is in the event of a fire where Firefighters control the scene.

Coroners are an integral partner in the gathering and development of accurate data. Indeed, Coroners' efforts in suicide death investigations inform suicide prevention strategies throughout the state, ultimately driving prevention initiatives. Given the importance of Coroners in responding to a suicide death, this section of the toolkit includes practical tools that can be utilized during the death investigation process.

Coroner Resources:

- National Criteria for Determining Suicide
- Best Practices for Talking with Families
- Suicide Investigation Form
- Suicide Investigation Sample Forms
- Coroners Death Investigations: A Guide for Families

NATIONAL CRITERIA FOR DETERMINING SUICIDE

According to the Centers for Disease Control and Prevention, suicides are defined as the following:

1. **Self-Inflicted:** There is evidence that death was self-inflicted. This may be determined by pathologic (autopsy), toxicologic, investigatory, and psychologic evidence and by statements of the decedent or witnesses.

2. **Intent:** There is evidence (explicit and/or implicit) that, at the time of injury, the decedent intended to kill himself/herself or wished to die and that the decedent understood the probable consequences of his/her actions. This evidence may include:
   - Explicit verbal or nonverbal expression of intent to kill self.
   - Implicit or indirect evidence of intent to die, such as:
     - preparations for death inappropriate to or unexpected in the context of the decedent's life,
     - expression of farewell or the desire to die or an acknowledgment of impending death,
     - expression of hopelessness,
     - expression of great emotional or physical pain or distress,
     - effort to procure or learn about means of death or to rehearse fatal behavior, precautions to avoid rescue,
     - evidence that decedent recognized high potential lethality of means of death, previous suicide attempt, previous suicide threat,
     - stressful events or significant losses (actual or threatened), or serious depression or mental disorder.

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This was adapted from the CDC's "Current Trends Operational Criteria for Determining Suicide" webpage which can be found https://wonder.cdc.gov/wonder/prevguid/p0000164/p0000164.asp.

BEST PRACTICES FOR TALKING WITH FAMILIES

When a Coroner arrives at the scene after a suicide death, they often talk with the family. It can be helpful to keep the following in mind when talking with families:

WHERE: When possible, it is best to have the conversation with survivors in a place that is familiar to them (e.g. home), where they feel safe. Try to do this in a room where families can be sitting down, and you should be sitting as well looking at them, rather than standing over them and looking down on them. If home is not an option, find a quiet room away from police, EMTs, media, and other disruptions.

HOW: It is important you share this information directly and compassionately. Begin by saying, "I am very sorry, but your _____ has died," Be brief and only share what is most important and known at the that time with the family. Avoid sharing details of suicide method with youth, or unnecessary details.

Do not speculate or try to explain why the suicide happened, rather be patient with them as the shock sets in. Be prepared for them to have a range of emotions and be in denial and be angry with you, someone else, God, etc. They might demand to see their loved one. Help families with their grief by assuring them that "what you are thinking, and feeling is normal when someone dies by suicide." We may never know the exact reason(s) why it happened. Let the family know it is normal to ask “why” for as long as they need to. Ensure that they know that there is no right or wrong way to grieve when someone has died, that everyone does it differently.

Avoid using medical or legal terms. Be aware that you may have to repeat things several times. Let survivors know that it is not uncommon for family members left behind to think about suicide. Tell them that if suicidal ideation happens to them or another family member, help is available, they should talk about it with trusted loved ones, and contact a crisis service immediately.

Address Expressed Feelings of Guilt: Survivors of suicide loss almost always experience a deep sense of guilt. Let families know that this is very common. Help them by explaining that there are many factors that contribute to a person taking their life, and that no one person or event causes suicide. Remind the family that sometimes people die of an illness regardless of the treatment they seek or how much they are loved and cared for.

Handle Suicide Notes Carefully: Be aware of how suicide notes are handled in your jurisdiction. Sometimes a note will need to be held as evidence by police.

- Try to obtain a copy of the note for the family.
- Prepare the family that the contents of the note may not answer their questions.
- Remind the spouse or parent next-of-kin to keep the note in a safe place.
- When no note is left, inform the family this is common and that only 20-25% of those who die by suicide leave a note.

This was adapted from the CDC’s “Current Trends Operational Criteria for Determining Suicide” webpage which can be found https://wonder.cdc.gov/wonder/prevguid/p0000164/p0000164.asp. This information was also adapted from OJP Diagnostic Center’s “First Do No Harm” Model Practices for Law Enforcement Agencies When Arresting Parents in the Presence of Children,” which can be found here: https://strategiesforyouth.org/sfysite/wp-content/uploads/2012/09/First_Do_No_Harm_Report.pdf.

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When talking with children, keep the following in mind:

- Always have permission from parents or guardians before talking about a suicide death. When possible, have a guardian present.
- Ensure a child knows that the suicide death was not their fault. Children often feel it happened because of something they did.
- Be direct and speak in short, simple sentences appropriate for the age of the child.
- Use words that the children know and can understand. Do not speak in medical or legal terms. Ask the child if they understood what you told them before you leave.
- Ensure you are comfortable talking with various age groups of youth.
- Reassure children that suicide is not common, not contagious, and will not happen to them.
- Reassure children that they are not alone and will be taken care of. When a parent or guardian dies, children often are afraid their other parent or guardian will leave.
- Let children know that they might have more questions later and that it's ok to keep talking about the suicide death and to continue to ask questions as long as they need. Reassure a child that there are people there to help them at any time.
- Refer families to additional resources for talking to children about suicide and grief.

Respond Ethically to Requests to Change Manner of Death: Sometimes family members will place pressure on a Coroner to change the manner of death so that it is not suicide. Let them know that you cannot submit to such a request. For example, if they say that insurance will not cover a death by suicide, explain that it would be unethical and illegal to change the manner in order to help them collect on a policy, and recommend they call their insurance agent or an attorney. Others may ask you to change the manner to protect children or the family's reputation. Let them know that you cannot do this, and that they will find caring and supportive people in their community to help them in their grief, no matter the manner of their loved one's death. Finally, let them know that if more information becomes available in the future, the manner of death can be changed.

Proactively Inform Families that the Manner of Death is Public Record:

In some cases, families may wish to keep the manner of death secret due to the stigma, shame, and guilt that persists surrounding a death by suicide. It is important, therefore, that you inform the family up front that the death of their loved one is public record, and that the true manner of death may not remain secret. Be familiar with the public records laws to help the family make an informed decision.

Resources for Families

- Suicide Awareness Voices of Education (www.save.org)
- www.befrienders.org/bereaved-by-suicide
- www.nami.org/personal-stories
- SAMHSA Therapist Finder (https://findtreatment.samhsa.gov/)
- www.mentalhealthamerica.net/finding-therapy
- http://www.who.int/mental_health/en/
- American Foundation for Suicide Prevention (https://afsp.org/ive-lost-someone)

SUICIDE DEATH INVESTIGATION FORM

This Suicide Death Investigation Form was originally developed by the state of Colorado but has been adapted for the purposes of this toolkit. The purpose of the form is to capture risk factor and circumstance data in suspected or known cases of suicide, as well as general mortality information to be used in prevention efforts, not to determine possible negligence or accountability.

Suicide Death Investigation: Full Form

1. Administrative information:

a. Date report completed (MM/DD/YYYY):

b. Date of incident (MM/DD/YYYY):

c. Reporting agency name:

d. Please indicate which types of sources were available (check all that apply):

- ☐ Employment/Personnel record
- ☐ Medical record
- ☐ Autopsy report
- ☐ Ballistics report
- ☐ Financial (debt) report
- ☐ Suicide note
- ☐ Investigative report
- ☐ Interviews
- ☐ School records
- ☐ Other, specify:

2. Decedent information:

a. Decedent name:

First:

Middle:

Last:

b. Date of birth (MM/DD/YYYY):

☐ Unknown

c. Date of death (MM/DD/YYYY):

☐ Unknown

3. Education:

Highest education level completed:

- ☐ High school
- ☐ GED
- ☐ Some college
- ☐ Associate degree
- ☐ Bachelor-level degree
- ☐ Masters-level degree
- ☐ Doctorate-level degree
- ☐ Unknown
- ☐ Less than high school, specify highest grade completed:

4. Race (check all that apply):

- ☐ White
- ☐ African-American
- ☐ American-Indian/Alaska Native
- ☐ Asian/Pacific Islander
- ☐ Unknown
- ☐ Other, specify:

5. Hispanic origin:

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown

6. Relationship and family status:

a. Current relationship status:

- ☐ In a relationship
- ☐ Not in a relationship
- ☐ Unknown

b. Marital status

- ☐ Never married
- ☐ Married
- ☐ Divorced/Legally separated
- ☐ Widowed
- ☐ Remarried
- ☐ Separated
- ☐ Living together
- ☐ Unknown

c. If separated/divorced/widowed, date (MM/DD/YYYY):

7. Residence information:

a. Type of residence:

- ☐ House/Townhome
- ☐ Apartment
- ☐ Homeless
- ☐ Treatment facility
- ☐ Correctional facility
- ☐ Unknown
- ☐ Other, specify:

b. Residing with (check all that apply):

- ☐ Spouse/Significant other
- ☐ Roommate(s)
- ☐ Parent(s)
- ☐ Child(ren)
- ☐ No one, resided alone
- ☐ Unknown
- ☐ Other, specify:

c. Recent residence problems?

- ☐ Recent eviction/threat of eviction
- ☐ Recent foreclosure/threat of foreclosure

This was adapted from the State of Colorado's Suicide Investigation form, found here: cdphe.colorado.gov/suicide-prevention/suicide-investigation-form.

8. Armed services history:

a. Military service:

- ☐ Yes, specify years of service:
- ☐ No military service
- ☐ Unknown

b. Eligible for services from the VA?

- ☐ Yes, and receiving services
- ☐ Yes, but not receiving services
- ☐ No
- ☐ Unknown
- ☐ Other, specify:

9. Employment information:

Industry and Occupation are terms used by National Institute for Occupational Safety and Health and represent the usual or lifetime career of an individual. The occupation is the actual job or position of the individual. For more information visit: https://www.cdc.gov/niosh/docs/2012-149/pdfs/2012-149.pdf

a. Decedent's employment status prior to death:

- ☐ Employed
- ☐ Student
- ☐ Unemployed
- ☐ Homemaker
- ☐ Retired
- ☐ Unknown
- ☐ On disability
- ☐ Other, specify:

b. If decedent was employed, specify the occupation:

10. Incident information:

a. By whom was the body first encountered/discovered?

- ☐ Family member, specify relationship to decedent:
- ☐ Coworker
- ☐ Friend
- ☐ Emergency responder
- ☐ Police Officer
- ☐ Firefighter
- ☐ Stranger
- ☐ Other, specify:

b. Were grief/survivor resources offered to the person(s) in range to intervene or to those who found the body?

- ☐ Yes
- ☐ No
- ☐ Unknown

c. Injury location:

- ☐ Own residence
- ☐ Hospital/Medical facility
- ☐ Natural area (e.g. state park)
- ☐ Park, playground, public area
- ☐ Hotel/Motel
- ☐ Street/Road, sidewalk, alleyway
- ☐ Highway/Freeway
- ☐ School
- ☐ Motor vehicle
- ☐ Industrial/Construction area
- ☐ Parking lot/Public garage
- ☐ Supervised residential facility
- ☐ Other commercial establishment
- ☐ Jail/Correctional facility
- ☐ Other, specify:

d. Was planning or preparation involved in this death?

- ☐ Yes (apparent ritual, preparation, etc.)
- ☐ No (no apparent ritual, preparation, etc.)
- ☐ Unknown

e. Any evidence the incident involved the following (check all that apply):

- ☐ A suicide cluster (multiple suicides that fall within an accelerated time frame and within a defined geographical area)
- ☐ Death-risk game (e.g. Russian Roulette, playing chicken, or choking game)?
- ☐ Suicide pact with another individual?

f. Did the decedent communicate suicidal ideation or threats (e.g. days, weeks, months) **prior to death?**

- ☐ Yes
- ☐ No
- ☐ Unknown

If yes, describe how was it expressed and to whom was it expressed:

g. EMS on scene:

- ☐ Yes
- ☐ No
- ☐ Unknown

h. Was a suicide note found on scene?

- ☐ Yes
- ☐ No
- ☐ Unknown

i. Suicide note format, if applicable:

- ☐ Paper/physical copy
- ☐ On cell phone
- ☐ On personal computer
- ☐ On social media
- ☐ Other, specify:

j. List of prescriptions or substances found on scene:

k. Was there evidence of substance involvement? (check all that apply)

- ☐ No
- ☐ Alcohol
- ☐ Stimulants
- ☐ Depressants
- ☐ Hallucinogens
- ☐ Inhalants
- ☐ Over the counter products
- ☐ Prescription drugs (only if prescribed to decedent)
- ☐ Prescription drugs (not prescribed to decedent)
- ☐ Other

11. Cause of injury leading to death:

a. Method used to inflict fatal injury:

- ☐ Firearm/Gunshot
- ☐ Jumping/fall from height
- ☐ Poisoning/overdose
- ☐ Sharp Instrument
- ☐ Carbon monoxide/Helium/ Inhalant
- ☐ Hanging, strangulation, suffocation
- ☐ Motor vehicle collision
- ☐ Other, specify:

12. If firearm caused injury:

a. Type of firearm used:

- ☐ Handgun
- ☐ Revolver
- ☐ Shotgun
- ☐ Rifle
- ☐ Other, specify:

b. Who owned firearm?

- ☐ Decedent
- ☐ Parent
- ☐ Other family member
- ☐ Friend
- ☐ Unknown
- ☐ FirearmStolen
- ☐ Other, specify:

c. How was the firearm usually stored?

- ☐ Locked cabinet/safe
- ☐ Unlocked cabinet
- ☐ Unsecured (e.g., closet, bedside table), specify:
- ☐ Unknown
- ☐ Other, specify:

d. Firearm stored:

- ☐ Loaded
- ☐ Unloaded
- ☐ Unloaded with ammunition
- ☐ Unknown

e. What were the safety features on the firearm?

13. Life stressors:

a. Relationship stressors (check all that apply)**:**

- ☐ Intimate partner problem
- ☐ Family relationship problem
- ☐ Other relationship problem, specify:

- ☐ Recent argument
- ☐ Timing of argument:

b. Additional life stressors (check all that apply)**:**

- ☐ Civil legal problems (e.g., divorce, bankruptcy, eviction)
- ☐ Criminal legal problems (e.g. parole, probation, arrest)
- ☐ Domestic violence
- ☐ Physical health problem
- ☐ Job problem/dissatisfaction
- ☐ Financial problem
- ☐ School problem
- ☐ Lack of housing/homelessness
- ☐ Suicide of friend or family member
- ☐ Non-suicide death of friend or family member
- ☐ Disaster exposure (flood, fire, etc.)
- ☐ Assault/Trauma

Describe:

c. Other important information:

14. Youth suicide information (only complete for decedents under 18 at the time of death)**:**

a. School history (check all that apply)**:**

- ☐ School failure
- ☐ Move/new school
- ☐ Problems with grades
- ☐ Individualized education plan
- ☐ Suspension
- ☐ Expulsion
- ☐ Loss of extracurricular activities

Other serious school problems, specify:

b. Relationship stressors (check all that apply)**:**

- ☐ Argument with significant other
- ☐ Argument with family/relatives
- ☐ Breakup
- ☐ Conflict with peers
- ☐ Argument with friends
- ☐ Rumor mongering (i.e. gossip)
- ☐ Physical abuse/assault
- ☐ Rape/sexual abuse
- ☐ Online community/social media conflict

Other, specify:

c. Family circumstances (check all that apply)**:**

- ☐ Intact family
- ☐ Parents separated
- ☐ Parents divorced
- ☐ Ongoing custody issues
- ☐ Single parent home
- ☐ Foster care or other out of home placement
- ☐ Ongoing family discord
- ☐ Incarcerated parent
- ☐ Parent in the military

Other, specify:

d. Type of bullying (check all that apply)**:**

- ☐ Experienced bullying as victim
- ☐ Participated in bullying as the perpetrator
- ☐ Unknown

15. Medical history:

a. Did the individual have any of the following medical problems?

- ☐ Recent life-changing diagnosis (e.g. cancer, HIV+)
- ☐ Chronic Illness/condition (e.g. back pain, migraines, diabetes)
- ☐ Recent serious injury (i.e. car accident, fall)
- ☐ History of brain trauma/concussion

If yes, please specify and describe how recently it took place:

b. Any currently prescribed medications?

- ☐ Unknown
- ☐ No
- ☐ Yes, specify the medications and who supervised the prescribed medications (e.g. psychiatrist):

c. Did decedent have health insurance?

- ☐ Yes
- ☐ No
- ☐ Unknown

16. Substance Use Disorder history:

a. Did the decedent have any alcohol-related problems?

- ☐ Binge drinking
- ☐ Alcohol use disorder or dependence
- ☐ Driving under the influence
- ☐ Other alcohol-related arrests
- ☐ Unknown

If yes, how recent:

b. Did the decedent use tobacco?

- ☐ Yes
- ☐ No
- ☐ Unknown

c. Did the decedent have a history of drug overdose?

- ☐ Yes
- ☐ No
- ☐ Unknown

d. Any change in alcohol or drug use behavior within 2 weeks of death?

- ☐ Increase
- ☐ Decrease
- ☐ No change
- ☐ Unknown

e. Substance use disorder history (check all that apply):

Non-prescription, illicit, or diverted substances:

- ☐ Cocaine
- ☐ Marijuana
- ☐ Methamphetamine
- ☐ Heroin
- ☐ Prescription opiates (not prescribed to decedent)
- ☐ Hallucinogens
- ☐ Inhalants
- ☐ Unknown

Other, specify:

Prescription drugs:

- ☐ Prescription opiates (only if prescribed to decedent)
- ☐ Benzodiazepines
- ☐ Barbiturates
- ☐ Muscle relaxants
- ☐ Over the counter
- ☐ Steroids
- ☐ Unknown
- ☐ Other, specify:

If yes, how recent:

17. Mental health history:

a. Did the decedent recently express/demonstrate any of the following? (Check all that apply)**:**

- ☐ A desire to die
- ☐ Lack of interest in usual activities
- ☐ Feelings of hopelessness/uselessness
- ☐ Feelings of powerlessness
- ☐ Feelings of failure
- ☐ Feelings of shame, guilt or remorse
- ☐ Changes in eating patterns
- ☐ Change in usual mood
- ☐ Feeling of being a burden to others
- ☐ Feelings of anxiety
- ☐ Running away/disappearing
- ☐ Impulsivity
- ☐ A desire to be free of all problems
- ☐ Feelings of depression
- ☐ Changes in usual sleep patterns
- ☐ Weight gain/loss
- ☐ Rejection by a loved one
- ☐ Loneliness
- ☐ Isolation
- ☐ Self-deprecation
- ☐ Agitation
- ☐ Self-mutilation/cutting

b. Did decedent have a known crisis in the two weeks preceding death?

- ☐ Yes
- ☐ No
- ☐ Unknown

If yes, please describe:

c. Excluding the decedent, any family history of? (Check all that apply)**:**

- ☐ Substance use disorder
- ☐ Depression
- ☐ Suicide gestures/attempts
- ☐ Homicide
- ☐ Suicide
- ☐ Child abuse/neglect
- ☐ Domestic violence
- ☐ Sexual assault
- ☐ Other mental health conditions, specify:

18. Incident/Investigation Narrative:

For a quicker version of the form, we have developed a supplementary two-page form for both adult (p. 142-143) and youth deaths (p.144-145). The two versions are included in the four subsequent pages. These forms eliminate much of the demographic information that may be captured in other forms and can be used as supplementary suicide investigation tools with a regular death investigation form.

Suicide Death Investigation: Adult Form

Incident information:

a. By whom was the body first encountered/discovered?

- ☐ Family member, specify relationship to decedent:
- ☐ Coworker
- ☐ Friend
- ☐ Emergency responder
- ☐ Police Officer
- ☐ Firefighter
- ☐ Stranger
- ☐ Other, specify:

b. Were grief/survivor resources offered to the person(s) in range to intervene or to those who found the body?

- ☐ Yes
- ☐ No
- ☐ Unknown

c. Injury location:

- ☐ Own residence
- ☐ Hospital/Medical facility
- ☐ Natural area (e.g. state park)
- ☐ Park, playground, public area
- ☐ Hotel/Motel
- ☐ Street/Road, sidewalk, alleyway
- ☐ Highway/Freeway
- ☐ School
- ☐ Motor vehicle
- ☐ Industrial/Construction area
- ☐ Parking lot/Public garage
- ☐ Supervised residential facility
- ☐ Other commercial establishment
- ☐ Jail/Correctional facility
- ☐ Other, specify:

d. Was planning or preparation involved in this death?

- ☐ Yes (apparent ritual, preparation, etc.)
- ☐ No (no apparent ritual, preparation, etc.)
- ☐ Unknown

e. Any evidence the incident involved the following (check all that apply):

- ☐ A suicide cluster (multiple suicides that fall within an accelerated time frame and within a defined geographical area)
- ☐ Death-risk game (e.g. Russian Roulette, playing chicken, or choking game)?
- ☐ Suicide pact with another individual?

f. Did the decedent communicate suicidal ideation or threats (e.g. days, weeks, months) **prior to death?**

- ☐ Yes — If yes, describe how was it expressed and to whom was it expressed:
- ☐ No
- ☐ Unknown

g. EMS on scene:

- ☐ Yes
- ☐ No
- ☐ Unknown

h. Was a suicide note found on scene?

- ☐ Yes
- ☐ No
- ☐ Unknown

i. Suicide note format, if applicable:

- ☐ Paper/physical copy
- ☐ On cell phone
- ☐ On personal computer
- ☐ On social media
- ☐ Other, specify:

j. List of prescriptions or substances found on scene:

k. Was there evidence of substance involvement? (check all that apply)

- ☐ No
- ☐ Alcohol
- ☐ Stimulants
- ☐ Depressants
- ☐ Hallucinogens
- ☐ Inhalants
- ☐ Over the counter products
- ☐ Prescription drugs (only if prescribed to decedent)
- ☐ Prescription drugs (not prescribed to decedent)
- ☐ Other

Life stressors:

a. Relationship stressors (check all that apply)**:**

- ☐ Intimate partner problem
- ☐ Family relationship problem
- ☐ Other relationship problem, specify:
- ☐ Recent argument
- ☐ Timing of argument:

b. Additional life stressors (check all that apply)**:**

- ☐ Civil legal problems (e.g., divorce, bankruptcy, eviction)
- ☐ Criminal legal problems (e.g. parole, probation, arrest)
- ☐ Domestic violence
- ☐ Physical health problem
- ☐ Job problem/dissatisfaction
- ☐ Financial problem
- ☐ School problem
- ☐ Lack of housing/homelessness
- ☐ Suicide of friend or family member
- ☐ Non-suicide death of friend or family member
- ☐ Disaster exposure (flood, fire, etc.)
- ☐ Assault/Trauma

Describe:

c. Other important information:

Medical history:

a. Did the individual have any of the following medical problems?

- ☐ Recent life-changing diagnosis (e.g. cancer, HIV+)
- ☐ Chronic Illness/condition (e.g. back pain, migraines, diabetes)
- ☐ Recent serious injury (i.e. car accident, fall)
- ☐ History of brain trauma/concussion

If yes, please specify and describe how recently it took place:

b. Any currently prescribed medications?

- ☐ Unknown
- ☐ No
- ☐ Yes, specify the medications and who supervised the prescribed medications (e.g. psychiatrist):

c. Did decedent have health insurance?

- ☐ Yes
- ☐ No
- ☐ Unknown

Substance Use Disorder history:

a. Did the decedent have any alcohol-related problems?

- ☐ Binge drinking
- ☐ Alcohol use disorder
- ☐ Driving under the influence
- ☐ Other alcohol-related arrests
- ☐ Unknown

If yes, how recent:

b. Did the decedent use tobacco?

- ☐ Yes
- ☐ No
- ☐ Unknown

c. Did the decedent have a history of drug overdose?

- ☐ Yes
- ☐ No
- ☐ Unknown

d. Any change in alcohol or drug use behavior within 2 weeks of death?

- ☐ Increase
- ☐ Decrease
- ☐ No change
- ☐ Unknown

e. Substance use disorder history (check all that apply):

Non-prescription, illicit, or diverted substances:

- ☐ Cocaine
- ☐ Marijuana
- ☐ Methamphetamine
- ☐ Heroin
- ☐ Prescription opiates (not prescribed to decedent)
- ☐ Hallucinogens
- ☐ Inhalants
- ☐ Unknown

Other, specify:

Prescription drugs:

- ☐ Prescription opiates (only if prescribed to decedent)
- ☐ Benzodiazepines
- ☐ Barbiturates
- ☐ Muscle relaxants
- ☐ Over the counter
- ☐ Steroids
- ☐ Unknown
- ☐ Other, specify:

If yes, how recent:

Mental health history:

a. Did the decedent recently express/demonstrate any of the following? (Check all that apply)**:**

- ☐ A desire to die
- ☐ Lack of interest in usual activities
- ☐ Feelings of hopelessness/uselessness
- ☐ Feelings of powerlessness
- ☐ Feelings of failure
- ☐ Feelings of shame, guilt or remorse
- ☐ Changes in eating patterns
- ☐ Change in usual mood
- ☐ Feeling of being a burden to others
- ☐ Feelings of anxiety
- ☐ Running away/disappearing
- ☐ Impulsivity
- ☐ A desire to be free of all problems
- ☐ Feelings of depression
- ☐ Changes in usual sleep patterns
- ☐ Weight gain/loss
- ☐ Rejection by a loved one
- ☐ Loneliness
- ☐ Isolation
- ☐ Self-deprecation
- ☐ Agitation
- ☐ Self-mutilation/cutting

b. Had the decedent been receiving mental health services?

c. Did decedent have a known crisis in the two weeks preceding death?

- ☐ Yes
- ☐ No
- ☐ Unknown

If yes, please describe:

d. Excluding the decedent, any family history of? (Check all that apply)**:**

- ☐ Substance use disorder
- ☐ Depression
- ☐ Suicide gestures /attempts
- ☐ Homicide
- ☐ Suicide
- ☐ Child abuse/neglect
- ☐ Domestic violence
- ☐ Sexual assault
- ☐ Other mental health conditions, specify:

Suicide Death Investigation: Youth Form

Incident information:

a. By whom was the body first encountered/discovered?

- ☐ Family member, specify relationship to decedent:
- ☐ Coworker
- ☐ Friend
- ☐ Emergency responder
- ☐ Police Officer
- ☐ Firefighter
- ☐ Stranger
- ☐ Other, specify:

b. Were grief/survivor resources offered to the person(s) in range to intervene or to those who found the body?

- ☐ Yes
- ☐ No
- ☐ Unknown

c. Injury location:

- ☐ Own residence
- ☐ Hospital/Medical facility
- ☐ Natural area (e.g. state park)
- ☐ Park, playground, public area
- ☐ Hotel/Motel
- ☐ Street/Road, sidewalk, alleyway
- ☐ Highway/Freeway
- ☐ School
- ☐ Motor vehicle
- ☐ Industrial/Construction area
- ☐ Parking lot/Public garage
- ☐ Supervised residential facility
- ☐ Other commercial establishment
- ☐ Jail/Correctional facility
- ☐ Other, specify:

d. Was planning or preparation involved in this death?

- ☐ Yes (apparent ritual, preparation, etc.)
- ☐ No (no apparent ritual, preparation, etc.)
- ☐ Unknown

e. Any evidence the incident involved the following (check all that apply):

- ☐ A suicide cluster (multiple suicides that fall within an accelerated time frame and within a defined geographical area)
- ☐ Death-risk game (e.g. Russian Roulette, playing chicken, or choking game)?
- ☐ Suicide pact with another individual?

f. Did the decedent communicate suicidal ideation or threats (e.g. days, weeks, months) **prior to death?**

- ☐ Yes
- ☐ No
- ☐ Unknown

If yes, describe how was it expressed and to whom was it expressed:

g. EMS on scene:

- ☐ Yes
- ☐ No
- ☐ Unknown

h. Was a suicide note found on scene?

- ☐ Yes
- ☐ No
- ☐ Unknown

i. Suicide note format, if applicable:

- ☐ Paper/physical copy
- ☐ On cell phone
- ☐ On personal computer
- ☐ On social media
- ☐ Other, specify:

j. List of prescriptions or substances found on scene:

k. Was there evidence of substance involvement? (check all that apply)

- ☐ No
- ☐ Alcohol
- ☐ Stimulants
- ☐ Depressants
- ☐ Hallucinogens
- ☐ Inhalants
- ☐ Over the counter products
- ☐ Prescription drugs (if prescribed to decedent)
- ☐ Prescription drugs (not prescribed to decedent)
- ☐ Other

Life stressors:

a. School history (check all that apply)**:**

- ☐ School failure
- ☐ Move/new school
- ☐ Problems with grades
- ☐ Individualized education plan
- ☐ Suspension
- ☐ Expulsion
- ☐ Loss of extracurricular activities

Other serious school problems, specify:

b. Relationship stressors (check all that apply)**:**

- ☐ Argument with significant other
- ☐ Argument with family/relatives
- ☐ Breakup
- ☐ Conflict with peers
- ☐ Argument with friends
- ☐ Rumor mongering (i. e. gossip)
- ☐ Physical abuse/assault
- ☐ Rape/sexual abuse
- ☐ Online community/social media conflict

Other, specify:

c. Family circumstances (check all that apply)**:**

- ☐ Intact family
- ☐ Parents separated
- ☐ Parents divorced
- ☐ Ongoing custody issues
- ☐ Single parent home
- ☐ Foster care or other out of home placement
- ☐ Ongoing family discord
- ☐ Incarcerated parent
- ☐ Parent in the military

Other, specify:

d. Type of bullying (check all that apply)**:**

- ☐ Experienced bullying as victim
- ☐ Participated in bullying as the perpetrator
- ☐ Unknown

e. Type of bullying (check all that apply)**:**

- ☐ Intimate partner problem
- ☐ Family relationship problem
- ☐ Other relationship problem, specify:
- ☐ Recent argument, timing of argument:

f. Additional life stressors (check all that apply)**:**

- ☐ Civil legal problems (e.g., divorce,)
- ☐ Criminal legal problems (e.g. arrest)
- ☐ Domestic violence
- ☐ Physical health problem
- ☐ Job problem/dissatisfaction
- ☐ Financial problem
- ☐ School problem
- ☐ Lack of housing/homelessness
- ☐ Suicide of friend or family member
- ☐ Non-suicide death of friend or family member
- ☐ Disaster exposure (flood, fire, etc.)
- ☐ Assault/Trauma

Describe:

g. Other important information:

Medical history:

a. Did the individual have any of the following medical problems?

- ☐ Recent life-changing diagnosis (e.g. cancer, HIV+)
- ☐ Chronic Illness/condition (e.g. back pain, migraines, diabetes)
- ☐ Recent serious injury (i.e. car accident, fall)
- ☐ History of brain trauma/concussion

If yes, please specify and describe how recently it took place:

b. Any currently prescribed medications?

- ☐ Yes. If so, specify the medications and who supervised the prescribed medications (e.g. psychiatrist):
- ☐ No
- ☐ Unknown

c. Did decedent have health insurance?

- ☐ Yes
- ☐ No
- ☐ Unknown

Substance Use Disorder history:

a. Did the decedent have any alcohol-related problems?

- ☐ Binge drinking
- ☐ Alcohol use disorder
- ☐ Driving under the influence
- ☐ Other alcohol-related arrests
- ☐ Unknown

If yes, how recent:

b. Did the decedent use tobacco?

- ☐ Yes
- ☐ No
- ☐ Unknown

c. Did the decedent have a history of drug overdose?

- ☐ Yes
- ☐ No
- ☐ Unknown

d. Any change in alcohol or drug use behavior within two weeks of death?

- ☐ Increase
- ☐ Decrease
- ☐ No change
- ☐ Unknown

e. Substance use disorder history (check all that apply):

Non-prescription, illicit, or diverted substances:

- ☐ Cocaine
- ☐ Marijuana
- ☐ Methamphetamine
- ☐ Heroin
- ☐ Prescription opiates (not prescribed to decedent)
- ☐ Hallucinogens
- ☐ Inhalants
- ☐ Unknown
- ☐ Other, specify:

Prescription drugs:

- ☐ Prescription opiates (only if prescribed to decedent)
- ☐ Benzodiazepines
- ☐ Barbiturates
- ☐ Muscle relaxants
- ☐ Over the counter
- ☐ Steroids
- ☐ Unknown
- ☐ Other, specify:

If yes to any on the left, how recent:

Mental health history:

a. Did the decedent recently express/demonstrate any of the following? (Check all that apply)**:**

- ☐ A desire to die
- ☐ Lack of interest in usual activities
- ☐ Feelings of hopelessness/uselessness
- ☐ Feelings of powerlessness
- ☐ Feelings of failure
- ☐ Feelings of shame, guilt or remorse
- ☐ Changes in eating patterns
- ☐ Change in usual mood
- ☐ Feeling of being a burden to others
- ☐ Feelings of anxiety
- ☐ Running away/disappearing
- ☐ Impulsivity
- ☐ A desire to be free of all problems
- ☐ Feelings of depression
- ☐ Changes in usual sleep patterns
- ☐ Weight gain/loss
- ☐ Rejection by a loved one
- ☐ Loneliness
- ☐ Isolation
- ☐ Self-deprecation
- ☐ Agitation
- ☐ Self-mutilation/cutting

b. Had the decedent been receiving mental health services?

c. Excluding the decedent, any family history of? (Check all that apply)**:**

- ☐ Substance use disorder
- ☐ Depression
- ☐ Suicide gestures /attempts
- ☐ Homicide
- ☐ Suicide
- ☐ Child abuse/neglect
- ☐ Domestic violence
- ☐ Sexual assault
- ☐ Other mental health conditions, specify:

SUICIDE INVESTIGATION SAMPLE FORMS

The next four pages are death investigation-related forms shared with permission from the Marion County Coroner's Office. These serve as examples of current forms being utilized in Indiana.

DEATH INVESTIGATIVE WORKSHEET FOR EXAMINATION

Date: Investigator Name/Agency:	Request Type: ☐Full Autopsy ☐External Exam Investigation Agency Case #:
DECEDENT INFORMATION	
Decedent's Full Name:	Sex: ☐ Male ☐ Female
Date of Death (mm-dd-yyyy):	Time Pronounced:
Date of Birth: Age:	SSN:
Residential Address:	City/State/Zip:
Decedent's Race: ☐White ☐Black ☐Hispanic ☐Asian ☐Other (Specify):	
How was identification made?:	Decedent on Active Military Duty? ☐Yes ☐No
Decedent's Usual Occupation:	Last Seen Alive:
Decedent's Education: ☐Elementary/Secondary ☐College ☐Graduate School ☐ N/A	
Place of Death: ☐Inpatient ☐ER/Outpatient ☐Nursing Home ☐Residence ☐Other (Specify): Location Name/Address:	
Degree of Rigor: ☐None ☐Full body ☐Undeterminable	Position Body Found:
Livor Location: ☐None ☐Anterior ☐Posterior ☐Lower Extremities ☐Undeterminable	
CASE DESCRIPTION	
Criteria for Case: ☐ Unknown ☐ Apparent Natural ☐ Accident ☐ Suicide ☐ Homicide	
Is Motor Vehicle Collision Involved? ☐Yes ☐ No. If Yes, Decedent's Position: ☐ Driver ☐Passenger Another Vehicle Involved? ☐ Yes ☐ No Was Decedent Restrained? ☐Yes ☐ No	
Are Criminal Charges Anticipated? ☐Yes ☐ No. If Yes, Why?	
Weapon Involved? ☐Yes ☐No If Yes, Weapon Types:	
Injury Information:	

This was adapted from the Marion County Coroner's Office's "Death Investigative Worksheet for Examination" which can be found https://citybase-cms-prod.s3.amazonaws.com/6e96a3bfd7db414db8ff1de6edc4a3d1.pdf This was also adapted from the "Form for Reporting Deaths to the Coroner's Office" which can be found https://citybase-cms-prod.s3.amazonaws.com/7c9d84a5c9b54ca9a1412a44101a6611.pdf.

Circumstances of Death/Terminal Episode:
Scene Examination/Physical Examination (including body temperature):
Personal Property/Clothing:
Past Medical History [Including Social/Psychiatric/Surgical/Family/Drug-Rx/Illegal/ETOH History]:

Name of Medication	Prescribing Doctor	Dosage	Date Filled/Amount	Amount Remaining

NEXT OF KIN

NOK Name:	NOK Relationship:
NOK Address/Phone:	NOK Notified of Death? ☐ Yes ☐ No
Informant's Name and Relationship:	

MISCELLANOUS

Will agency have someone present during Autopsy ☐Yes ☐No and for taking photos? ☐Yes ☐No

If Yes, Enter Name(s)/Agency/Phone Number:

☐ By checking this box, I certify that the above information has been completed to the best of my knowledge and ability

SUMMARY OF CASE / ADDITONAL COMMENTS

Marion County Coroner's Office

521 W McCarty St, Indianapolis, IN 46225
Tel: (317) 327-4744; Fax: (317) 327-4563
After Hours Tel: 317-202-7373

FORM FOR REPORTING DEATHS TO THE CORONER'S OFFICE
PLEASE SPEAK TO A DEPUTY CORONER AND FAX THIS FORM TO THE OFFICE
[Please Print]

TODAY'S DATE:	**TIME:**	**DEPUTY CORONER:**
FACILITY REQUESTING ASSISTANCE:		**PHONE #:**
PERSON REQUESTING ASSISTANCE:		**PHONE #:**

DECEDENT INFORMATION

SUBJECT'S NAME:	**DOB:**	**SEX:**
STREET ADDRESS:	**AGE:**	**RACE:**
CITY:	**STATE:**	**ZIP CODE:**
MARITAL STATUS:		**SSN:**
NEAREST RELATIVE:	**RELATIONSHIP:**	**PHONE #:**
NOTIFIED?: YES / NO	**IF YES, BY WHOM:**	**TIME:**

COMMENTS OR CIRCUMSTANCES THAT RESULTED IN DEATH (E.G. MEDICAL HISTORY)

_____

_____

_____

_____

THE INFORMATION BELOW IS VITAL AND MUST BE COMPLETED

DATE OF DEATH:	**TIME OF DEATH:**	**PRONOUNCED BY:**
LOCATION OF DEATH:		
PRESUMPTIVE CAUSE OF DEATH:		
PHYSICIAN SIGNING DEATH CERTIFICATE:		
PHYSICIAN OFFICE PHONE NUMBER:		

What do I do next when a loved one dies?

Life as you know it has changed forever. You may feel numb and lost, not knowing where to turn. Experiencing a range of emotions is common: fear, anger, relief, abandonment, guilt, shame, and perhaps even responsibility for your loved one's death. These can change rapidly, and family members may have different reactions at different times which sometimes can lead to conflict.

Know that others have walked this difficult path before you. Reach out to those who have survived a suicide loss. Move forward step by step at your own pace and do not allow anyone to rush or criticize your grieving process. YOU ARE NOT ALONE. There are many ways to connect to others—staying in contact with others can help you through your grief.

As a part of this process, you will be working with the Coroner's Office. This brochure is meant to be used as a guide to learn more about this process. Again, you are not alone.

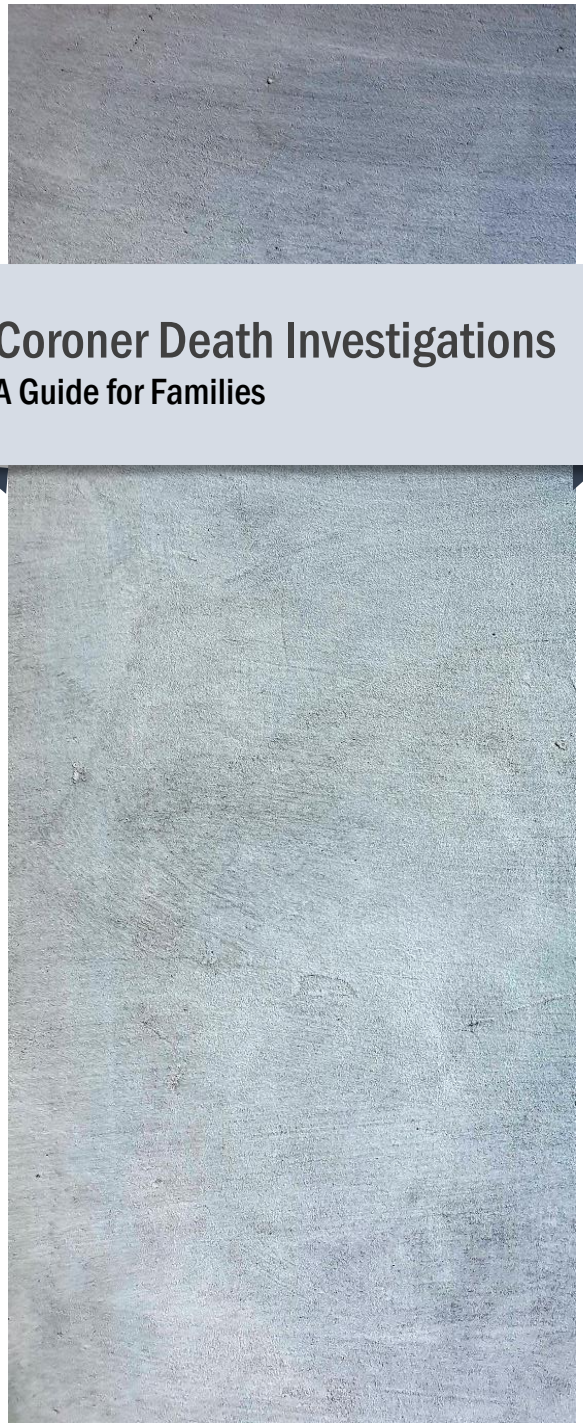
Indiana Department of Health

Further Information

This guide was developed as a part of the Suicide Learning Collaborative Toolkit. To find out more about suicide prevention in Indiana and nationally, please visit:

In.gov/issp
In.gov/isdh/21838.htm
Indianasuicideprevention.org
afsp.org
sprc.org

The information in this pamphlet was largely adapted from The Marion County Coroner's Office. This document can be originally found here: https://www.indy.gov/activity/death-investigations There was also information added from a brochure from the Jefferson County Coroner's Office. The original document can be found here: https://www.jccal.org/Sites/Jefferson_County/Documents/Coroner_Medical%20Examiner%20Office/Family%20Information%20brochure%205-28-20.pdf



Coroner Death Investigations

A Guide for Families

Coroner Information

The Coroner's office is contacted in the following situations. The Coroner will then determine whether to investigate.

- Sudden death of a healthy child
- Death occurring within 24 hours of admission at a hospital or health care facility
- Physician unable to state cause of death, after careful review of medical chart, or deceased had no physician
- Known or suspected homicide
- Known or suspected suicide
- Related to or following known suspected self-induced or criminal abortion
- Following an accident or injury primary or contributory, either old or recent
- Drowning, fire, exposure, acute alcoholism, substance use disorder, strangulation, aspiration, or malnutrition
- Accidental poisoning (food, chemical, drug, therapeutic agents)
- Occupational disease or occupational hazards
- Known or suspected contagious disease constituting a public hazard, excluding AIDS
- All deaths where patient is under anesthetic
- Incarceration
- All deaths of unidentified persons

Investigation types

Investigation types fall into the following categories below.

- Autopsy: Autopsy performed by a forensic pathologist
- External: Body taken into custody; only external examination performed
- SOS: Body released at scene to next of kin
- Consults: The office is notified of death, but case is declined due to not fitting Coroner's investigation criteria

Death investigation process

Death scene investigation by the Deputy Coroner

During the death scene investigation, the Coroner gathers scene information, takes photographs, and arranges for the removal of the body. The family should contact the funeral home at their earliest convenience. The funeral home begins the death certificate process.

Post-mortem examination

A certified forensic pathologist does the post-mortem physical exam. The forensic pathologist also does an autopsy, if needed. Body fluids/tissues may be sent for lab analysis such as toxicology and histology. The body is made available for pickup by the funeral home after the exam. Then the forensic pathologist will complete a comprehensive pathology report identifying the cause and manner of death.

Death certification

The Coroner's Office reviews the results of the exam. The Coroner's Office certifies the cause and manner of death in the death certificate. Contact the Coroner's Office with any questions.

Autopsies

Autopsies are performed mainly to determine the medical cause of death and to gather evidence for court. The Coroner typically will not perform an autopsy if the manner of death is "natural" and the cause of death can be determined by past medical history or an external exam.

Funeral arrangements

Contact a funeral director to arrange a funeral for your loved one. A funeral director will coordinate further arrangements with the Forensic Pathology Department and help you prepare for the funeral. You may visit a loved one only at the funeral home, not at the Forensic Pathology Department because of legal and health reasons.

Contact us:

_____ County Coroner's Office

_____

_____

_____

Hours: _____

Address: _____

Family

Introduction

Suicide deaths have been increasing gradually for Hoosier youth ages 19 and younger. In 2018, 83 youth died by suicide, this represents an increase from 71 deaths in 2017 and 57 deaths in 2016.[15] It is evident that suicide prevention strategies would be well utilized in the hands of youth workers, coaches, and youth. Youth services, for the purpose of this document, serve to support schools, afterschool activities, out-of-school programs, parents, guardians, and youth.

As far as the intersection between Hoosier youth and suicide:

- Youth are most likely to attempt a suicide between 5-7pm on weekdays.[16]
- The highest rate of suicide attempts is between the ages of 14 and 17.[16]
- 19.8% percent of Hoosier youth have seriously considered attempting suicide at some point in the past year.[15]

This section of the toolkit is to provide both youth and parents needed suicide prevention resources. The beginning portion is for parents, the pocket cards are for both, and the ending portion is for youth.

Family Resources:

- Parent Guide on Suicide and Social Media
- Dos and Don'ts when Talking to Your Child about Suicide
- Shared Risk and Protective Factors Guide
- After an Attempt: What Family Members Need to Know
- After a Suicide Loss: What Family Members Need to Know
    - *Also included in the First Responders and Healthcare sections of the toolkit
- Pocket Cards: "Facts" of Suicide Awareness
- Pocket Cards: Having a Conversation Around Suicide
- How to Talk to a Friend who is Struggling with Suicide
- If You or a Friend Has Lost Someone to Suicide….
- No Need to Be an Expert, Just Be a Friend
- Suicide Resources: Youth, Caregivers, and Mentors (p. 216-217)

PARENT GUIDE ON SUICIDE AND SOCIAL MEDIA

Mental health, non-suicidal self-harm, and suicide themes on social media continue to be an issue both youth and adults face on a daily basis. Experts recognize that youth engagement with social media includes positive and negative aspects and our goal is to help maximize the benefits while reducing any potential harms. For adults who interact with youth, the following tips can be helpful to keep in mind:

Find out what is going on

As parents often do not use the same social media platforms as youth, it can be helpful to educate themselves. It is important to keep the following questions in mind:

1. What are the current trends in social media?
2. How many accounts does the youth/child have? Which sites/apps?
3. Which are for talking to friends and which are just for fun?

Monitor the child's usage

When a parent or caregiver is monitoring the child's usage, be sure to keep this in line with developmental level and mental health status.

1. Be aware of violent and self-harm images that youth come into contact with (some children are going to be more vulnerable than others)
2. Ask youth/child about their digital lives: how it affects them and what is their experience. Be sure to ask about both positive and negative experiences. Ask them questions like "what's your favorite thing about social media?" and "what's the worst thing about social media?"

Control and limit the usage on social media

If you determine that it would be in the child's best interest to curtail their social media use, there are several different avenues which parents and caregivers can pursue.

1. Carriers: Major cell phone carriers can limit the time on specific apps.
2. Hardware: Many options available for limiting Wi-fi on certain devices.
3. Internet filter: most browsers/apps allow for restrictive access based on age.

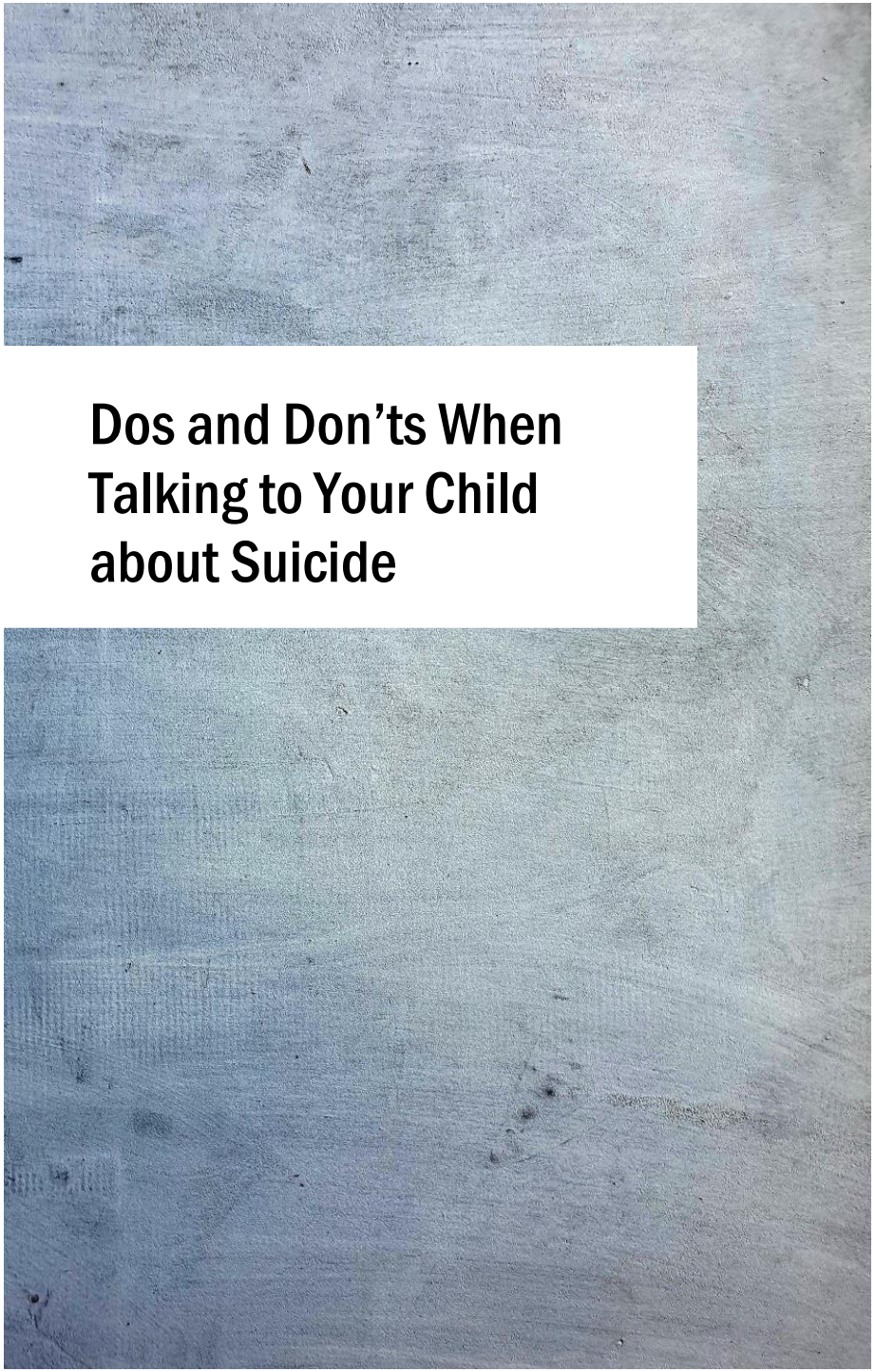
This plan has been developed using information from "Suicide and Social Media" from Suicidology at https://suicidology.org/wp-content/uploads/2019/07/SUICIDE-SOCIAL-MEDIA.pdf

Further Information

This guide was developed as a part of the Suicide Learning Collaborative Toolkit. To find out more about suicide prevention in Indiana and nationally, please visit:

In.gov/issp
In.gov/isdh/21838.htm
Indianasuicideprevention.org
afsp.org
sprc.org

This plan has been developed using information from "How to Help a Child with Suicidal Thoughts" by Rise and Shine. This can originally be found here: https://riseandshine.childrensnational.org/how-to-help-a-



Dos and Don'ts When Talking to Your Child about Suicide

DO stay calm. This helps your child see that you are not upset at them and that they are not in trouble. It is good to be aware of this when it comes to potential triggers.

DO be direct. Ask them, "Are you thinking of suicide?" Being able to openly discuss these thoughts and feelings is critical.

DO reassure. Let your child know that there is help and that this feeling will not last forever. Ask your child what you can do for them during moments of distress, whether it is sitting with them, giving them a hug, or doing a shared activity together. Talk with other siblings in the house to help them understand what is going on.

DO remove means for self-harm. Work to keep the home environment safe by removing unsafe items such as weapons, sharp objects, medications, belts, ropes, and cords. If these items cannot be removed, having a safe place where they are locked is an alternative option.

DO connect the child to resources. Ensure that they know the National Suicide Prevention Lifeline (1-800-273-8255 [TALK]) or the text line (Text "IN" to 741-741). Create a safety plan together in the event of suicidal ideation.

DON'T judge. Create a safe space for your child and show them that that talking about suicide and safety are things they can do with you. The thoughts and feelings they are experiencing reflect the pain they are experiencing. As a parent, you can show empathy and validation, which will help your child feel heard and increase their comfort talking about these difficult feelings.

DON'T leave them alone. If your child is expressing thoughts of harming themselves, do not leave them on their own. Encourage your child to keep the bedroom door open and monitor them regularly.

Risk Factors

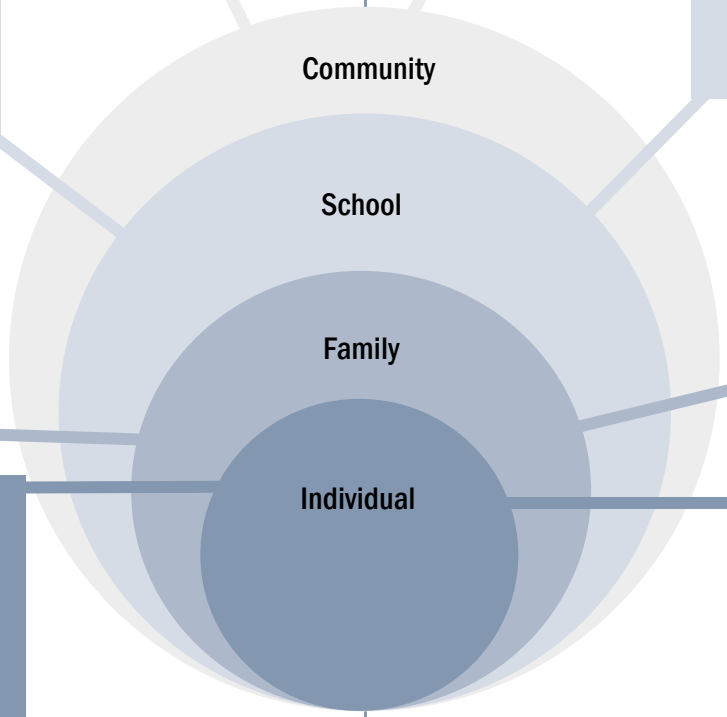
Characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes.

- Low community attachment and organization
- Community/personal transitions and mobility
- Laws and norms favorable to drug use
- Perceived availability of drugs
- Economic disadvantage

- Academic failure or low academic achievement
- Low commitment to school
- Bullying

- Poor family management and discipline
- Family conflict
- Family history of antisocial behavior
- Favorable parental attitudes toward problem behavior

- Rebelliousness
- Early initiation of problem behavior ; impulsiveness
- Antisocial behavior
- Favorable attitudes toward problem behavior
- Interaction with friends involved in problem behavior
- Sensation seeking
- Rewards for antisocial involvement



Protective Factors

Characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact.

- Opportunities for prosocial involvement in the community
- Recognition of prosocial involvement
- Exposure to evidence-based programs and strategies

- Opportunities for prosocial involvement in school
- Recognition of prosocial involvement

- Attachment and bonding to family
- Opportunities for prosocial involvement in family
- Recognition of prosocial involvement

- Social skills
- Belief in moral order
- Emotional control
- Interaction with prosocial peers

This plan has been developed using information from Montgomery County Alcohol Drug Addiction and Mental Health Services document, "Utilizing the Entire Spectrum of Prevention Strategies," which can be found here: https://csw.osu.edu/wp-content/uploads/2019/03/Hoff-Andrea-Handouts.pdf

Indiana Department of Health

AFTER AN ATTEMPT: What Family Members Need to Know

Suicide is a traumatic experience for both the individual who attempted and the family. As the family member, you may feel numb and lost, not knowing where to turn. Experiencing a range of emotions is completely normal. When it comes time for that individual to come home, it can be good to start thinking about safety. Research shows that when an individual has a previous attempted, they do have higher risk of later dying by suicide. As a family member, you can help your loved by reducing risk.

Reduce the Risk at Home—To help reduce the risk of self-harm or suicide at home, here are some things to consider:

- Guns are high risk and the leading means of death for individuals experiencing suicidal ideation —they should be taken out of the home and secured.
- Overdoses are common and can be lethal—if it is necessary to keep pain relievers such as aspirin, Advil, and Tylenol in the home, only keep small quantities or consider keeping medications in a locked container. Remove unused or expired medicine from the home.
- Alcohol use or abuse can decrease inhibitions and cause people to act more freely on their feelings. As with pain relievers, keep only small quantities of alcohol in the home, or none at all.

Create a Safety Plan—Following a suicide attempt, a safety plan should be created to help prevent another attempt. The plan should be a joint effort between your relative and his or her doctor, therapist, or the emergency department staff, and you. As a family member, you should know your relative's safety plan and understand your role in it, including:

- Knowing your family member's "triggers," such as an anniversary of a loss, alcohol, or stress from relationships.
- Building supports for your family member with mental health professionals, family, friends, and community resources.
- Working with your family member's strengths to promote his or her safety.
- Promoting communication and honesty in your relationship with your family member.

Remember that safety cannot be guaranteed by anyone—the goal is to reduce the risks and build supports for everyone in the family. However, it is important for you to believe that the safety plan can help keep your relative safe. If you do not feel that it can, let the emergency department staff know before you leave.

Maintain Hope and Self-Care—Families commonly provide a safety net and a vision of hope for their relative experiencing suicidal ideation, and that can be emotionally exhausting. Never try to handle this situation alone—get support from friends, relatives, and organizations such as the National Alliance on Mental Illness (NAMI), and get professional input whenever possible. Use the resources on the back pages of this brochure, the Internet, family, and friends to help create a support network. You are not alone.

This was adapted from "After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department." This can be found here: https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4357eng.pdf. The graphics are from Noun Project (Check Mark by P.J. Onori, US)

Indiana Department of Health

AFTER A SUICIDE LOSS: What Family Members Need to Know

Life as you know it has changed forever. You may feel numb and lost, not knowing where to turn. Experiencing a range of emotions is common: fear, anger, relief, abandonment, guilt, shame, and perhaps even responsibility for your loved one's death. These can change rapidly, and family members may have different reactions at different times which sometimes can lead to conflict.

Know that others have walked this difficult path before you. Reach out to those who have survived a suicide loss. Move forward step by step at your own pace and do not allow anyone to rush or criticize your grieving process. YOU ARE NOT ALONE. There are many ways to connect to others—staying in contact with others can help you through your grief.

Reach out for support:

- Attend a support group for suicide loss survivors (in person or online)
- Talk to a professional grief counselor
- Seek a licensed mental health provider, if needed
- Talk with those you trust (family, friends, faith leader, neighbors) to share your loss and pain
- Continue to ask the "why?" questions as long as you need to

Grieving can take over your life, so taking care of yourself is important:

- Try to get plenty of sleep, rest, and be gentle with yourself
- Eat healthy food and drink water
- Keep yourself busy by doing something you enjoy
- Continue your exercise routine

When a loved one passes away, it can be a very difficult time. Trying to remember all of the details that must be taken care of related to a person's death is hard. In the next few pages, there are a list of items marked as things to do immediately, within a few days, and within a few weeks.

This was adapted from "Health & Hope: For Survivors of Suicide Loss." This can be found here: http://www.sprc.org/sites/default/files/resource-program/Help-and-Hope-For-Survivors-of-Suicide-Loss.pdf. This was also adapted from Ever Loved's "What to Do When Someone Dies: A Checklist," which can be found here: https://everloved.com/articles/end-of-life-affairs/what-to-do-when-someone-dies-checklist/

What to do immediately

19. **Get a death certificate.** If your loved one died in a hospital, a doctor can take care of this for you. However, if your loved one passed at home or in another location, you'll need to know who to call. If your family member wasn't at a hospital, call 911.

20. **Arrange for organ donation, if applicable.** Check your loved one's driver's license and/or advance directive (living will or health care proxy) to see if he or she was an organ donor. If so, let hospital staff know immediately (or call a nearby hospital if your loved one died at home).

21. **Contact immediate family.** Every family is different, and there's no one right way to do this. For some families, sharing the news in-person or over the phone is critical. For others an email or text message may be alright.

22. **Enlist help from family and friends.** There are a number of ways family and friends can help you, such as: answering the phone; collecting mail; caring for pets; finding important items (such as keys, insurance policies, claims forms, addresses for magazine subscriptions, etc.); staying at the home during the wake, funeral, and/or memorial services to guard against break-ins; organizing food for family and friends after the services.

23. **Notify the individual's religious leader, if applicable.** Contact the deceased's Pastor, Rabbi, Priest or other religious leader if there is one. He or she can help with counseling for surviving family and friends. They can also help you make funeral arrangements or services.

24. **Decide what you'd like to do with your loved one's body and arrange transportation.** First, check to see if your loved one expressed any wishes about final disposition or had made prepayments to a funeral home or cemetery. Ideally, there will be documentation with other medical documents. If no wishes or plans have been stated, you have three main options:
    - *Call a funeral home.* A funeral home can help you arrange either a burial or cremation. Check reviews and prices for a few different funeral homes before making a decision.
    - *Call a crematory.* While you can arrange a cremation through a funeral home, there are also crematories that will work with you directly if you aren't interested in the added services of a funeral director.
    - *Call a full-body donation organization.* Your loved one may have already registered to be a body donor, so check for paperwork. If he or she hasn't, there are still many programs that accept donations from next of kin.

25. **Arrange care for any pets or dependents.** If your loved one was responsible for caring for one or more people or pets, quickly find someone who can care for them temporarily.

26. **Secure major property.** If your loved one lived on their own, make sure his or her home and any vehicles are locked up. If it will sit vacant for some time, consider notifying the landlord and/or the police, so they can help to keep an eye on it.

27. **Notify the person's employer.** If the deceased was employed (or actively volunteering), call to let them know that your loved one has passed away. This is also a good time to ask about pay owed, benefits and life insurance.

What to do within a few days

17. **Decide on funeral plans.** If you decided to work with a funeral home, meet with the funeral director to go through your options. If you opted for an immediate burial (burial without any ceremonies), cremation or donation to science, you may also choose to hold a memorial service or celebration of life at a later date.

18. **Order a casket or urn.** You may choose to purchase a casket or urn directly through the funeral home. However, you can often find caskets online for hundreds (even thousands) of dollars less, and some websites even offer free overnight delivery.

19. **For a veteran, ask about special arrangements.** A range of benefits can help tailor a veteran's service. You may be able to get assistance with the funeral, burial plot or other benefits. You can find many details about options as well as potential survivor benefits at the U.S. Department of Veterans Affairs website.

20. **Consider whether you need or want other financial assistance for the funeral and burial.** Help might be available from a number of sources, including a church, a union or a fraternal organization that the deceased belonged to.

21. **Ask the post office to forward mail.** If the person lived alone, this will prevent mail from piling up and showing that no one is living in the home. The mail may also help you identify bills that need to be paid and accounts that should be closed. You'll need to file a request at the post office, show proof that you are an appointed executor, and authorized to manage his/her mail.

22. **Perform a check of the person's home.** Throw out any food that will expire, water plants, and look for anything else that may need regular care.

23. **Update the utilities.** Tell local utilities (telephone, gas, electricity, cable) about the death, only if someone else wants to be put on the accounts. Otherwise wait until you decide whether or not and when the utilities are to be turned off.

24. **Prepare an obituary.** The funeral home might offer the service, or you might want to write an obituary yourself. If you want to publish it in a newspaper, check on rates, deadlines and submission guidelines.

What to do within a few weeks

43. **Order a headstone.** Since headstones are rarely ready in time for a burial, you can save this until after the funeral when you have some more time. You can order a headstone through the cemetery, but you'll have more options (and often lower prices) if you look online.

44. **Order several copies of the death certificate.** You will likely need anywhere between 5 and 10 copies (but possibly more), depending on the accounts that your loved one had open. Your funeral director may be able to help you order them, or you can order them yourself from city hall or another local records office. Your certified copies should say display an official seal and say, *"This is an exact copy of the death certificate received for filing in_____ County*."

45. **Start the probate process with the will.** If the estate is relatively small, doesn't contain unusual assets and isn't likely to be disputed by family members you may be able to handle it yourself.

46. **Contact the Social Security office.** Your funeral director may have already done this, so find out if this is the case. If you need to contact social security yourself, you can reach them by phone at 1-800-772-1213. Through Social Security you may be able to apply for survivor benefits.

47. **Handle Medicare.** If your loved one received Medicare, Social Security will inform the program of the death. If the deceased had been enrolled in Medicare Prescription Drug Coverage (Part D), Medicare Advantage plan or had a Medigap policy, contact these plans at the phone numbers provided on each plan membership card to cancel the insurance.

48. **Notify any banks or mortgage companies.** If you're unsure of what accounts your loved one held, use their mail and any online accounts you have access to in order to identify what accounts may be open. Then, take copies of the death certificate to each bank and change ownership of the accounts.

49. **Reach out to any financial advisors or brokers.** Try to identify any additional financial and investment accounts that your loved one held. Work with each one to transfer ownership. You'll likely need a death certificate for each account.

50. **Contact a tax accountant.** You'll need to file a return for both the individual and the estate.

51. **Notify life insurance companies.** Fill out the claim form for any life insurance policies that the deceased had. Also, suggest that friends and family who may have listed your loved one on their own life insurance policies update theirs.

52. **Cancel insurance policies.** This could include health insurance, car insurance, homeowner's insurance or anything else. Depending on the policy, reach out to either the insurance company or your loved one's employer to stop coverage.

53. **Determine any employment benefits.** If your loved one was working at the time of their death, contact their employer to find out about union death benefits, pension plans and credit unions.

54. **Identify and pay important bills.** Make a list of bills that are likely to be due (e.g. mortgage, car payments, electricity), tracking them down via the person's mail and online accounts.

55. **Close credit card accounts.** Leverage your loved one's mail, wallet and any online accounts you have access to in order to identify open credit card accounts. For each one, you'll likely need to call customer service and then email or mail a copy of the death certificate.

56. **Notify credit reporting agencies.** Provide copies of the death certificate to Experian, Equifax and TransUnion in order to reduce the chances of identity theft. It's also a good idea to check your loved one's credit history in another month to confirm that no new accounts have been opened.

57. **Creditors.** Letters should be sent to all creditors informing them of the person's death. If any life insurance coverage can pay off the balances, a copy of the death certificate will be needed. Do not tell any of them you will be paying the balances with your own money. The estate needs to pay these, not family members, no matter what the creditors tell you. If nothing is left in the estate to pay off debts, then tell the creditors this.

58. **Contact a tax preparer.** A return will need to be filed for the individual, as well as for an estate return. Keep monthly bank statements on all individual and joint accounts that show the account balance on the day of death.

59. **Cancel the person's driver's license.** Go online or call your state's DMV for instructions, having a copy of the death certificate ready. Additionally, notify the local election board. This will help to prevent identity theft and voter fraud.

60. **Memorialize your loved one's Facebook account.** If your loved one was on Facebook, you can memorialize their account. This will let current friends continue to post and share memories but will keep anyone from logging into it in the future.

61. **Close email accounts.** Once you feel confident that you have necessary information on other accounts, it's a good idea to permanently close your loved one's email accounts as an additional step to prevent fraud and identity theft.

62. **Dispose of Personal Items and Clothing.** It is hard, but as soon as possible, you should try to dispose items which will no longer be used by the survivors. Everyone does this at a different time. Ask for help with this, if you need it. No items should be moved, sold, or given away if they have been identified in the person's will to be given out to survivors.

63. **Find Important Documents.** There are some documents that may be needed or at least helpful in settling the estate of the deceased. Documents might include: *safe deposit rental agreement and keys; trust agreements; nuptial agreements/marriage licenses/prenuptial agreements/divorce papers; life insurance policies or statements; pension, IRA, retirement statements; income tax returns for the past three years/W-2 form; loan and installment payment books and contracts; gift tax returns; birth and death certificates; social security card; military records and discharge papers; budgets; bank statements, checkbooks, check registers, certificates of deposits; deeds, deeds of trust, mortgages and mortgage releases, title policies, leases; motor vehicle titles and registration papers; stock and bond certificates and account statements; unpaid bills; health/accident and sickness policies; bankruptcy papers.*

POCKET CARDS: "FACTS" OF SUICIDE AWARENESS

If an individual is concerned that someone they know may be at risk for suicide, the first step in helping may be as simple as learning the FACTS or warning signs. The following signs may mean that a youth is at risk for suicide, particularly if that person has attempted suicide in the past.

(front of card)

FEELINGS – Expressing hopelessness about the future.

ACTIONS – Displaying severe/overwhelming pain or distress.

CHANGES – Showing worrisome behavioral cues or marked changes in behavior, including withdrawal from friends or changes in social activities; anger or hostility; or changes in sleep.

THREATS – Talking about, writing about, or making plan for suicide.

SITUATIONS – Experiencing stressful situations including those that involve loss, change, create personal humiliation, or involve getting into trouble at home, in school or with the law. These kinds of situations can serve as triggers for suicide.

(back of card)

You are not alone.

National Resources

National Suicide Prevention Hotline:
- Call 1-800-273-8255
- Text "IN" to 741741

Veterans Crisis Line
- Call (800)273-TALK (8255)
- Text anything to 838255

Trevor Project (LGBTQ+ youth line)
- Call (866)488-7386
- Text "TREVOR" to (202)304-1200

Trans Lifeline
- Call (877)565-8860

Crisis Line for Individuals Deaf and Hard of Hearing
- Call (800) 273-8255, video relay service or voice/caption phone
- Call (800)799-4889, TTY

Ayuda En Español
- Llama al número (888)628-9454

National Teen Dating Abuse Helpline
- Call (866)331-9474

RAINN National Sexual Assault Hotline
- Call (800)656-HOPE (4673)

This plan has been developed using information from the "FACTS" document, found here: http://www.sptsusa.org/wp-content/uploads/2015/05/FACTS-Green.pdf

Indiana Department of Health

POCKET CARDS: HAVING A CONVERSATION AROUND SUICIDE

When talking with someone about suicide, Mental Health First Aid Recommends following "ALGEE" or the assess, listen, give, encourage, and encourage model. A pocket card template is available below.

(front of card)

ASSESS for risk of suicide or harm.

LISTEN non-judgmentally.

GIVE re-assurance and information.

ENCOURAGE appropriate professional help.

ENCOURAGE self-help and other support strategies.

(back of card)

You are not alone.

National Resources

National Suicide Prevention Hotline:
- Call 1-800-273-8255
- Text "IN" to 741741

Veterans Crisis Line
- Call (800)273-TALK (8255)
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RAINN National Sexual Assault Hotline
- Call (800)656-HOPE (4673)

This plan has been developed using information from Mental Health First Aid's "ALGEE: The Action Plan," which can be found here: https://www.mentalhealthfirstaid.org/external/2017/09/algee-action-helping-friend-need/.

Indiana Department of Health

How to Talk with a Friend Who is Struggling with Suicide

You're not an expert, so you can be a friend. Here are some tips for how to talk with a friend about suicide.

What to say

"I know you're going through some stuff; I'm here for you."

"Is there anything you want to talk about?"

"Seem like something's up. Do you want to talk about what's going on?"

"There are people who can help you work through what you're feeling. Let's get you some help."

How to act

Keep it casual. Relax and think of it as a chill chat.

Let your friend take the lead. You can listen most of the time. No need for advice.

You can let them know it is okay to feel what they're feeling.

Be available and ask open-ended questions (more than "yes" or "no" answers)

- No need for pressure or judgement.
- Let them open up at their own speed

Encourage your friend to talk to an expert.

After the 1st conversation

Don't give up, be available even if they reject you. Keep inviting them to stuff

Keep gossiping out of this. Your friend needs trust and care.

They may ask you not to talk to anyone, but if your friend's life is in danger you need to reach out to a trusted adult.

Places your friend can get help

For non-emergencies there are many free and professional ways to get 24/7 help:

- National Suicide Hotline: Call 1-800-273-8255, Text "IN" to 741741
- Trevor Project (LGBTQ+ youth): Call (866)488-7386, Text "TREVOR" to (202)304-1200
- Trans Lifeline: Call (877)565-8860

For urgent help:

- Call 911
- Take your friend to the emergency room.

This plan has been developed using information from "When a Friend Dies By Suicide" by *Society for the Prevention of Teen Suicide.* A copy of this information and more can be found here: https://sptsusa.org/teens/when-a-friend-dies-by-suicide/ . And information from the website *Seize the Awkward* which can be found at https://seizetheawkward.org/home#what-is-seize-the-awkward

Indiana Department of Health

If you or a friend has lost someone to suicide....

- It can be really hard to feel and understand. Many people feel those emotions. You are not alone. You are not responsible. No matter what.
- It can take a long time for the shock to wear off and for the new reality to stick
- Talk to friends about. You all are going through something similar and can help one another. You can also reach out to an adult to talk about. It is okay to be slow to talk.
- Talking can be simple, “Wow, I am blown away by this.” It could be a heart-to-heart.
- If you start thinking about suicide, then talk to a trusted adult about it.
- Run memorial ideas by a trusted adult. Sometimes it can actually encourage others to go forward with a suicide.

It will get better. You will learn a lot from your healing, and it could help you save a life.

This plan has been developed using information from “When a Friend Dies By Suicide” by *Society for the Prevention of Teen Suicide.* A copy of this information and more can be found here: https://sptsusa.org/teens/when-a-friend-dies-by-suicide/ . And information from the website *Seize the Awkward* which can be found at https://seizetheawkward.org/home#what-is-seize-the-awkward

Indiana Department of Health

NO NEED TO BE AN EXPERT. JUST BE A FRIEND.

It's hard to know what to say to someone who is struggling with depression, anxiety or other mental health issues. Here are a few phrases that you can use when talking with a friend.

Ask open-ended questions. Help them to talk, not just say "yes" or "no".

Keep it causal. Relax: think of it as a chill chat, not a therapy session.

Let them open up at their own speed.

Make yourself available. Be the friend they can rely on.

Avoid offering advice or trying to fix their problems.

Listen up. Let them take the lead.

Don't demand answers or force them to say anything they're not ready to.

Tell them you won't ever judge them.

Let them know that this won't change how you feel about them.

Let them know it's OK to feel the way they do.

Ask them if they have seen a doctor.

Encourage them to talk to an expert.

Indiana Department of Health

This plan has been developed from the Seize the Awkward campaign, which can be found here: https://seizetheawkward.org/?gclid=EAIaIQobChMIvPO1jt7y6gIVgYbACh0dDwqPEAAYASAAEgKj2vD_BwE

Education

Introduction

Among our neighboring states, Indiana has the highest percentage of students who seriously considered attempting suicide and the highest percentage of students who made a suicide plan. Per the Indiana Youth Institute's Data Book, 33.5% of Indiana high school students reported feeling sad or hopeless in the past year. Needless to say, there is ample room for education to intervene.[15]

Suicide prevention, intervention, and postvention are complex issues to tackle, regardless of the setting, but especially in schools. Schools already have numerous competing requirements, they are under resourced, and with students the majority of the day. That is why we have put together an assortment of various tools for those in education to use when addressing suicide prevention.

Education Resources:

- Indiana Requirements for Youth Suicide Prevention
- Suicide Prevention in Schools Poster
- Suicide Prevention Ideas
- Model School District Policy Checklist and Sample
- Suicidal Ideation Protocol
- Re-Entry Protocol
- Sample Guidelines for Staff Meetings after a Suicide
- Sample Death Notification Statements for Students
- Dos and Don'ts when Talking to your Students about Suicide
- Parent Letter Script
- Suicide Resources: Education (p. 218-219)

INDIANA REQUIREMENTS FOR YOUTH SUICIDE PREVENTION

When thinking through different prevention and intervention strategies to pursue, it is vital that Indiana schools know what is required from them legally. Below are the various policies that must be followed when it comes to suicide prevention.

Suicide Prevention Policy (IC 20-26-5-34.4)

Per IC 20-26-5-34.4, school corporations shall adopt a policy addressing measures intended to increase child suicide awareness and prevention. The policy must address the following:

1. Counseling services for the child and the child's family related to suicide prevention.
2. Availability of referral information for crisis intervention to children, parents, and school corporation staff.
3. Increasing awareness of the relationship between suicide and drug and alcohol use.
4. Training on warning signs and tendencies that may evidence that a child is considering suicide.
5. Availability of information concerning suicide prevention services in the community.
6. Cooperation among the school corporation and suicide prevention services in the community.
7. Development of a plan to assist survivors of attempted suicide and to assist children and school corporation staff in coping with an attempted suicide or death of a student or school employee.
8. Development of any other program or activity that is appropriate.

Youth Suicide Awareness and Prevention Training (IC 20-28-3-6)

Per IC 20-28-3-6, superintendents, principals, teachers, librarians, school counselors, school psychologists, school nurses, and school social workers employed at schools that provide instruction to students in grades 5-12, are required to participate in at least 2 hours of youth suicide awareness and prevention training every 3 school years. The training must be during the employee's contracted day or at a time chosen by the employee; shall count toward professional development requirements; must be demonstrated to be an effective or promising program and recommended by the Indiana Suicide Prevention Network Advisory Council.

This information was found in "Suicide Prevention & Response Comprehensive Resource Guide for Indiana Schools 2018" at https://www.doe.in.gov/sites/default/files/sebw/suicide-resource-guide-indiana-schools-4.pdf

Indiana Department of Health

Suicide Prevention in Schools

Information for Teachers and School Staff

WARNING SIGNS OF SUICIDE

TALK

If a student talks about…..

- Being a burden
- Feeling unbearable pain
- Having no reason to live
- Feeling trapped or hopeless
- Killing themselves

BEHAVIOR

If a student shows…..

- Drastic changes in behavior or academics
- Acting recklessly; getting in trouble
- Withdrawing from activities
- Giving away possessions; telling people goodbye
- Alcohol/drug use

MOOD

If a student shows…..

- Drastic change in mood
- Depression
- Loss of interest
- Irritability
- Anxiety

TALK WITH AT RISK STUDENTS

1. ASK

Pull the student aside and share what you have noticed. Ask them if they are experiencing suicidal ideation.

"I've noticed _____. Sometimes when someone is _____ they are thinking about suicide. Are you thinking about suicide?"

2. LISTEN

Listen to what the student shares with you. Validate and acknowledge their feelings.

"Let's talk about this."
"Tell me more."
"It sounds like you're going through a really difficult time."

3. CONNECT

If the student shares they are experiencing suicidal ideation or you suspect they are in danger of hurting themselves, connect them with someone to help keep them safe.

DO NOT leave the student unsupervised.

This information was found on Teachers Pay Teacher's "Suicide Prevention in School Informational Poster," which can be found here: https://www.teacherspayteachers.com/Product/Suicide-Prevention-in-School-Informational-Poster-3161305

Indiana Department of Health

Suicide Prevention and Education Activities

Develop a referral process to inpatient or outpatient therapeutic services

Set aside a regulation room

Education on warning signs and symptoms

Review the student's safety plan with the student and family before the student returns to school

Integrate Social-Emotional Learning (SEL) into classroom settings

Develop a culture that validates emotions and feelings, creating a rapport with students

Require diversity and racism training to students and staff

Create a suicidal ideation protocol including a mental status assessment / self-harm assessment (i.e. Columbia suicide rating scale)

Teach emotional regulation, daily emotional check ins, teach coping skills

Require all teachers to complete an online suicide training module or an in-person training

Develop partnerships with Community Mental Health Centers (CMHCs) and other local provider organizations

Hire a school counselor, school psychologist, and a youth social worker

Have a Bully Box and anonymous tip line for students

Be aware of a child's background, supports, and family dynamics

Designate a Social-Emotional Learning (SEL) coordinator

This template was provided by Sharon Elementary School to IDOH for purposes of this toolkit.

Indiana Department of Health

MODEL SCHOOL SUICIDE POLICY CHECKLIST AND SAMPLE

If school districts already have suicide prevention, intervention, and postvention protocols, the district can measure their plan against the list below.

- ☐ Requirement for training — ideally at least one hour every year for all school staff, including bus drivers, cafeteria staff, coaches, security, etc. — on suicide prevention, including education about mental health and warning signs or risk
- ☐ Consideration of populations at high risk for suicide, such as LGBTQ+ youth
- ☐ Requirement for a designated school suicide prevention coordinator
- ☐ Description of all suicide prevention team member roles and responsibilities, and the flow of communication and tasks
- ☐ Designation of the process for suicide risk assessments (either with school-employed mental health professionals or by arrangement with a community mental health professional)
- ☐ Requirement for continuously updated referral list that has, at the minimum, emergency contacts such as local hospitals and their mental health clinics and referral numbers
- ☐ Procedures for in-school suicide attempt, including re-entry processes
- ☐ Consideration of out-of-school suicide attempts and how parents should be informed and involved
- ☐ Postvention procedures that follow the After a Suicide: A Toolkit for Schools recommendations and safely discuss a suicide attempt or death with the school community

If the district has yet to develop a policy, they can access model school policy in Appendix B of "Suicide Prevention & Response: A Comprehensive Resource Guide for Indiana Schools," developed by the Indiana Department of Education, found here: https://www.doe.in.gov/sites/default/files/sebw/suicide-resource-guide-indiana-schools-4.pdf. A sample policy and protocol from Hamilton Southeastern Schools can be found on the subsequent pages.

This information was found in "Model School District Policy" by AFSP, found here: https://www.datocms-assets.com/12810/1576931010-13820afspmodelschoolpolicybookletm1v3.pdf. Also from SPRC's "Suicide Prevention among LGBT Youth: A workshop for professionals who serve youth," which can be found here: https://www.sprc.org/resources-programs/suicide-prevention-among-lgbt-youth-workshop-professionals-who-serve-youth-0

Sample Suicide Prevention Policy

The Board of School Trustees of _____ recognizes that suicide is one of the leading causes of death for Indiana youth. This policy is meant to increase the awareness and prevention of child suicide. The Board believes there must be a partnership between families, the community, and _____ to effectively support our students with mental health needs.

To that end, the Board partners with the broader community including local and regional suicide prevention services. Information regarding such suicide prevention services located in our community can be found on our website or by contacting the school counselor in any of our schools. Further, information regarding crisis intervention referral is available to students, parents, and _____ employees by contacting school counselors, the _____ Mental Health Coordinator, or Student Support Services at the _____ central office by calling (317) 594-4100. In cases of emergency please dial 911 for immediate assistance.

_____ Schools provides school counseling services for students and families related to suicide prevention.

_____ Schools also refers students and families to in-school mental health counseling/therapy.

_____ Schools recognizes the relationship between suicide and drug and alcohol use. The plan, training, and any other program authorized under this policy will address awareness of this correlation. _____ Schools will make certain that employees meet training requirements consistent with Indiana law on suicide prevention and awareness. All _____ teachers are to be trained in suicide prevention. The training addresses warning signs and tendencies that may indicate a student is considering suicide. Teachers, school counselors, and staff are also trained on specific procedures to follow if they are concerned about a student.

Consistent with Indiana law, the Superintendent or his/her designee shall develop a plan to assist survivors of attempted suicide and to assist students and _____ Schools employees in coping with a suicide or attempted suicide. The Superintendent or his/her designee may develop any other program or activity appropriate for increasing awareness and prevention of child suicide.

SUICIDAL IDEATION PROTOCOL

When a student expresses suicidal ideation, it is important to have a procedure in place. Hamilton Southeastern Schools shared their procedural response for purposes of this toolkit. Dependent on the different types of school personnel available, some of these steps may be completed by different individuals

Student Name:	**Date:**
School:	**Grade:**
Student referred by:	**Interview conducted by:**
SRO Involvement:	

Reason for referral:

1. **Inform student that it is required to report harm to self or others**

2. **Date and time of student interview:**

3. **Summary of interview:**

4. **Notification of necessary parties:**
   a. **Name of Parent/Guardian Contacted:** **Date Contacted:** **Time Contacted:**
   b. **Name of Building administrator:** **Date Contacted:** **Time Contacted:**

5. **Result of Columbia Suicide Screener for Schools:**
   Note: Always ask #1 and #2 on the Columbia Suicide Screening

6. **Parent follow-up: Select:**
   a. ☐ **Parent Contacted**
   b. ☐ **Scheduled parent in person meeting** **Date:**
   c. ☐ **Parent refused; additional referral needed**
   d. ☐ **Parent and School in agreement: NO FURTHER ACTION NEEDED**

If further evaluation or support is needed complete the following steps:

7. **Meeting with Parent/Guardian instructions prior to student leaving school:**
   a. *Keep student under direct supervision at all times during the process.* ***Do not send the student home on the bus or release to drive home alone or with other students. Advise parents it is a district policy.***
   b. *School staff will share with parent that staff believes that the student needs to be assessed by a mental health provider to discuss a possible evaluation/hospital placement regarding the student's risk level and suicidal ideation. The school requests, but does not require, a written report (safety plan) from the mental health provider be provided to the school prior to the student's return so that the school can make a plan to support the student. If the student is already working with an outside mental health provider, the family may choose to have the student evaluated by them.*

c. *Seek a signed Release of Information granting permission to contact and discuss student's needs with the outside mental health provider, unless a release is already on file.*

d. *School staff contact a SRO to make necessary arrangements if parents are refusing to come to the school.*

Notes:

8. **Prior to returning to classes the school counselor will discuss with parent/guardian and student a transition/safety plan to be implemented while student is in attendance or on school property.**
   a. **Date and time of meeting**
   Attended by:
   Student:
   Parent/Guardian:
   School Counselor:
   Other: **Title:**
   Other: **Title:**
   Reviewed Student's Safety Plan:

   b. **Transition/School Safety plan (choose the options that best applies to the student:**
      a) ☐ **Check-in with a school staff member**
      Staff Member:
      Frequency of Check-in: ☐ Daily ☐ Weekly ☐ Bi-Weekly
      b) ☐ **Involve student in a group led by school counselor (i.e. social skills, friendship group, coping strategies)**
      c) ☐ **Referral to Mental Health Provider**
      d) ☐ **Referral to Youth Assistance Program**
      e) ☐ **Supervised transportation to and from school:**
      f) ☐ **Escort plan outlining all aspects of the day, including student drop off and pick up from school, restroom, lunch, passing periods, extracurricular activities:**
      g) ☐ **Student shall remain under direct supervision for a determined amount of time**
      Follow-up review scheduled for:
      h) ☐ **If applicable, plan for student to attend field trips**
      i) ☐ **Working with crisis liaison _____(name)_____ from _____(local health system)_____**
      j) ☐ **Student added to Student Assistance Team**

9. **Notify school personnel (i.e. classroom teachers) to be alert of specific behaviors or discussions based on information shared in the safety plan:**

10. **Long-term plan to monitor student risk once direct supervision lifted***: As data is collected and deemed necessary, based on patterns of behavior and continued needs, please consider eligibility for a 504 plan or Special Education referral if this becomes a pattern or there is a medical diagnosis. Please consult with the school psychologist assigned to your building as well as Special Education Administrators as needed.*
    Notes:

11. **Send completed form to the following Central office personnel as notification:**
    ☐ _____
    ☐ _____

Re-Entry Protocol

Re-entry meetings are for students that have been out of school due to suicide ideation, suicide attempt, and/or psychological hospital treatment. This meeting will take place prior to the student's return to discuss systems of care/support and determine the best course of action to meet the needs of the student. The re-entry process is vital to ensure the safety and wellbeing of students who have previously attempted. This process reduces the risk of another attempt.

Who should be at the re-entry meeting? (not all of the below staff need to be at the meeting but do need to be looped into the coordination, planning, and final outcome of the re-entry meeting)

- School administrator
- Suicide Prevention Coordinator; School Counselor/Social Worker/Mental Health Provider
- Parent/Guardian and student, if parent/guardian deems ready
- Other appropriate attendees include: School nurse; school psychologist; outside family therapist/counselor; teacher; coach (someone that is a key support to the student)

Purpose of re-entry meeting

- Review family's course of action since becoming aware of suicide ideation
- Discuss the existing resources and supports in place for the student and family
- Discuss any additional supports or resources the family/student may need
- Family is encouraged to share any assessments/notes from outside therapy and/or services that the family obtained
- Family is encouraged to bring any recommendations from outside mental health providers and/or treatment facility so school can work to provide continuous care
- Discuss absences and missing homework/tests to begin developing a plan with the family and student to make-up any required assignments/tests
- Review the Safety Plan that was previously developed and make necessary adjustments. Discuss the below items to gauge if they need to be included in the revised Safety Plan.
    - Will the student check-in before and after school?
    - Will the student be supervised during passing periods?
    - Will the student be supervised in the bathroom?
    - Does the student need to be supervised at lunch?
    - Does the student need a quiet area at lunch time? Is the cafeteria loud/ busy?
    - How does the student access the nurse if they need to see the nurse?
    - Who does the student feel the most comfortable talking to if they are feeling anxious/stressed/depressed?
    - Does the student need supervision after school hours?
    - How often will the Suicide Prevention Coordinator check-in with the student? *During these check-ins, a suicide risk monitoring tool will be used.*
    - What is the duration of the safety plan?
- Fill out the "Safety Plan: Instructions for Teachers/Support Staff," provided on the next page.

This information was found in DOE's Suicide Prevention & Response: A Comprehensive Resource Guide for Indiana Schools 2018. The document was named "Re-entry Protocol" and can be found here: https://www.doe.in.gov/sites/default/files/sebw/suicide-resource-guide-indiana-schools-4.pdf

Indiana Department of Health

Safety Plan: Instructions for Teachers/Support Staff (Template)

Today's Date: _____ Staff Member Preparing Safety Plan: _____

_____ (Student's name) has a Safety Plan. While the student is in your classroom or under your supervision, please follow the procedures marked below. This plan is confidential and will stay in place until further notice. If the student has permission to leave your class unsupervised to use the bathroom or visit another classroom, please monitor the time the student is gone. Call the office at extension _____if you are concerned that the student has been gone too long. If he/she is visibly upset or expressing thoughts of unsafe behavior, call the office at extension _____. Please escort the student to the office or wait until the office can send an escort for the student. It is important to never allow the student to be unaccompanied when you are concerned about his/her wellbeing.

Please remember to include this document with your sub notes when you are absent.

□ [Insert items from the student's safety plan]
□
□
□
□
□
□

Thank you for all you do to support students!

Student's School Counselor: _____

SAMPLE GUIDELINES FOR STAFF MEETINGS AFTER A SUICIDE

When a suicide completion occurs, a school needs to be ready to respond. The initial staff meeting (outlined below) should be held as soon as possible, ideally before school starts.

Goals of Initial Meeting (allow at least one hour to do the following):

- Take attendance and make note of any staff who are not present and plan to reach out or contact those staff members
- Share accurate factual information about the death, honoring the family's request for privacy.
- Have a trained professional present that the meeting so that staff may access them for support if needed.
- Allow staff an opportunity to express their own reactions and grief; identify anyone who may need additional support and refer them to appropriate resources.
- Have substitute teachers available to replace any teachers who are too upset to teach (a task for the principal or designee).
- Remind staff of the school's policy or response following a student death and any considerations specifically for a suicide death.
- Share with staff how to handle parent inquiries and plans for communicating with parents, including who parents should contact for further information and resources.
- Explain plans for the day, how classroom meetings will be conducted, and locations of crisis counseling rooms or other supports that will be present in the building.
- Remind all staff of the following:
    - How they respond to the crisis can have a strong impact on their students. They need to project that they are in control and are concerned about their students' mental health, if their emotions become too strong encourage them to reach out to admin for support and classroom coverage.
    - They can play an important role in identifying changes in students' behavior. Discuss a plan for handling students who are having difficulty.
- Brief staff about identifying and referring at-risk students as well as the need to keep records of those efforts (letting school counselor know of students of concern).
- Remind staff to be on the lookout for rumors and to notify an individual leading the crisis response immediately if they hear rumors. Staff should not engage in discussions that may contribute to the spread of rumors.
- Remind staff to limit use of social media and to avoid tagging those who may be close to the incident. Furthermore, encourage staff to wait to post information so family, students, and staff can be made aware before learning about the incident on social media.
- Identify which Crisis Response Team member has been designated as the media spokesperson and instruct staff to refer all media inquiries to them.

This information was found in SPRC's "After a Suicide: A Toolkit for Schools," which can be found here: https://www.sprc.org/sites/default/files/resource-program/AfteraSuicideToolkitforSchools.pdf

SAMPLE DEATH NOTIFICATION STATEMENT FOR STUDENTS

Depending on how the school wants to address the suicide death, they may want to make an announcement to students. This death notification statement should be shared with students in small groups, such as homerooms or advisories, not in assemblies or over loudspeakers.

Option 1: When the Death Has Been Ruled a Suicide

"I am so sorry to tell you all that one of our students, [NAME], has died. I'm also very sad to tell you that the cause of death was suicide.

Many of you may also feel very sad. Others may feel other emotions such as anger or confusion. It's okay to feel whatever emotions you might be feeling. When someone takes their own life, it leads to a lot of questions, some of which may never be completely answered.

While we may never know why [NAME] ended [HIS/HER] life, we do know that suicide has many causes. In many cases, a mental health condition is part of it, and these conditions are treatable. It's really important if you're not feeling well in any way to reach out for help. Suicide should not be an option.

Rumors may come out about what happened, but please don't spread them. They may turn out to be untrue and can be deeply hurtful and unfair to [NAME] and [HIS/HER] family and friends. I'm going to do my best to give you the most accurate information as soon as I know it.

Each of us will react to [NAME]'s death in our own way, and we need to be respectful of each other. Some of us may have known [NAME] well, and some of us may not. But either way, we may have strong feelings. You might find it difficult to concentrate on schoolwork for a little while. On the other hand, you might find that focusing on school helps take your mind off what has happened. Either is okay.

I want you to know that your teachers and I are here for you. We also have counselors here to help us all cope with what happened. If you'd like to talk to one of them, just let me or one of your teachers know or look for the counselors in [NOTE SPECIFIC LOCATION] between classes or during lunch.

We are all here for you. We are all in this together, and the school staff will do whatever we can to help you get through this."

This information was found in SPRC's "After a Suicide: A Toolkit for Schools," which can be found here: https://www.sprc.org/sites/default/files/resource-program/AfteraSuicideToolkitforSchools.pdf

Option 2: When the Cause of Death is Unconfirmed

"I am so sorry to tell you all that one of our students, [NAME], has died. The cause of death has not yet been determined.

We are aware that there has been some talk that this might have been a suicide death. Rumors may begin to come out, but please don't spread them. They may turn out to be untrue and can be deeply hurtful and unfair to [NAME] and [HIS/HER] family and friends. I'm going to do my best to give you the most accurate information as soon as I know it.

Since the subject has been raised, I do want to take this chance to remind you that suicide, when it does occur, is very complicated. No one single thing causes it. But in many cases, a mental health condition is part of it, and these conditions are treatable. It's really important if you're not feeling well in any way to reach out for help. Suicide should not be an option.

Each of us will react to [NAME]'s death in our own way, and we need to be respectful of each other. Right now, I'm feeling very sad, and many of you may feel sad too. Others may feel anger or confusion. It's okay to feel whatever emotions you might be feeling. Some of us may have known [NAME] well, and some of us may not. But either way, we may have strong feelings. You might find it difficult to concentrate on schoolwork for a little while. On the other hand, you might find that focusing on school helps take your mind off what has happened. Either is okay.

I want you to know that your teachers and I are here for you. We also have counselors here to help us all understand what happened. If you'd like to talk to one of them, just let me or one of your teachers know, or you can seek out the counselors in [NOTE SPECIFIC LOCATION] between classes or during your lunch. We are all here for you.

We are all in this together, and the school staff will do whatever we can to help you get through this."

Option 3: When the Family Has Requested the Cause of Death Not Be Disclosed

"I am so sorry to tell you all that one of our students, [NAME], has died. The family has requested that information about the cause of death not be shared at this time.

We are aware that there has been some talk that this might have been a suicide death. Rumors may begin to come out, but please don't spread them. They may turn out to be untrue and can be deeply hurtful and unfair to [NAME] and [HIS/HER] family and friends. I'm going to do my best to give you the most accurate information as soon as I know it.

Since the subject has been raised, I do want to take this chance to remind you that suicide, when it does occur, is very complicated. No one single thing causes it. But in many cases, a mental health condition is part of it, and these conditions are treatable. It's really important if you're not feeling well in any way to reach out for help. Suicide should not be an option.

Each of us will react to [NAME]'s death in our own way, and we need to be respectful of each other. Right now, I'm feeling very sad, and many of you may feel sad too. Others may feel anger or confusion. It's okay to feel whatever emotions you might be feeling. Some of us may have known [NAME] well, and some of us may not. But either way, we may have strong feelings. You might find it difficult to concentrate on schoolwork for a little while. On the other hand, you might find that focusing on school helps take your mind off what has happened. Either is okay.

I want you to know that your teachers and I are here for you. We also have counselors here to help us all understand what happened. If you'd like to talk to one of them, just let me or one of your teachers know, or you can seek out the counselors in [NOTE SPECIFIC LOCATION] between classes or during your lunch.

We are all here for you. We are all in this together, and the school staff will do whatever we can to help you get through this."

Further Information

This guide was developed as a part of the Suicide Learning Collaborative Toolkit. To find out more about suicide prevention in Indiana and nationally, please visit:

In.gov/issp
In.gov/isdh/21838.htm
Indianasuicideprevention.org
afsp.org
sprc.org

This information was found in SPRC's "After a Suicide: A Toolkit for Schools," which can be found here: https://www.sprc.org/sites/default/files/resource-program/AfteraSuicideToolkitforSchools.pdf

Dos and Don'ts When Talking to Your Students about Suicide

Youth Warning Signs

If you see the following behavioral changes…

- Withdrawal from or change in social connections or situations
- Changes in sleep (increased or decreased)
- Anger or hostility that seems out of character
- Recent increased agitation or irritability

…..then take these recommended steps right away:

- Ask the student if they are having thoughts of suicide.
- Express your concern about what you are observing in his or her behavior.
- Listen attentively and nonjudgmentally.
- Reflect what the student shares and let the student know he or she has been heard.
- Tell the student that he or she is not alone.
- Let the student know that help is available
- If you or the student are concerned, guide him or her to additional professional help, or to call the National Suicide Prevention Lifeline.

If you see the following suicide risk signals….

- Talking about or making plans for suicide
- Expressing hopelessness about the future
- Displaying severe/overwhelming emotional pain or distress

……then take these recommended steps right away:

- Do not leave the student alone and unsupervised. Make sure the student is in a secure environment supervised by caring adults until he or she can be seen by the school mental health contact.
- Make sure the student is escorted to the school's mental health professional.
- Provide any additional information to the school's mental health contact that will assist with the assessment of the student.

Suicide is a difficult topic for most people to talk about. This tool suggests ways to talk about key issues that may come up when someone dies by suicide.

Give accurate information about suicide.	By saying….
Suicide is a complicated behavior. It is not caused by a single event. In many cases, mental health conditions, such as depression, bipolar disorder, PTSD, or psychosis, or a substance use disorder are present leading up to a suicide. Mental health conditions affect how people feel and prevent them from thinking clearly. Having a mental health problem is actually common and nothing to be ashamed of. Help is available. Talking about suicide in a calm, straightforward way does not put the idea into people's minds.	"The cause of [NAME]'s death was suicide. Suicide is not caused by a single event. In many cases, the person has a mental health or substance use disorder and then other life issues occur at the same time leading to overwhelming mental and/or physical pain, distress, and hopelessness." "There are effective treatments to help people with mental health or substance abuse problems or who are having suicidal thoughts." "Mental health problems are not something to be ashamed of. They are a type of health issue."

Address feelings of responsibility.	By saying….
Help students understand that they are not responsible for the suicide of the deceased. Reassure those who feel responsible or think they could have done something to save the deceased.	"This death is not your fault. We cannot always see the signs because a suicidal person may hide them." "We cannot always predict someone else's behavior."

Do not focus on the method	By saying….
Talking in detail about the method can create images that are upsetting and can increase the risk of imitative behavior by vulnerable individuals. The focus should not be on how someone killed themselves but rather on how to cope with feelings of sadness, loss, anger, etc.	"Let's talk about how [NAME]'s death has affected you and ways you can handle it." "How can you deal with your loss and grief?"

Address blaming and scapegoating	By saying….
It is common to try to answer the question "why?" after a suicide death. Sometimes this turns into blaming others for the death.	"Blaming others or the person who died does not consider the fact that the person was experiencing a lot of distress and pain. Blaming is not fair and can hurt another person deeply."

Address anger.	By saying….
Accept expressions of anger at the deceased and explain that these feelings are normal.	"It is okay to feel angry. These feelings are normal, and it doesn't mean that you didn't care about [NAME]. You can be angry at someone's behavior and still care deeply about that person."

Promote help-seeking.	By saying….
Encourage students to seek help from a trusted adult if they or a friend are feeling depressed.	"Seeking help is a sign of strength, not weakness." "We are always here to help you through any problem, no matter what. Who are the people you would go to if you or a friend were feeling worried or depressed or had thoughts of suicide?" "If you are concerned about yourself or a friend, talk with a trusted adult."

PARENT LETTER SCRIPT

In cases of either a student or staff member death by suicide, it is a wise idea to be in communication with parents. In the subsequent pages, there are a few different parent letter scripts, dependent on the ruling of the death and whether the family wants to disclose the cause of death.

Option 1: Parent Letter Script When Cause of Death is Unconfirmed

Dear Families,

It is with a great deal of sadness that we have learned of the passing of [NAME], a former [ROLE] at [NAME] School. The cause of death is unconfirmed. Our crisis response team is working with building administrators to provide support to students and staff.
We encourage you to speak with your student and have provided resources below. Additionally, we will have teachers conducting classroom meetings as well as our counselors available in the coming days and weeks. If you have questions, concerns or need additional support, please contact your child's school counselor.

Everyone processes grief differently and the reaction children may have to a traumatic event is often strongly influenced by the actions and support of the adults around them. Attached and below are additional resources to assist you in supporting your child(ren) during this difficult time.

1. **Children need factual, age appropriate information.** Control rumors and correct any myths they may have heard regarding the event and reactions to it. Limit exposure to news coverage of the event this evening and in the coming weeks. This can be traumatic for children.
2. **Provide repeated opportunities for children to talk**. Use it as an opportunity to talk about what they learned about their community and how people help each other in tough situations. Also make sure the child knows you are listening. Older children may want to journal.
3. **Normalize children's reactions and feelings.** Let them know that their feelings, behavior, etc. are common reactions, even for adults.
4. **Keep routines.** Return to your family's daily routines as soon as possible. This will decrease out of control feelings. Remind your child of what has not changed and most importantly that you have each other.
5. **Identify support systems.** Talk about the family plan for coping and recovery and how long it may take. Help children identify and/or reconnect with their support systems. This may be family members, school staff, coaches, etc.

Please know that supporting our students and staff during this difficult time is our top priority. We wish [NAME] family and friends comfort during this time.

Sincerely,

Option 2: Parent Letter Script When Cause of Death is Suicide

Dear Families,

It is with a great deal of sadness that we have learned of the passing of [NAME], a former [ROLE] at [NAME] School. The cause of death was suicide. Suicide is a very complicated act. Although we may never know why [NAME] ended [HIS/HER] life, we do know that suicide has multiple causes. In many cases, a mental health condition is part of it. But these conditions are treatable. It's really important if you or your child are not feeling well in any way to reach out for help. Suicide should not be an option. I am including some information that may be helpful to you in discussing suicide with your child.

Our crisis response team is working with building administrators to provide support to students and staff. We encourage you to speak with your student and have provided resources below. Additionally, we will have teachers conducting classroom meetings as well as our counselors available in the coming days and weeks. If you have questions, concerns or need additional support, please contact your child's school counselor.
Everyone processes grief differently and the reaction children may have to a traumatic event is often strongly influenced by the actions and support of the adults around them. Attached and below are additional resources to assist you in supporting your child(ren) during this difficult time.

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5. **Identify support systems.** Talk about the family plan for coping and recovery and how long it may take. Help children identify and/or reconnect with their support systems. This may be family members, school staff, coaches, etc.

Information about the funeral service will be made available as soon as we have it. If your child wishes to attend, we strongly encourage you to accompany him or her to the service. If the funeral is scheduled during school hours, students who wish to attend will need parental permission to be released from school. Please know that supporting our students and staff during this difficult time is our top priority. We wish [NAME] family and friends comfort during this time.

Sincerely,

Option 3: Parent Letter Script When the Family has Requested the Cause of Death not be Disclosed

Dear Families,

It is with a great deal of sadness that we have learned of the passing of [NAME], a former [ROLE] at [NAME] School. Our crisis response team is working with building administrators to provide support to students and staff.

The family has requested that information about the cause of death not be shared at this time. We are aware there have been rumors that this was a suicide death. Since the subject has been raised, we want to take this opportunity to remind our community that suicide, when it does occur, is a very complicated act. No one single thing causes it. But in many cases, a mental health condition is part of it, and these conditions are treatable. It's really important if you or your child is not feeling well in any way to reach out for help. Suicide should not be an option.

We encourage you to speak with your student and have provided resources below. Additionally, we will have teachers conducting classroom meetings as well as our counselors available in the coming days and weeks. If you have questions, concerns or need additional support, please contact your child's school counselor.

Everyone processes grief differently and the reaction children may have to a traumatic event is often strongly influenced by the actions and support of the adults around them. Attached and below are additional resources to assist you in supporting your child(ren) during this difficult time.

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5. **Identify support systems.** Talk about the family plan for coping and recovery and how long it may take. Help children identify and/or reconnect with their support systems. This may be family members, school staff, coaches, etc.

Please know that supporting our students and staff during this difficult time is our top priority. We wish [NAME] family and friends comfort during this time.

Sincerely,

Populations of Special Consideration

Introduction

While the majority of this toolkit is broken into profession-specific groupings, it is important to acknowledge the populations of special consideration. That being said, we have chosen to create an additional section to encapsulate some of the pertinent tools and resources available.

While many groups are at risk for suicide, research shows that individuals who are LGBTQIA+, people of Tribal Nations, and individuals who are veterans are at a higher risk of suicide, when compared with the general population. That is why it is vital to have actionable population-specific tools readily available. In this next section, each group's shared risk and protective factors are highlighted along with several usable tools.

None of these tools fully encapsulate a comprehensive approach to suicide prevention, intervention, and postvention. That is why it is recommended that professionals read through other resources referenced in the following pages for further context and detail.

Populations of Special Consideration Resources:

- LGBTQIA+ resources
    - LGBTQIA+ risk and protective factors
    - Checking in on your Mental Health poster
    - Suicide Prevention for LGBTQIA+ Youth and Young Adults Brochure
    - LGBTQIA+ resources
- Veterans resources
    - Veterans risk and protective factors
    - 10 things you can do to prevent veteran suicide
    - Safe firearm storage poster
    - Veteran resources
- People of Tribal Nations resources
    - People of Tribal Nations risk and protective factors
    - Zero suicide for People of Tribal Nations
    - Mental health support guide for native families
    - People of Tribal Nations resources

LGBTQIA+ RISK AND PROTECTIVE FACTORS

Individuals who are lesbian, gay, bisexual, transgender, queer, intersex, asexual (LGBTQIA+), and/or other sexual orientation (e.g. MSM or Men Who have Sex with Men) and gender identities (individuals who are nonbinary) frequently experience prejudice and discrimination. Research indicates that mental health problems, misuse of alcohol and other drugs, and suicidal ideation are more common in this group than in the general population. Suicide prevention efforts seek to reduce risk factors for suicide and strengthen the factors that help strengthen individuals and protect them from suicide (protective factors). Here are a few examples:

Stress from prejudice and discrimination (family rejection, harassment, bullying, violence)	Family acceptance
Depression and other mental health problems (i.e. substance use disorder)	Sense of safety
Feelings of social isolation	Connections to friends and others who care about them

This information was adapted from SPRC's "Lesbian, Gay, Bisexual and/or Transgender People," found here: https://www.sprc.org/populations/lgbt

Indiana Department of Health

CHECKING IN ON YOUR MENTAL HEALTH

Feeling sad or alone can be overwhelming, especially if people in your life are unsupportive. While these feelings are completely normal, it's important to keep an eye out for warning signs of larger mental health struggles. You are not alone and asking for help is a sign of strength.

Have You Felt...?

Unimportant

Trapped and/or hopeless

Overwhelmed and/or unmotivated

Alone, angry, and/or irritable

Thoughts of suicide

Have You Been...?

Using drugs or alcohol more than usual

Acting differently than usual

Giving away your most valuable possessions

Losing interest in your favorite things to do

Planning for death by writing a will or letter

Eating or sleeping more or less than usual

Feeling more sick, tired, or achy than usual

Do You...?

Not care about the future

Put yourself down (and think you deserve it)

Plan to say goodbye to important people

Have a specific plan for suicide

If you answered yes to any/several of these questions, you can reach out to a trained crisis counselor for support by calling the National Suicide Prevention Lifeline (1.800.273.8255 [TALK]) or texting "IN" to 741741. For youth who are LGBTQIA+ there is also the TrevorLifeline (866.488.7386) or texting "START" to 678678 for TrevorText — we're here for you 24/7. **You are not alone.**

This information was adapted from The Trevor Project's "Coming Out Handbook," found here: https://www.thetrevorproject.org/wp-content/uploads/2019/10/Coming-Out-Handbook.pdf.

Indiana Department of Health

The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, queer, and questioning youth and young adults. These services include:

- **Trevor Lifeline** – The only nationwide, around-the-clock crisis and suicide prevention lifeline for LGBTQ youth and young adults. Call toll-free, 24/7 at 866-488-7386.
- **Trevor Chat** – A free, confidential, and secure online messaging service that provides live help by trained volunteers.
- **Trevor Space** – An online, social networking community for LGBTQ youth and young adults ages 13-24, their friends, and allies. Join at Trevor Space.org.
- **Ask Trevor** – An online, confidential Q&A forum for young people to ask non-time-sensitive questions surrounding sexual orientation and gender identity.

TransLifeLine is a peer support hotline run by and for trans people, providing everything from microgrants around legal name changes to updating IDs. Connect further here:

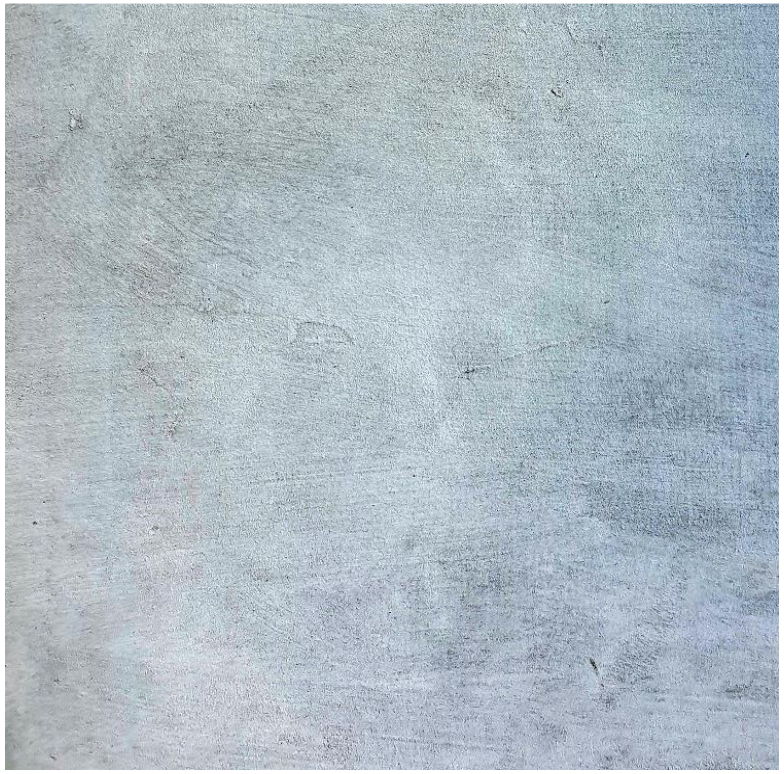
- TransLifeLine.org
- 877.565.8860

Indiana Department of Health

This guide was developed as a part of the Suicide Learning Collaborative Toolkit. To find out more about suicide prevention in Indiana and nationally, please visit: In.gov/issp, In.gov/isdh/21838.htm

This information was adapted from a brochure by The Trevor Project, which can be found here: https://www.thetrevorproject.org/wp-content/uploads/2017/09/The-Trevor-Project-Youth-Brochure.pdf

Suicide Prevention for LGBTQIA+ Youth and Young Adults



Suicide is PREVENTABLE. The majority of young people having thoughts of suicide give some sort of clue about their intentions. If someone you know is depressed or exhibiting any of these warning signs, ask them if they are considering suicide.

Warning Signs:

- Developing a plan for suicide and/or obtaining the means to follow through on a suicide attempt.
- Experiencing suicidal ideation (e.g. “I want to kill myself,” “I wish my life were over,” or “Life isn’t worth living”).
- Making final arrangements, talking about their funeral, and giving away valued possessions.
- Displaying signs of depression (e.g. loss of pleasure in activities they used to enjoy, prolonged sad mood, changes in eating or sleeping patterns, expressing feelings of hopelessness or guilt).
- Engaging in self-destructive behavior (e.g. start of or increase in alcohol or drug use, risky sexual behavior, reckless driving).
- Expressing that they are suffering a great deal and feel that there is no hope for a better future with phrases such as, “It won’t matter soon anyway.”
- Pulling away from family and friends.

Y-CARE

You

are never alone. As friends, family, and loved ones, all you can do is listen, support, and assist the person in getting the help they need.

Connect

the person to resources and to a supportive, trusted adult.

Accept

and listen to the person’s feelings, taking them seriously.

Respond

if a person has a plan to attempt suicide and tell someone you trust.

Empower

the person to get help and call the Trevor Lifeline (866-488-7386) or the National Suicide Prevention Lifeline (200-273-8255) together.

LGBTQIA+ RESOURCES

Gay, Lesbian, and Straight Education Network
This organization is working to create safe and affirming schools for all, regardless of sexual orientation, gender identity, or gender expression. GLSEN.org

Gender Spectrum
This organization is working to help create gender-sensitive and -inclusive environments for all children and teens. genderspectrum.org

GLBT Near Me
This is a database of LGBTQ resources, offering a national hotline and a youth talk line. glbtnearme.org

GSA Network
This is network of trans and queer youth uniting for racial and gender justice. gsanetwork.org

It Gets Better Project
This project was created to encourage media sharing stories around the resilience of LGBTQ people across the globe. itgetsbetter.org

TransLifeLine
This peer support hotline run by and for trans people provides microgrants around legal name changes or updating IDs. TransLifeLine.org, 877.565.8860

Parents, Families and Friends of Lesbians and Gays (PFLAG)
This is the nation's largest family and ally organization). PFLAG.org

The Institute for Welcoming Resources
This international organization is working to make churches become welcoming and affirming spaces for all congregants regardless of sexual orientation and gender identity. welcomingresources.org

Trans Youth Family Allies
This organization partners with educators, service providers, and communities to develop supportive environments in which gender may be expressed and respected. imatyfa.org

Trevor Project
This organization provides crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, queer, and questioning [LGBTQ] young people under 25). thetrevorproject.org, 24/7 helpline at 866-488-7386

Indiana-specific Resources

TransIndy
This is a peer-led social support group for transgender and gender diverse people in central Indiana. https://transindy.org/

Indiana Youth Group
IYG creates safer spaces to foster community and provides programming that empowers LGBTQ+ youth and magnifies their voices. https://www.indianayouthgroup.org/

Gender Nexus
Gender Nexus is bringing transgender and nonbinary communities together across Indiana to foster a community that is healthy, informed, and empowered by increasing access to care in all seven dimensions of wellness. https://www.gendernexus.org

This information was adapted from The Trevor Project's "Coming Out Handbook," found here: https://www.thetrevorproject.org/wp-content/uploads/2019/10/Coming-Out-Handbook.pdf.

Indiana Department of Health

VETERANS RISK AND PROTECTIVE FACTORS

Suicide is an important problem affecting military service members and veterans. The military services include an Active Component (Air Force, Army, Marine Corps, Navy, Space Force, Coast Guard) and a Reserve Component (Army National Guard, Air National Guard). Suicide prevention efforts seek to reduce risk factors for suicide and strengthen the factors that help strengthen individuals and protect them from suicide (protective factors). Here are a few examples:

Mental health issues (i.e. mood disorders, anxiety disorders, substance use disorder)	Effective care for mental and physical health problems
Stressful situations (i.e. childhood trauma, relationship problems, legal issues, financial troubles)	Life skills training (i.e. financial management, communication, family relationships, conflict resolution)
Physical health problems	Social connectedness
Prior suicide attempt	

This information was adapted from SPRC's "Military Service Members and Veterans," found here: https://www.sprc.org/populations/military-veterans

Indiana Department of Health

10 THINGS YOU CAN DO TO PREVENT VETERAN SUICIDE

Recent estimates suggest that 22 veterans may die by suicide each day. It is important to know that suicide is preventable and there are things you can do to prevent veteran suicide. If a veteran has not gone through a transition back to civilian life program, this tool can also be useful.

1. Recognize warning signs of suicidal ideation.

Many veterans may not show any signs of intent to harm themselves before doing so, but some actions can be signs that they need help. Veterans who are considering suicide often show signs of depression, anxiety, low self-esteem, and/or hopelessness. These include:

- Appearing sad or depressed, feeling anxious or agitated, and being unable to sleep
- Having trouble sleeping and eating, or showing loss of interest, which doesn't go away or continues to get worse
- Deteriorating physical appearance and neglecting personal welfare
- Withdrawing from friends, family, and society, or sleeping all the time
- Losing interest in hobbies, work, school, or other things one used to care about
- Frequent and dramatic mood changes
- Feelings of failure or decreased performance and excessive guilt or shame
- Feeling that life is not worth living, having no sense of purpose in life
- Talking about feeling trapped, like there is no way out of a situation
- Feelings of desperation, and saying that there's no solution to their problem

Their actions may be dramatically different from their normal behavior, or they may appear to be actively contemplating or preparing for a suicide attempt. Unusual behaviors include:

- Performing poorly at work or school
- Acting recklessly or engaging in risky activities such as driving fast or running red lights
- Showing violent behavior, such as punching holes in walls, getting into fights, or engaging in self-destructive violence, and feeling rage or uncontrolled anger or seeking revenge
- Looking as though one has a "death wish"
- Putting affairs in order or making out a will and giving away prized possessions
- Seeking access to firearms, pills, or other means of harming oneself

Signs of suicide may appear to be very similar to Post-traumatic Stress Disorder (PTSD) symptoms; however, PTSD symptoms slightly differentiate to include having nightmares, vivid memories, or flashbacks of the event that make the individual feel like it's happening all over again, feeling constantly on guard, and being jumpy or easily startled. The determination of whether the individual was experiencing suicidal ideation and/or PTSD would be made by a medical provider.

This information was adapted from the VA's "Community Toolkit," which can be found here: https://www.va.gov/ve/docs/outreachToolkitPreventingVeteranSuicideIsEveryonesBusiness.pdf and https://www.maketheconnection.net/conditions/ptsd?gclid=EAIaIQobChMIlYi8-v2e7AIViovlCh33_AEmEAAYASAAEgK7MfD_BwE

Indiana Department of Health

2. Validate the veteran's experience: Show compassion.

Crisis provides an opportunity to help people and give them hope. Suicide is preventable. Be willing to listen and allow the veteran to express his or her feelings. Recognize that the situation is serious. Do not pass judgment. Reassure the veteran that help is available and offer hope. Show compassion by looking at the person talking or telling them that you care; compassion can be heard through your voice and translates through your nonverbal communication.

3. Ask the question: Are you having thoughts of suicide?

Many people fear that asking about suicide puts people more at risk. This is not true. By asking if someone is having thoughts of suicide or has hurt himself or herself, you are giving the person in need an opportunity to open up and share his or her feelings. **DO** ask the question if you've identified warning signs or symptoms. **DON'T** ask the question as though you are looking for a "no" answer: "You aren't thinking of killing yourself, are you?"

4. Means do matter: Know how to safely store firearms in your home.

Most veterans who die by suicide use firearms. Though many veterans are well-versed in gun safety, all veterans and their families should understand how to properly handle and store firearms in the home. The risk of unintentional firearm deaths among youth drops by 80 percent when guns are stored separately from ammunition in a lock box.

Veterans also tend to inflict self-harm by overdosing on medication. Encourage health care providers to limit the number of pills in any single prescription, especially if there is a significant risk of overdose. People who have recently been in an inpatient psychiatric unit or an emergency room for mental health or substance use are at increased risk for suicide 90 days following discharge.

5. Encourage treatment and expedite getting help.

Take the veteran to a local walk-in crisis center or call the national suicide prevention lifeline. Try to get the person to seek immediate help from his or her doctor or the nearest hospital emergency room or call 911. Once you have gotten the veteran to seek help, reach out to them to show that you care. Follow up with the person after the event; let him or her know that treatment works, and that life can get better. Use the resource locator: VeteransCrisisLine.net/ResourceLocator and use SAMHSA's Find Help and Treatment Locator: www.samhsa.gov/find-help.

6. Promote veteran employment: Help transition servicemembers to civilian life.

Finding employment, understanding the opportunities available from vocational rehabilitation programs, and financial stress can be overwhelming for anyone. Employers can work with VA community employment coordinators (CECs) — based at nearly every VA medical center — to share job openings and set up interviews with qualified veterans.

7. Intentionally connect with female veterans.

Female veterans have a significantly higher suicide risk than their non-Veteran civilian counterparts: Adjusting for differences in age, risk for suicide is 2.4 times higher among female veterans when compared with U.S. civilian adult females.

Consider reaching out to partners to ensure that any messaging for Veterans considers women and men. Host an event for female veterans and consider reaching out to key leaders in the community who can help connect them to one another. Health care providers should take care to assess all women in crisis against the same criteria used for men: veteran status, access to firearms, substance misuse, and level of connectedness.

8. Connect veterans to each other and to service.

Veterans who have served their country have a range of skills and values that can benefit their communities. Encourage members of your community to host service days or other opportunities for veterans to support fellow veterans, servicemembers, and the community at large.

Male veterans over the age of 65 are at increased risk for suicide. This is a time in life that can include retirement, loss of family members, or long-term depression, which can all lead to increased substance use and social isolation. Inquire about what skills a veteran has gained during and after military service and offer him or her opportunities to connect with others.

9. Get technical: Using technology to reach veterans and enhance connectedness.

Reach out to your community to find people, companies, and nonprofit organizations that are using social media, email, or text messages to reach out and connect to people. Some health care providers are using video technology, referred to as telehealth, to improve how people receive health care, especially those who live in more rural settings.

10. Treatment works: Promoting substance use treatment and mental health recovery.

Many communities are unaware of the resources they already have to help people who are facing an emotional crisis or substance use problems. Consider hosting community events where local providers can offer education and resources to veterans and their families. Promote sobriety with family-friendly events, such as block parties, farmers markets, and athletic events like a 5K walk/run. Work to engage substance use disorder prevention organizations and treatment centers in the event, promoting recovery.

Most people who die by suicide were last provided health care in a primary physician's office. Connect with health professionals in your area and give them information on military and veteran culture. Encourage providers to have direct discussions with their patients about preventing suicide and amplify suicide prevention messaging in their clinics. Direct them to training and resources from their local VA Suicide Prevention Coordinator or other online sources.

Safe firearm storage matters...

Because no one can un-fire a firearm

For someone in crisis, a locked firearm can mean the difference between a tragic outcome and a life saved. Though many veterans are well-versed in firearm safety, all veterans and their families should understand how to properly handle and store firearms in the home.

Firearm injuries were the **second leading cause** of injury-related deaths nationwide in 2015.

– CDC Report, 2017

A 2014 study showed that firearms could be found in roughly **31% of households** nationwide.

– General Social Survey, 2014

Research shows there is a **70% lower risk** of unintentional firearm-related injury and death among youths when guns are stored safely.

– Journal of the American Medical Association, 2015

Take these simple steps to keep your family safe:

- ☐ Make sure firearms cannot be accessed by children and unauthorized adults by keeping guns locked and unloaded when not in use.
- ☐ Store ammunition separately from firearms and out of reach of children and unauthorized adults.
- ☐ Regularly reassess steps to ensure safe storage and use of firearms, especially during periods of increased stress or emotional crisis.
- ☐ Request a gunlock from your local VA Suicide Prevention Coordinator. Find your local SPC at VeteransCrisisLine.net/ResourceLocator.

Learn more about how you and your family can be there for a veteran or servicemember in crisis:
bethereforveterans.com

This information was adapted from the VA's "Veterans Crisis Line Shareable Materials," found here: https://www.veteranscrisisline.net/support/shareable-materials. The graphics are from Noun Project (United States Map by Randomhero; House by Pascal Heß; safe locked by Hea Poh Lin)

Indiana Department of Health

VETERAN RESOURCES

U.S. Department of Veterans Affairs
Explore the VA benefits that help veterans thrive.
www.explore.va.gov

Center for Women Veterans
Women are one of the fastest-growing subgroups of veterans, and they are signing up for VA health care and benefits at higher rates than ever before.
www.va.gov/womenvet

MyHealtheVet
veterans can use this portal to access pharmacies, appointments, messages, and health records.
www.myhealth.va.gov

VA's Self-Paced Online Training
The VA offers self-paced online trainings to veterans with topics such as "Moving Forward: Overcoming Life's Challenges" and "Anger and Irritability Management Skills.
www.veterantraining.va.gov/.

Homeless Veterans or Those at Risk of Becoming Homeless
This helpline is for veterans who are experiencing homelessness or are at risk of becoming homeless. 1-877-4AID-VET (1-877-424-3838)

Caregiver Support Program and Phone Line (1-855-260-3274)
These programs are available both in and out of your home to help support veteran families.
www.caregiver.va.gov

Coaching Into Care (1-888-823-7458)
Coaching Into Care is a national telephone service at VA that aims to educate, support, and empower family members and friends who are seeking care or services for a veteran.
www.mirecc.va.gov/coaching

Make the Connection
This online resource is designed to connect veterans, their family members and friends, and other supporters with information, resources, and solutions to issues affecting their lives.
www.MakeTheConnection.net/resources/spread-the-word

Veterans Crisis Line
Call 1-800-273-8255 and press 1, text to 838255, or chat online at VeteransCrisisLine.net/Chat.

Indiana-specific Resources

Indiana National Guard Crisis Intervention
The Indiana National Guard (INNG) Crisis Team operates two 24-hour crisis lines for INNG soldiers; www.in.ng.mil, Crisis Intervention Team: 317-247-3114, INNG Behavioral Health Access Line: 317-247-3155

Indiana Vet Centers
For those veterans who may not be eligible for mental health services through the VA, or for those who would prefer not to go to the VA for mental health services, the Vet Center provides a broad range of counseling, outreach, and referral services to combat veterans and their families. Vet Centers also guide veterans and their families through many of the major adjustments in lifestyle that often occur after a veteran returns from combat. For more information on Vet Centers, go to www.vetcenter.va.gov

- Indianapolis Vet Center – (317) 988-1600 or (877) 927-8387
- Gary Area Vet Center – (219) 736-5633 or (877) 927-8387
- Evansville Vet Center – (812) 473-5993 or (877) 927-8387
- Fort Wayne Vet Center – (260) 460-1456 or (877) 927-8387
- South Bend Vet Center – (574) 231-8480 or (877) 927-8387

This information was adapted from the VA's "Community Toolkit," which can be found here: https://www.va.gov/ve/docs/outreachToolkitPreventingVeteranSuicideIsEveryonesBusiness.pdf

PEOPLE OF TRIBAL NATIONS RISK AND PROTECTIVE FACTORS

People of Tribal Nations have experienced devastating collective, intergenerational massive group trauma and compounding discrimination, racism, and oppression. Suicide prevention efforts seek to reduce risk factors for suicide and strengthen the factors that help strengthen individuals and protect them from suicide (protective factors). Here are a few examples:

Substance use and community violence

Historical trauma and discrimination (forced relocation, removal of children to boarding schools, etc.)

Alienation (i.e. disconnection from their family of origin or culture) or acculturation

Mental health services access and use

Cultural identification and connectedness (i.e. religion, culture)

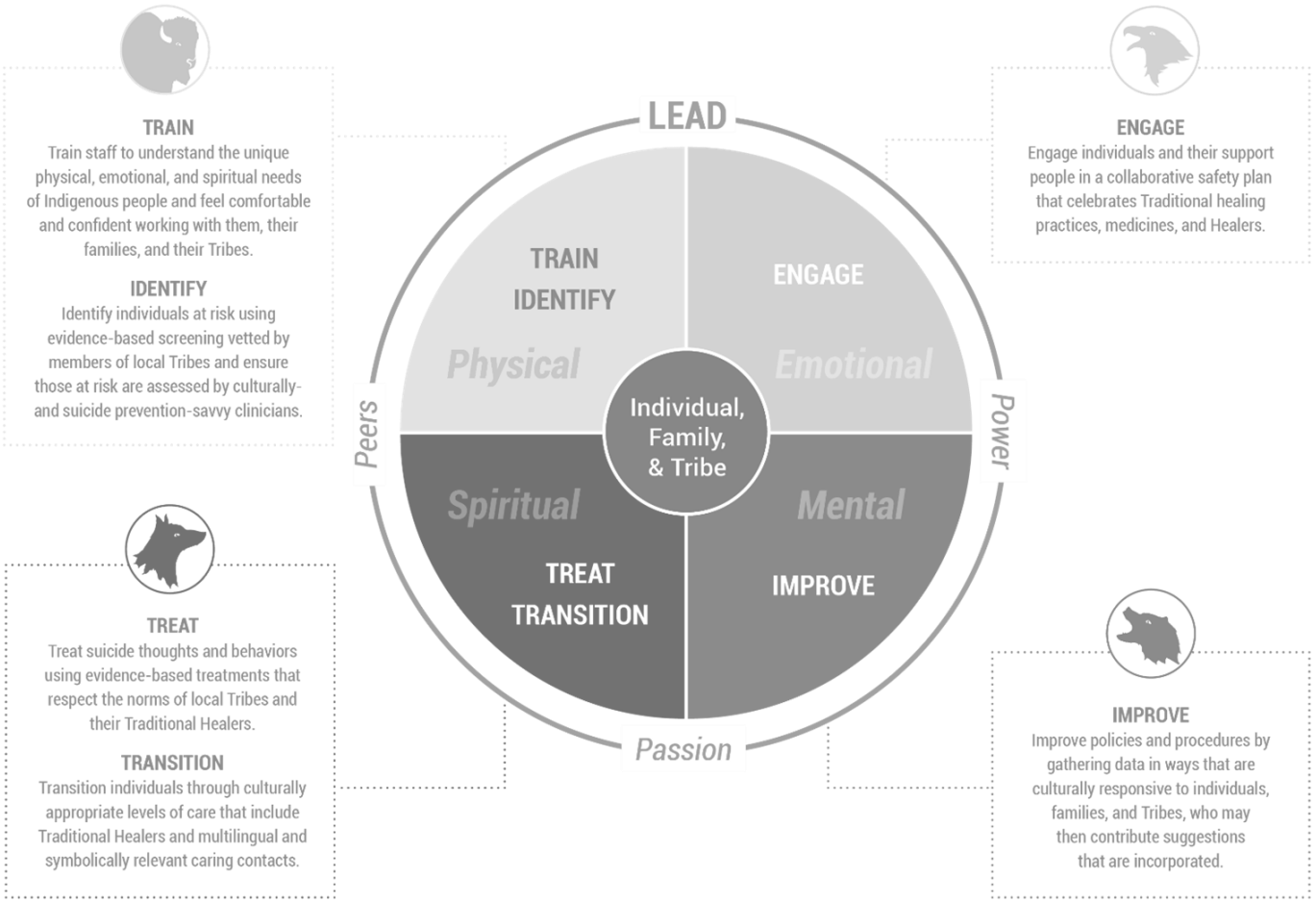
Spirituality (commitment to tribal spirituality)

Community control (ability to implement programs and have centralized forms of governance and structure)

This information was adapted from the SPRC's page on "American Indians and Alaskan Natives) which can be found here: sprc.org/populations/aian

Indiana Department of Health

ZERO SUICIDE FOR PEOPLE OF TRIBAL NATIONS



Zero Suicide's Indian Country toolkit contains recommendations for the implementation of Zero Suicide in Tribal Nations.

It is important to note that there is no such thing as "Native Culture"; rather, there are thousands of unique cultures into which—if done with cultural humility and with focused attention on the Tribe itself, its healing ways, its leadership (i.e. chief, governor, president, and/or chairperson, as well as the tribal council and its youth and elders councils)—Zero Suicide may be implemented effectively and appropriately.

More information can be found about this toolkit here: https://zerosuicide.edc.org/toolkit/indian-country#quicktabs-native_american=0

Indiana Department of Health

How History Affects the Present

Many families of all backgrounds have experienced some type of trauma, but for families from Tribal Nations, there has often been both personal and historical trauma. People who have been through many difficult experiences (especially if these happen in childhood) are more likely to face health, mental health, and substance use challenges.

Individuals from Tribal Nations…

- experience serious psychological distress 1.5x more often than the general population
- experience PTSD more than twice as often
- experience substance use disorder at younger ages, and at higher rates, than in all other ethnic groups

"By reflecting on how these experiences may have shaped our families, we are taking the first step in recognizing both the strengths we have as a community, and the ways of coping that may no longer be serving us. With this self-knowledge and historical knowledge, we can help our children draw from our community's strengths and find new ways of healing and living that will allow them to have better mental health and wellbeing. Our history does not define our destiny."

- Circles of Care California Cohort

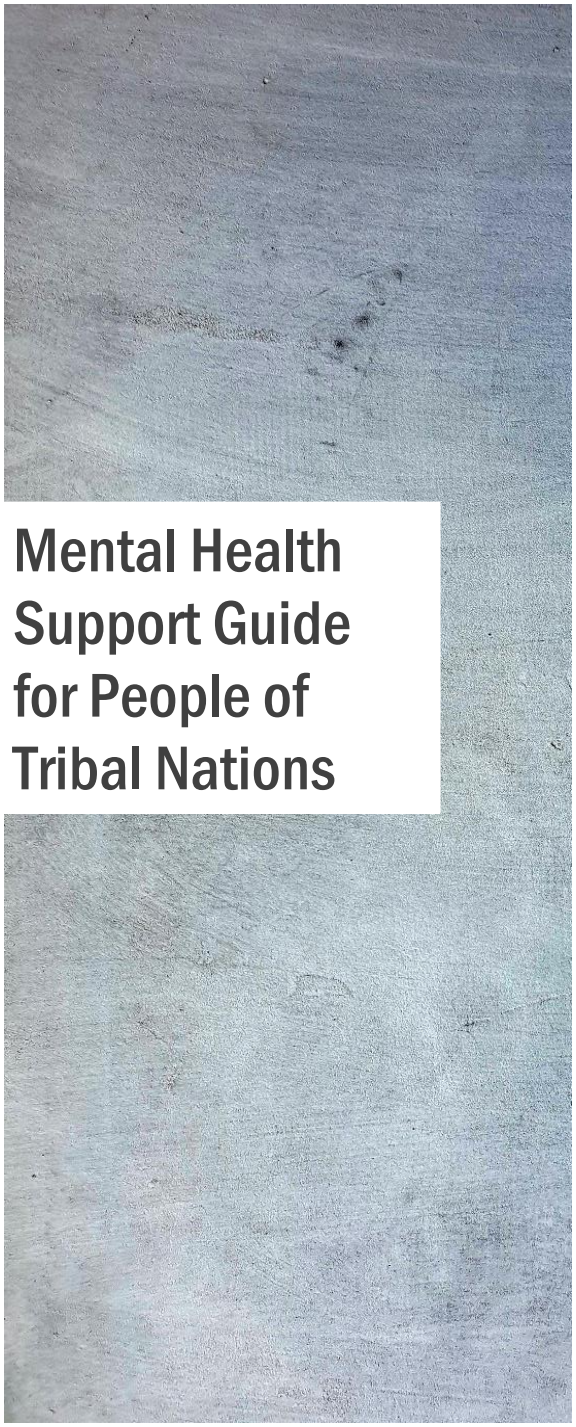
Indiana Department of Health

Further Information

This guide was developed as a part of the Suicide Learning Collaborative Toolkit. To find out more about suicide prevention in Indiana and nationally, please visit:

In.gov/issp
In.gov/isdh/21838.htm
Indianasuicideprevention.org
afsp.org
sprc.org

This information was adapted from a brochure by Each Mind Matters, which can be found here: https://ccuih.org/wp-content/uploads/2020/02/Mental-Health-Support-Guide-Native-Families.pdf



Mental Health Support Guide for People of Tribal Nations

Approaches to Healing

People from Tribal Nations are the product of a resilient, strong people and culture. This resilience and strength can help future generations to **heal, grow, and thrive**.

For example, many Native people have a strong sense of connectedness, reciprocity, balance, and completeness that frames their view of health. This holistic worldview can be the basis of healthy coping skills and improved mental well-being.

This worldview and sense of community can also give people of Tribal Nations a strong foundation when facing mental health challenges. Although adults may feel comfortable seeking support from a spiritual leader – for depression, anxiety, or alcohol and drug problems – young people may not have such strong ties to their ancestry, even though they still need welcoming community support to thrive.

When young people can call upon their community for support and reach out for additional tools like counseling from a mental health provider, they have the best opportunity for healing.

Different Forms of Support

Social support from parents, other caring adults, and peers is vital for Native youth to feel empowered to seek help for their mental health concerns. All children are unique, and a one-size-fits-all approach should never be forced onto someone seeking care. Healing happens when the child is provided with unconditional support.

For many young people, the most effective care is a mix of cultural tradition and medical intervention. **Seeking different types of support doesn't make a person any more or less a part of their community**.

Every step toward better mental health should be celebrated, and everyone's path to wellness is unique. Parents and professionals should respect the young person's self-knowledge and chosen way to heal.

If a therapist or medication isn't working for someone, **parents and young people have the right to be discerning consumers and ask for alternatives** or seek care that is a better fit.

Asking for help is a sign of **strength, not weakness.**

Where to Find More Support

National Suicide Prevention Lifeline
- Call 1.800.273.8255 (TALK)
- Text "IN" to 741741

Be Well Crisis Line
- Call 211, press 3

Veterans Crisis Line
- Call (800)273-TALK (8255)
- Text anything to 838255

Helping Young People in Crisis

A Native young person's community is the most important intervention point if they are going through a crisis. Help young people by:

1. **Learning** how to recognize the signs that they may be thinking of suicide
2. **Talking** with them about their feelings, and
3. **Connecting** them to someone who can help.

Know the signs of suicide, find the words, and reach out.
suicideispreventable.org

If you or someone you care about is in crisis, call the National Suicide Prevention Lifeline at **1-800-273-8255.**

PEOPLE OF TRIBAL NATIONS RESOURCES

WeRNative
This website provides mental health resources and stories by Native youth for Native youth. Content includes "When your friend is talking about suicide," deliberate self-harm, warning signs, and how you might feel if a friend takes their life or is experiencing suicidal ideation.
https://www.wernative.org/my-life/my-mind/suicide

Indian Health Service
Behavioral Health: Suicide Prevention
This webpage lists suicide prevention programs, resources, and documents for American Indian and Alaska Native communities.
http://www.ihs.gov/behavioral/index.cfm?module=BH&option=Suicide

Indian Health Service
AI/AN Community Crisis Response Guidelines
The Community Practice Guidelines are an effort to address the importance of federal and tribal partnerships in addressing suicide behavior-related crises.
https://www.ihs.gov/suicideprevention/communityguidelines/

Suicide Prevention Resource Center
Ai/AN Suicide Prevention
This website provides resources and knowledge specific for American Indian and Alaska Native populations to support suicide prevention and mental health promotion.
http://www.sprc.org/aian

National Suicide Prevention Lifeline
This site, home of the National Suicide Prevention Lifeline, gives suicide prevention materials and resources, specifically for Native individuals and communities in the U.S.
https://suicidepreventionlifeline.org/help-yourself/native-americans/

Action Alliance
Hope for Life Day Toolkit
This toolkit will help community organizers take specific steps to change the conversation about suicide, spread awareness, and foster hope to help address suicide in their communities.
https://theactionalliance.org/communities/american-indian-alaska-native/hope-life-day-toolkit

Center for Native American Youth at the ASPEN Institute
The Center for Native American Youth (CNAY) was created to raise awareness for and prevent teen suicide in Indian Country.
https://www.cnay.org/our-work/suicide-prevention/

Indiana-specific Resources

American Indian Center of Indiana, Inc.
The center provides health care resources, including a Native-focused guidebook for recovery after a suicide attempt.
http://www.americanindiancenter.org/default.php

The Pokagon Band of Potawatomi
This health clinic in South Bend, Indiana, provides behavioral health services and other medical services.
https://www.pokagonband-nsn.gov/government/departments/health-services

Urban Indians
This organization's resources are available to all members of tribes in the U.S., regardless of whether the individual resides on a reservation.
https://www.nuifc.org/

APPENDIX A: Suicide Care Training Options

The Suicide Care Training Options section highlights current trainings available pertinent to different professionals. This list is not an exhaustive list as new trainings have been developed since the release of this document.

This list was originally developed by Zero Suicide and was adapted for the purposes of the Indiana Suicide Prevention Resources Toolkit. The original document can be found here: http://zerosuicide.edc.org/sites/default/files/2020.2.17SuicideCareTrainingOptions.pdf.

SUICIDE CARE TRAINING OPTIONS

TRAININGS FOR ALL CLINICAL STAFF			
Training	**Program Description**	**Format**	**Target Audience**
Assessment of Suicidal Risk Using the Columbia Suicide Severity Rating Scale (C-SSRS) The Columbia Lighthouse Project https://cssrs.columbia.edu/training/training-options/	• Teaches how the C-SSRS is structured and how to administer the brief screening and full versions • Videos show how to use the scale's Suicidal Ideation and Suicidal Behavior sections in client interviews	30 min Online, self-paced	• Health and mental health professionals, paraprofessionals who screen individuals for suicidality
Veteran Barriers to Treatment PsychArmor Institute https://psycharmor.org/courses/bariers-to-treatment/	• Overview of military suicide, symptoms and treatment modalities related to suicide-related behavior • Explains how to help military or veteran patients overcome barriers to seeking treatment	14 min Online, self-paced	• Health, mental health, and public health professionals
Preventing Suicide in Emergency Department Patients Suicide Prevention Resource Center https://training.sprc.org/enrol/index.php?id=8	• Teaches how to conduct screening, assessment, and brief interventions, such as safety planning and lethal means counseling for patients in an Emergency Department • Addresses patient-centered care for persons with suicide risk, patient safety during the ED visit, and incorporating suicide prevention into discharge planning	2 hours Online, self-paced	• Open to anyone, especially designed for health care professionals (e.g., medical providers, nurses, behavioral health providers) who work in emergency departments

Question, Persuade, Refer (QPR): For Doctors and Physicians QPR Institute https://qprinstitute.com/professional-training	• Course teaches routine screening for suicide risk and how to conduct a brief best practice assessment	6 hours Online ($139), self- paced	• Health and mental health professionals • Customized versions available for nurses ($89), occupational/ physical therapists ($79), and pharmacists ($79)
Structured Follow-Up and Monitoring for Suicidal Individuals Maine Center for Disease Control and Prevention and Sweetser https://sweetser.academy.reliaslearning.com/Structured-Follow-Up-Monitoring-Online-Course--RFMH001.aspx	• Describes what structured follow-up and monitoring is and how it can help persons at risk for suicide • Teaches how to provide structured follow-up and monitoring for individuals after a crisis, during the time of transition from an emergency visit, when there is increased suicidal ideation, or after a suicide attempt	45 minutes Online, self-paced	• Health and mental health professionals and paraprofessionals who follow up with clients after a crisis
Safety Planning Intervention for Suicide Prevention Maine Center for Disease Control and Prevention https://sweetser.academy.reliaslearning.com/Safety-Planning-Intervention-for-Suicide-Prevention-Online-Course--SP-SP001.aspx	• Guides participants in developing a safety plan in collaboration with persons who are at high risk for suicide • Video examples show developing a safety plan with a client	45 min Online self-paced	• Health and mental health professionals and paraprofessionals • This version is a module that is often used as a part of a more comprehensive training; for in-depth training on implementing the intervention, contact the authors
Counseling on Access to Lethal Means (CALM) Suicide Prevention Resource Center https://training.sprc.org/enrol/index.php?id=20	• Covers the importance of reducing access to lethal means • Teaches practical skills on when and how to ask clients experiencing suicidal ideation about their access to lethal means and how to work with them to reduce that access	2 hours Online, self-paced	• Health and mental health professionals and paraprofessionals

TRAININGS FOR CLINICAL ASSESSMENT AND MANAGEMENT OF SUICIDE RISK

Training	Program Description	Format	Target Audience
Assessing and Managing Suicide Risk (AMSR) Suicide Prevention Resource Center http://zerosuicideinstitute.com/amsr/trainings	• Expands the clinical skills of providers and offers a clear and descriptive suicide risk formulation model to inform long-term treatment planning • Teaching and skills-building methods include video demonstrations, group discussion, written practice, case review	6.5 hours In-person or online ($135)	• Mental health professionals
Cognitive Behavioral Therapy (CBT) Aaron Beck Psychopathology Research Center https://beckinstitute.org/get-training/online-training/	• Training in Cognitive Therapy – Suicide Prevention (CT-SP), an evidence-based, time-limited therapeutic framework specifically for suicidal thoughts and behaviors	Varies In-person or online ($350)	• Mental health professionals • Additional training options include suicide risk assessment, safety planning intervention, and intensive training in CT-SP
Collaborative Assessment and Management of Suicidality (CAMS) CAMS-care, LLC https://cams-care.com/products/cams-foundational-online-training/	• Teaches the Collaborative Assessment and Management of Suicidality (CAMS), an evidence-based, therapeutic framework emphasizing collaborative assessment and treatment planning	Varies In-person, online ($99), or consultation	• Mental health professionals • There are various CAMS training options to meet the needs and expectations of a wide range of clinicians and systems of care
Dialectical Behavior Therapy (DBT) Behavioral Tech https://behavioraltech.org/store/online-training-courses/dbt-skills-training-powered-by-psychwire/	• Training in foundations and application of Dialectical Behavior Therapy, an evidence-based therapeutic framework	Varies In-person, online ($590), or consultation	• Mental health professionals • Various training options including suicide intervention and DBT certification
Addressing Suicidal Thoughts and Behaviors in SUD Treatment SAMHSA https://www.youtube.com/watch?v=1n2QZlheuzc&feature=youtu.be	• Provides necessary information on how to treat clients with SUD issues and suicidal thoughts/behaviors • Gives information on suicide, SUD (risk factors and warning signs), and follow up care	1 hour, 15 min Online, self-paced	• Anyone working in a Substance Use Disorder (SUD) treatment setting

TRAININGS FOR EMERGENCY DEPARTMENT AND PRIMARY CARE SETTINGS

Training	Program Description	Format	Target Audience
At-Risk in the ED Kognito https://kognito.com/products/at-risk-emergency-department	• Build skills in screening patients for substance use, mental health disorders, and suicide risk, collaboratively engaging in treatment planning, and referring patients for further support as part of routine care • Focused on integrating behavioral health in acute care	1 hour Online, self-paced	• Emergency department professionals (nurses & medical providers), and medical students
At-Risk in Primary Care Kognito https://kognito.com/products/at-risk-in- primary-care	• Prepares primary care personnel to screen patients for mental health and substance abuse disorders including suicide risk, perform brief interventions, and refer patients to treatment	1 hour Online, self-paced	• Primary care professionals who screen patients for mental health and substance abuse disorders
Recognizing & Responding to Suicide Risk in Primary Care American Association of Suicidology http://www.suicidology.org/training-accreditation/rrsr-pc	• Teaches how to integrate suicide risk assessments into routine office visits, to formulate relative risk, and to work collaboratively with patients to create treatment plans • Includes a pocket assessment tool and reproducible patient handouts	1 hour Online, self-paced	• Medical providers such as nurses, physicians, physician assistants, and nurse practitioners working in primary care
SafeSide Primary Care SafeSide Prevention https://www.safesideprevention.com/zs- programs	• Brief teaching, demonstrations, and group discussion that provide a framework and practical steps for primary care • Three 50-min group video sessions	Blended video and group- based learning	• Primary care providers and staff
Preventing Suicide in ED Patients SPRC https://training.sprc.org/enrol/index.php?id=30	• Teaches healthcare professionals how to conduct screening, assessment, and brief interventions • Addresses patient-centered care, patient safety, and discharge planning	2 hours Online, self-paced	• Healthcare professionals who work in EDs with patients at risk of suicide

TRAININGS FOR FIRST RESPONDERS			
Training	**Program Description**	**Format**	**Target Audience**
Safeguarding Children of Arrested Parents Office of Justice Programs https://www.youtube.com/watch?v=ir2xA6XniSA	• Introduces many core principles of the *Safeguarding Children of Arrested Parents Model Policy,* which serves as a template for law-enforcement agencies as they develop and/or revise policies and procedures addressing arrest processes. • Teaches how to mitigate the potential traumatic impact of a parent's arrest on children	16 minutes Online, self-paced	• All first responders who may interact with children
Mental Health First Aid for Public Safety Mental Health First Aid https://www.mentalhealthfirstaid.org/2020/04/coming-soon-virtual-option-for-mental-health-first-aid/	• An online version of the Mental Health First Aid training will soon become available. • Teaches individuals how to identify, understand and respond to signs of mental illnesses and substance use disorders.	6 hours Blended videos and group-based learning	• All first responders who may interact with children
Psychological First Aid American Red Cross https://www.redcross.org/take-a-class/classes/psychological-first-aid%3A-supporting-yourself-and-others-during-covid-19/a6R3o0000014ZIg.html	• Reviews basic principles of providing psychological first aid, including how to recognize and manage stress in yourself and in others and how to lend support to family members, friends and coworkers	Online, self-paced	• All first responders
Question, Persuade, Refer (QPR): For Law Enforcement QPR Institute https://qprinstitute.com/professional-training	• Course teaches what one needs to know to protect co-workers, friends, family, and community	6 hours Online ($59), self- paced	• Law enforcement professionals • Customized versions available for firefighters and EMS ($59)

Victim Assistance Training Online Office for Victims of Crime Training & Technical Assistance Center https://www.ovcttac.gov/views/TrainingMaterials/dspOnline_VATOnline.cfm	• Offers victim service providers and allied professionals the opportunity to acquire the essential skills and knowledge they need to more effectively assist victims of crime. • Includes various relevant topics such as: Crisis Intervention, Self-Care, Trauma-Informed Care, LGBTQ Populations, Victims with Mental Health Issues, Victims with Substance Abuse Issues reviewing basic principles of providing psychological first aid, including how to recognize and manage stress in yourself and in others and how to lend support to family members, friends and coworkers	30 min – 1 hour, varies Online, self-paced	• All first responders
CIT Training CIT Indiana https://www.cit-indiana.org/	• Focuses on collaborative relationships between Law Enforcement, mental health providers, and individuals impacted by mental illness. • The goal of this program is to increase safety, decrease the number of individuals with mental illness entering the criminal justice system and increasing referrals to mental health services.	40 hours In person (free)	• Law enforcement agencies • 10-20% of the seats for non-law enforcement (emergency center personnel, fire, EMS, or individuals working with other CIT-involved agencies
Applied Suicide Intervention Skills Training Living Works https://legacy.livingworks.net/training-and-trainers/find-a-training-workshop/?sort=date&type=20	• Applied Suicide Intervention Skills Training (ASIST) teaches trainees how to prevent suicide by recognizing signs, providing a skilled intervention, and developing a safety plan to keep someone alive.	15 hours In person Depends	• Anyone expected to intervene with high risk groups (i.e. Law enforcement, CIT officers, SWAT teams, Peer Support Teams)

TRAININGS FOR GOVERNMENT			
Resource	**Description**	**Format**	**Target Audience**
National Strategy for Suicide Prevention U.S. Surgeon General and the National Action Alliance for Suicide Prevention https://www.ncbi.nlm.nih.gov/books/NBK109917/	• The National Strategy is a call to action that is intended to guide suicide prevention actions in the United States • It outlines four strategic directions with 13 goals and 60 objectives that are meant to work together in a synergistic way to prevent suicide in the nation	Strategic Plan	• Anyone
Suicide Prevention Strategic Plan Centers for Disease Control and Prevention https://www.cdc.gov/violenceprevention/suicide/strategic-plan/index.html	• The CDC's strategic plan outlines four key strategies and goals: data, science, action, collaboration.	Strategic Plan	• Government officials (state and local), stakeholder groups
Preventing Suicide: A Technical Package of Policy, Programs, and Practices Centers for Disease Control and Prevention https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf	• This technical package represents a select group of strategies based on the best available evidence. • Strategies include strengthening economic supports; strengthening access and delivery of suicide care; creating protective environments; promoting connectedness; teaching coping and problem-solving skills; identifying and supporting people at risk; and lessening harms and preventing future risk.	Technical Package	• Government officials (state and local), stakeholder groups

Suicide Prevention Resources National Action Alliance for Suicide Prevention https://theactionalliance.org/	• The National Action Alliance boasts a variety of suicide prevention content with resources addressing suicide prevention in faith communities, juvenile justice, and workplace suicide prevention.	Organization	• Anyone
Locating and Understanding Data for Suicide Prevention Training SPRC https://training.sprc.org/enrol/index.php?id=35	• Presents a variety of data sources that are useful for finding information about suicide • Explains key concepts that will help one better understand data	2 hours Online, self-paced	• Anyone
A Strategic Planning Approach to Suicide Prevention Training SPRC https://training.sprc.org/enrol/index.php?id=31	• Identifies activities that will be effective in addressing the problem of suicide • Helps prioritize efforts	2-3 hours Online, self-paced	• Anyone
Crisis Worker Certification Training American Association of Suicidology https://www.suicidology.community/store/ViewProduct.aspx?ID=14160414	• This webinar helps prepare individuals for the AAS Crisis Worker Certification Exam • Completing the webinar does not lead to certification, but helps	Online, self-paced $25	• Anyone interested in becoming a crisis worker
LivingWorks Start Training LivingWorks https://www.livingworks.net/start	• Teaches trainees to recognize when someone is thinking about suicide and connect them to help	Online, self-paced, $30	• Anyone interested in becoming a crisis worker
S.A.V.E. Department of Veterans Affairs https://psycharmor.org/courses/s-a-v-e/	• Understand how to identify a veteran who may be at risk for suicide • Know what to do if a veteran is at risk	25 min Online, self-paced	• Anyone who interacts with Veterans
Lifeguard Workshop Trevor Project https://www.thetrevorproject.org/education/lifeguard-workshop/	• Identify the challenges faced by LGBTQ people • Recognize the warning signs of suicide • Respond to someone in crisis	15 min Online, self-paced	• Anyone who interacts with Veterans

Evidence-Based Program Repositories for Stakeholder Groups			
Training	**Program Description**	**Format**	**Target Audience**
National Registry of Evidence-Based Programs and Practices (NREPP) SAMHSA https://www.samhsa.gov/nrepp	• This searchable registry, maintained by the Substance Abuse and Mental Health Services Administration, lists programs with evidence of effectiveness in preventing or reducing behavioral health problems, including suicide.	Site	• All stakeholder groups
SAMHSA's Evidence-Based Practices Resource Center SAMHSA https://www.samhsa.gov/ebp-resource-center	• This Resource Center contains a collection of science-based resources for a broad range of audiences. The resources include Treatment Improvement Protocols, toolkits, clinical practice guidelines, and other resource types.	Site	• All stakeholder groups
SPRC Resources and Programs Repository Suicide Prevention Resource Center https://www.sprc.org/resources-programs	• This searchable repository provides information on several types of suicide prevention programs, such as education/training, screening, treatment, and environmental change.	Site	• All stakeholder groups
Promising Prevention Practices Suicide Prevention Resource Center https://www.sprc.org/aian/promising-prevention-practices	• This list of promising prevention practices is culturally appropriate for American Indian/Alaskan Native settings. The recommended resources below provide information on culturally appropriate practices that may reduce risk and increase protective factors for suicide.	Site	• All stakeholder groups
Evidence-Based Practices & Programs National Institutes of Health https://prevention.nih.gov/research-priorities/dissemination-implementation/evidence-based-practices-programs	• These federal resources can help individuals identify evidence-based disease prevention approaches that have the potential to impact public health.	Site	• All stakeholder groups
Evidence-Based Programs Directory Youth.gov https://youth.gov/evidence-innovation/evidence-based-program-directories	• Multiple federal agencies have put together registries that list evidence-based programs as a way to disseminate information about programs and their level of effectiveness.	Site	• All stakeholder groups

TRAININGS FOR INDIVIDUALS WHO WORK IN CORRECTIONAL FACILITIES			
Training	**Program Description**	**Format**	**Target Audience**
Inmate Suicide Prevention National Institute of Corrections https://nic.learn.com/courseredirect.asp?courseid=2395&DCT=1&sessionid=3-A6FFAC46-3895-45BE-B233-D24803C0EF09&lcid=178409&from=course	• Provides individuals with an overview of the problem of suicide within correctional facilities • Highlights ways employees can help prevent suicides in correctional facilities	1 hour Online, self-paced	• All correctional facility employees
PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting National Institute of Corrections https://nic.learn.com/courseredirect.asp?courseid=2047&DCT=1&sessionid=3-A6FFAC46-3895-45BE-B233-D24803C0EF09&lcid=178409&from=course	• Explains the knowledge, components, and considerations that individuals must use to be effective as a behavioral health care practitioner	3 hours Online, self-paced	• Behavioral health care practitioners working in correctional settings
Managing Inmates with Mental Illness American Correctional Association http://www.aca.org/ACA_Prod_iMIS/ItemDetail?iProductCode=EL-MIMI&Category=E-LEARNING&WebsiteKey=139f6b09-e150-4c56-9c66-284b92f21e51	• Reviews the factors that influence individuals who are justice involved with mental illness • Identifies the common signs of mental illness and examines how to manage these individuals	5 hours Online, self-paced $50	• All correctional facility employees
Understanding Mental Illness and Treatment in the Correctional Setting American Correctional Association http://www.aca.org/ACA_Prod_iMIS/ItemDetail?iProductCode=EL-UMIT&Category=E-LEARNING&WebsiteKey=139f6b09-e150-4c56-9c66-284b92f21e51	• Learn about mental illness and its definition, causes, and myths • Examine the common mental disorders of individuals who are justice involved • Study the treatment that is provided to individuals with justice involvement	11 hours Online, self-paced $50	• All correctional facility employees

Understanding and Preventing Suicides in Corrections American Correctional Association http://www.aca.org/ACA_Prod_iMIS/ItemDetail?iProductCode=EL-UMIT&Category=E-LEARNING&WebsiteKey=139f6b09-e150-4c56-9c66-284b92f21e51	• Discusses the common myths surrounding suicide and learn about stressors, critical times, risk factors, and warning signs • Examines how to identify at-risk individuals • Gives an in-depth understanding of comprehensive suicide prevention programs	14 hours Online, self-paced $50	• All correctional facility employees
Understanding and Preventing Suicides in Corrections American Correctional Association http://www.aca.org/ACA_Prod_iMIS/ItemDetail?iProductCode=EL-MDSI&Category=E-LEARNING&WebsiteKey=139f6b09-e150-4c56-9c66-284b92f21e51	• Discusses the five steps officers should take and illustrates how to communicate effectively • Examines the impact of suicide on staff and individuals with justice involvement	10 hours Online, self-paced $50	• All correctional facility employees

RESOURCES FOR YOUTH, CAREGIVERS, AND MENTORS

Resource	Description	Method of Delivery	Target Audience
You Matter Suicide Prevention Lifeline https://youmatter.suicidepreventionlifeline.org/about-you-matter-2/	• A blog for youth (13-24) to share their challenges with mental health and wellness	Online platform and sharing space	• Young teens to young adults
Lifeline Chat Suicide Prevention Lifeline https://suicidepreventionlifeline.org/chat/?_ga=2.149270782.93319875.1590590243-6828336.1589909396	• A chat platform that connects individuals with a counselor	Online platform and sharing space	• Any age
Active Minds https://www.activeminds.org/about-us/mission-and-impact/	• Peer-to-peer support model ideal for young adults	Peer-to-peer program	• Transition age teens
Seize the Awkward https://seizetheawkward.org/	• A resource around peer-to-peer conversations and mental health	Peer-to-peer media campaign	• Young teens and up
Now Matters Now https://www.nowmattersnow.org/skills	• Resource for coping strategies based on DBT (mindfulness, etc.)	Online platform	• Young teens and up
Trevor Project https://www.thetrevorproject.org/	• Provides programmatic support to LGBTQ youth through their lifeline, chat, text, and space	Online platform	• LGBTQ+ teens
Love is Respect https://www.loveisrespect.org/	• Resource for those in abusive relationships • Education on how to get help and healthy relationships	Online platform	• Youth, mentors, and advocates
Ditch the Label https://www.ditchthelabel.org/mental-health-support-hub/	• Mental health resources for those under 25	Online platform	• Youth, mentors

Emergency Taskforce on Black Youth Suicide and Mental Health Congressional Black Caucus https://watsoncoleman.house.gov/uploadedfiles/executive_summary_and_recs_only.pdf	• A report to Congress on the crisis of black youth suicide in America	Report	• Professionals, advocates, and providers
Mental Health and Latino Kids: A Research Review Salud America! https://salud-america.org/wp-content/uploads/2017/09/FINAL-mental-health-research-review-9-12-17.pdf	• Outlines the current state of suicide among the Latino population	Article	• Professionals, instructors and advocates/allies
National Asian American Pacific Islander Mental Health Association https://naapimha.org	• Organization that exists to promote the mental health of Asian American and Pacific Islander communities	Online platform	• Professionals, mentors, and organizations
WeRNative My Mind: Suicide https://www.wernative.org/my-life/my-mind/suicide	• Serves as a resource page specifically for native youth • Provides tools around topics such as depression, self-harm, and suicide	Online platform	• Native youth

RESOURCES FOR SCHOOLS			
Resource	**Description**	**Method of Delivery**	**Target Audience**
2018 Suicide Prevention and Response: A Comprehensive Resource Guide for Indiana Schools Indiana Department of Education https://www.doe.in.gov/sites/default/files/sebw/suicide-resource-guide-indiana-schools-4.pdf	• Guide for Indiana schools on prevention, intervention, and postvention • Model school policy language	Toolkit	• School administration
Suicide Prevention among LGBT Youth: A Workshop for Professionals Who Serve Youth Suicide Prevention Resource Center https://www.sprc.org/resources-programs/suicide-prevention-among-lgbt-youth-workshop-professionals-who-serve-youth-0	• A free kit of materials to help staff in schools, youth-serving agencies, and suicide prevention programs provide a workshop on suicide prevention among LGBT youth.	Toolkit	• School administration and youth-serving agencies
After a Suicide: A Toolkit for Schools Suicide Prevention Resource Center https://www.sprc.org/sites/default/files/resource-program/AfteraSuicideToolkitforSchools.pdf	• Full toolkit on the approach that schools should take to suicide prevention, intervention, and postvention	Toolkit	• School administration
Model School District Policy on Suicide Prevention: Model Language, Commentary, and Resources American Foundation for Suicide Prevention https://www.sprc.org/sites/default/files/resource-program/AfteraSuicideToolkitforSchools.pdf	• This document outlines several model school district policies around suicide • This can be pared with “After a Suicide: A Toolkit for Schools”	Toolkit	• School administration
Equity in Mental Health Framework Equity in Mental Health Framework https://equityinmentalhealth.org/framework/	• Recommendations for colleges and universities to fully support the mental health of students of color • How to apply a health-equity mindset to mental health frameworks	Toolkit	• College and university administrators

Seize the Awkward Campus Toolkit American Foundation for Suicide Prevention https://seizetheawkward.org/docs/STA_Campus_Toolkit.pdf	• Tips on how to help young adults and students who may be struggling with their mental health • Best practices to have supportive conversations about everyday challenges faced by students	Toolkit	• College and university administrators
Preventing suicide: Role of high school mental health providers Suicide Prevention Resource Center http://www.sprc.org/resources-programs/role-high-school-mental-health-providers-preventing-suicide-sprc-customized	• Information on recognizing and responding to suicide warning signs, resources about suicide prevention, and other information to help prevent suicide among students	Toolkit	• High school mental health providers

APPENDIX B: Works Cited

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APPENDIX C: Organizational Partners

Indiana Department of Health

Division of Mental Health and Addiction

INDIANA DEPARTMENT OF CHILD SERVICES

INDIANA SUICIDE PREVENTION NETWORK

IDHS

PARKVIEW BEHAVIORAL HEALTH INSTITUTE

NAMI Indiana
National Alliance on Mental Illness

Indiana Department of Education

Anthem

American Foundation for Suicide Prevention

Indiana Department of Correction

HAMILTON CENTER, INC.

WELLNESS COUNCIL OF INDIANA

PURDUE UNIVERSITY FORT WAYNE
Behavioral Health and Family Studies Institute

THE WEXFORD COMPANIES

DAC
Allen County Drug & Alcohol Consortium, Inc.

Marion County Coroner
Indianapolis

Plainfield Community School Corporation

WARRICK COUNTY School Corporation

Indiana Department of Health