

# **School Based Gatekeeper Training To Prevent Adolescent Suicide**

## ***The Safety N.E.T. Program: Notice, Engage, Talk***

***Materials Originally Developed With Support From:***

**Illinois Suicide Prevention Coalition  
Mental Health Association in Illinois**

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# Rationale of School-Based Gatekeeper Training to Prevent Adolescent Suicide

Student comes to attention of gatekeeper



- Notice
- Engage
- Talk



Student seen by in-school mental health professional



Preliminary suicide risk assessment conducted at the school:

*TIME or IS PATH WARM ?*

# Rationale of School-Based Gatekeeper Training to Prevent Adolescent Suicide

- Who is a “gatekeeper”?
- *Gatekeepers* are all adults who work in the school setting who regularly interact and/or observe students:
  - Teachers
  - Administrators
  - Clerical & support staff
  - School nurse
  - Counselors
  - School librarian
  - Custodial staff
  - Coaches
- A *Gatekeeper* is anyone who may be the first adult to observe signs and symptoms of adolescent depression and/or suicidal risk
- *Gatekeepers* are not expected to function as mental health providers, but to simply keep a watchful eye and are able to “sound the alarm” when an at-risk student is identified.
- It is the gatekeeper’s responsibility to refer students of concern to the appropriate in-school mental health professional for further evaluation.

# Rationale of School-Based Gatekeeper Training to Prevent Adolescent Suicide

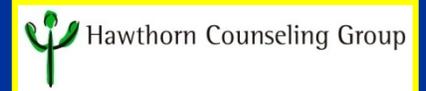
- Research findings have indicated that more than 25% of teachers have been approached by a suicidal adolescent, but that fewer than 9% felt confident in their abilities to recognize and manage the suicidal teenager.
- What factors might interfere with a gatekeepers' ability to make referrals of at-risk students?
  - Not having the opportunity to notice warning signs
  - Diffusion of responsibility—assuming someone else in the school will intervene and link student to necessary services
  - Reluctance to overstep professional bounds
  - Not wanting to “betray” the student by making the referral to resources within the school
  - Unfamiliarity with social services staff within the school, lack of relationship with the receiving counselor/social worker
  - Lack of confidence or reluctance to get involved, particularly with a difficult family who might object to interventions

# Adolescent Suicide: True or False?

## True or False?

1. **Adolescent suicide is an increasing problem in the U.S.**  
**TRUE** While the rate of suicide in the general population has been generally stable since the 1950's, adolescent suicide rates have more than tripled.
2. **Most teenagers will reveal that they are suicidal or if they having problems.**  
**TRUE** Most teens who are experiencing active suicidal ideation will admit their plans to someone who is concerned and inquires about their distress.
3. **Adolescents who talk about suicide are not the ones who actually make an attempt.**  
**FALSE** People usually give some advance indication of suicidal intent; suicidal threats, preoccupation or behavior must always be taken seriously.
4. **Talking with someone about suicide may promote suicidal ideas and behavior.**  
**FALSE** It is inner distress, psychiatric illness, serious life stressors and irrational thinking that lead to suicidal behavior, not expressions of concern by others.

**Source:** Florida Institute of Mental Health / University of South Florida (2003)



# Adolescent Suicide: True or False?

5. Parents are often unaware of their child's suicidal ideation and behavior.

**TRUE** Studies have shown that, among parents of children found to have suicidal ideation, up to 86% of parents were unaware of their child's suicidal risk.

6. The majority of adolescent suicides occur unexpectedly with no warning signs.

**FALSE** Over 90% of suicidal adolescents give clues to others prior to their attempt.

7. Most adolescents who attempt suicide fully intend to die.

**FALSE** As a rule, survivors of suicide attempts are relieved to have lived through their suicidal crisis and are grateful for intervention.

8. There are differences between adolescent males & females regarding suicidal behavior.

**TRUE** Females attempt suicide more frequently than males (3:1), however males complete suicide more frequently than females (4:1) because boys tend to use more lethal means (e.g., firearms)

9. Since adolescent females complete suicide less often than males, their attempts should not be taken seriously.

**FALSE** A prior attempt is a significant risk factor for later death by suicide—every threat or other form of suicidal behavior must be taken seriously.

Source: Florida Institute of Mental Health / University of South Florida (2003)



# Adolescent Suicide: True or False?

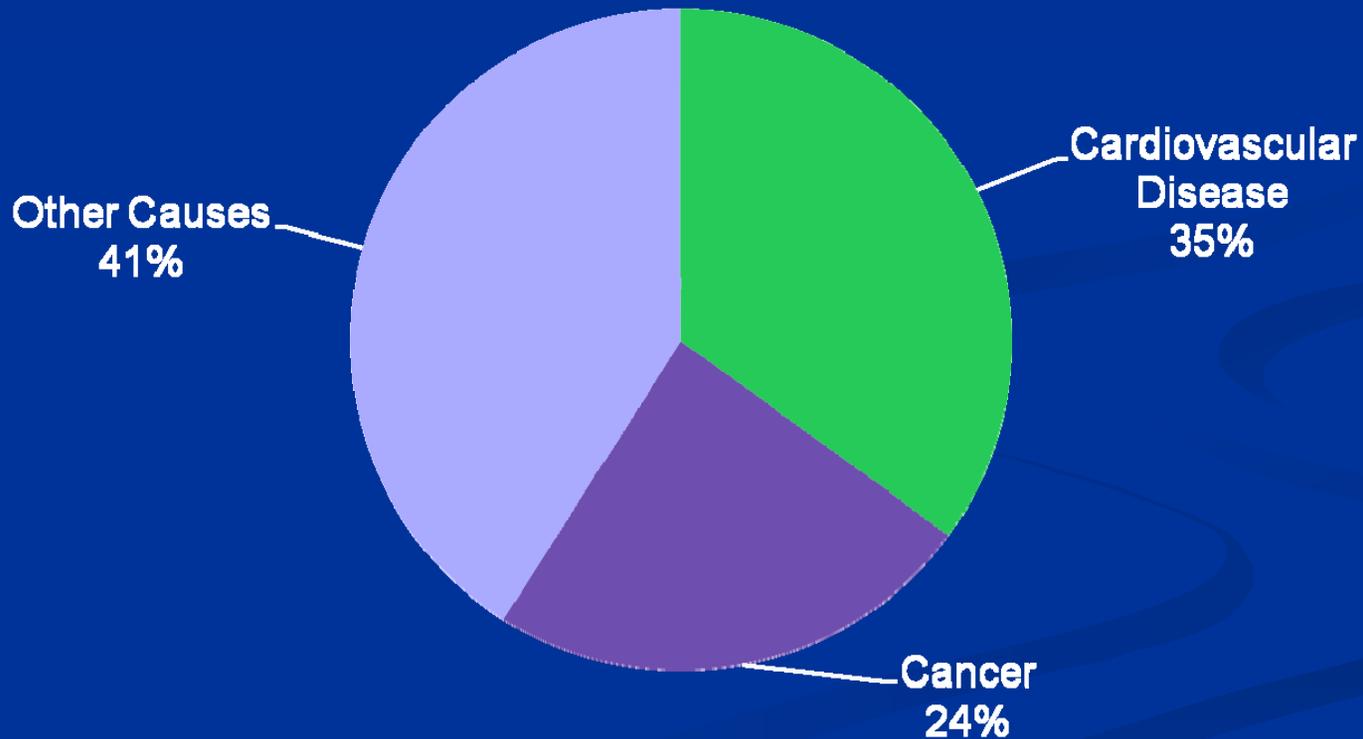
10. Adolescent suicide occurs mostly with lower SES (socioeconomic status) kids than among those with easier access to treatment resources.  
**FALSE** Adolescent suicide is a threat to kids of every socioeconomic level.
11. The only one who can be of help to a suicidal adolescent is a trained mental health professional.  
**FALSE** Most adolescents contemplating suicide are not under the care of a mental health professional and are more likely to initially come to the attention of non-professional, who then facilitates a referral.
12. A teacher who observes distress or warning signs in his/her student should not betray the student's trust by referring the student to the school social worker.  
**FALSE** Adolescent suicide is a serious public health issue and referral to in-school mental health resources should always occur whenever warning signs of suicide are observed.
13. If an adolescent wants to commit suicide there is nothing anyone can do to prevent its occurrence.  
**FALSE** Prompt identification, intervention, means restriction, support and treatment of an underlying condition are all effective means to prevent suicide.

Source: Florida Institute of Mental Health / University of South Florida (2003)



# Perspectives on Adolescent Health

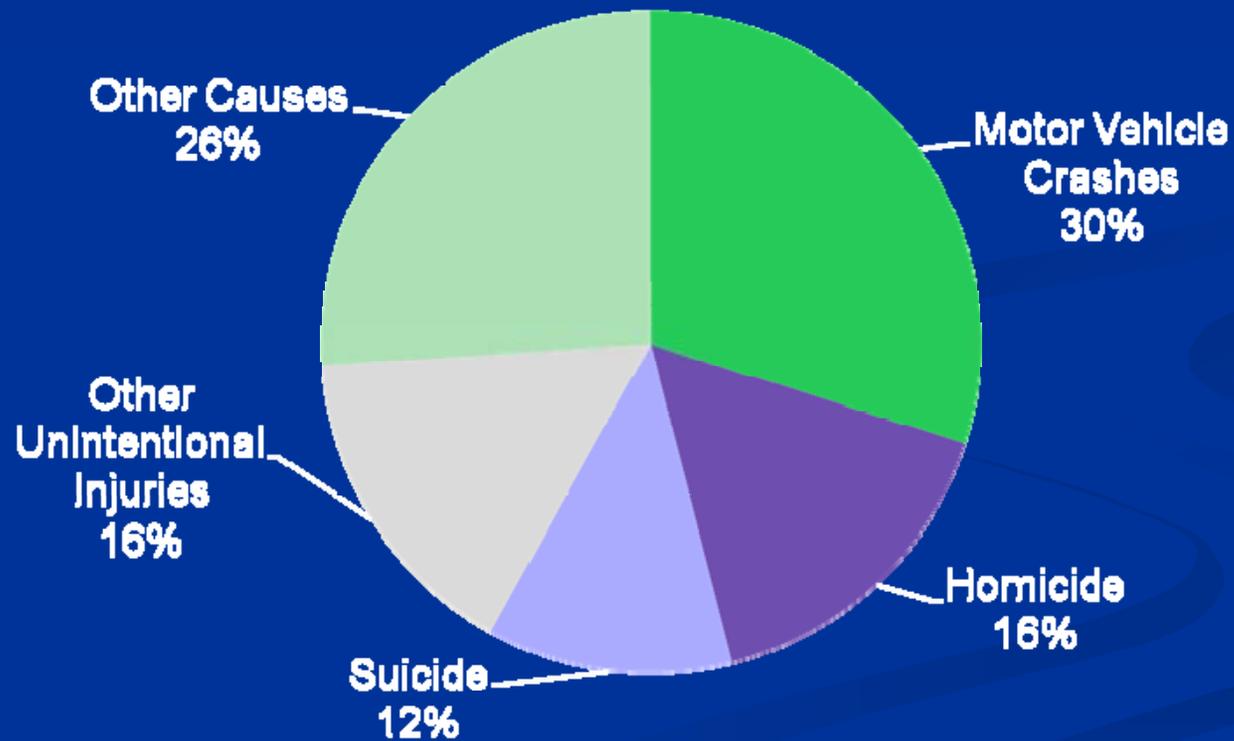
## Leading Causes of Death Among Persons Aged 25 Years and Older in the United States, 2006



**Source:** National Center for Injury Prevention and Control, Centers for Disease Control (2012).

# Perspectives on Adolescent Health

## Leading Causes of Death Among Persons Aged 10 – 24 Years in the United States, 2006



**Source:** National Center for Injury Prevention and Control, Centers for Disease Control (2012).

# Perspectives on Adolescent Health

## 10 Leading Causes of Death by Age Group, United States – 2008

Rank	Age Groups										Total
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Congenital Anomalies 5,638	Unintentional Injury 1,469	Unintentional Injury 835	Unintentional Injury 1,024	Unintentional Injury 14,089	Unintentional Injury 14,588	Unintentional Injury 16,065	Malignant Neoplasms 50,403	Malignant Neoplasms 104,091	Heart Disease 495,730	Heart Disease 616,828
2	Short Gestation 4,754	Congenital Anomalies 521	Malignant Neoplasms 457	Malignant Neoplasms 433	Homicide 5,275	Suicide 5,300	Malignant Neoplasms 12,699	Heart Disease 37,892	Heart Disease 66,711	Malignant Neoplasms 391,729	Malignant Neoplasms 565,469
3	SIDS 2,353	Homicide 421	Congenital Anomalies 170	Suicide 215	Suicide 4,298	Homicide 4,610	Heart Disease 11,336	Unintentional Injury 20,354	Chronic Low. Respiratory Disease 14,042	Chronic Low. Respiratory Disease 121,223	Chronic Low. Respiratory Disease 141,090
4	Maternal Pregnancy Comp. 1,765	Malignant Neoplasms 394	Homicide 113	Homicide 207	Malignant Neoplasms 1,663	Malignant Neoplasms 3,521	Suicide 6,703	Suicide 8,287	Unintentional Injury 12,782	Cerebrovascular 114,508	Cerebrovascular 134,148
5	Unintentional Injury 1,315	Heart Disease 186	Heart Disease 97	Congenital Anomalies 161	Heart Disease 1,065	Heart Disease 3,254	Homicide 2,906	Liver Disease 8,220	Diabetes Mellitus 11,370	Alzheimer's Disease 81,573	Unintentional Injury 121,902
6	Placenta Cord Membranes 1,080	Influenza & Pneumonia 142	Benign Neoplasms 59	Heart Disease 132	Congenital Anomalies 467	HIV 975	HIV 2,838	Cerebrovascular 6,112	Cerebrovascular 10,459	Diabetes Mellitus 50,883	Alzheimer's Disease 82,435
7	Bacterial Sepsis 700	Septicemia 93	Chronic Low. Respiratory Disease 55	Chronic Low. Respiratory Disease 64	Influenza & Pneumonia 206	Diabetes Mellitus 574	Liver Disease 2,562	Diabetes Mellitus 5,622	Liver Disease 8,526	Influenza & Pneumonia 48,382	Diabetes Mellitus 70,553
8	Respiratory Distress 630	Cerebrovascular 63	Cerebrovascular 41	Cerebrovascular 56	Diabetes Mellitus 204	Cerebrovascular 539	Cerebrovascular 2,035	Chronic Low. Respiratory Disease 4,392	Suicide 5,465	Nephritis 39,921	Influenza & Pneumonia 56,284
9	Circulatory System Disease 594	Chronic Low. Respiratory Disease 54	Influenza & Pneumonia 40	Influenza & Pneumonia 49	Cerebrovascular 189	Liver Disease 423	Diabetes Mellitus 1,854	HIV 3,730	Nephritis 4,803	Unintentional Injury 39,359	Nephritis 48,237
10	Neonatal Hemorrhage 556	Perinatal Period 51	Septicemia 25	Septicemia 36	Complicated Pregnancy 169	Congenital Anomalies 379	Septicemia 892	Viral Hepatitis 2,732	Septicemia 4,552	Septicemia 27,028	Suicide 36,035



Centers for Disease Control and Prevention  
National Center for Injury Prevention and Control

Source: National Vital Statistics System, National Center for Health Statistics, CDC.  
Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC.

CS227502

# Adolescent Suicide: Scope of the Problem

- Adolescent suicide is a major public health problem.
- In 2009 there were a total of 36,909 suicides in the United States. Of these, 4,371 were among persons aged 15-24 years of age.
- In 2009 suicide accounted for 1.5% of all deaths in the U.S. but was the cause of 14% of all deaths among 15-24 year olds.
- Although rates vary somewhat by geographic location, it is likely that three students (one boy & two girls) within a typical high school classroom have made a suicide attempt in the past year.

**Source:** American Association of Suicidology, 2006

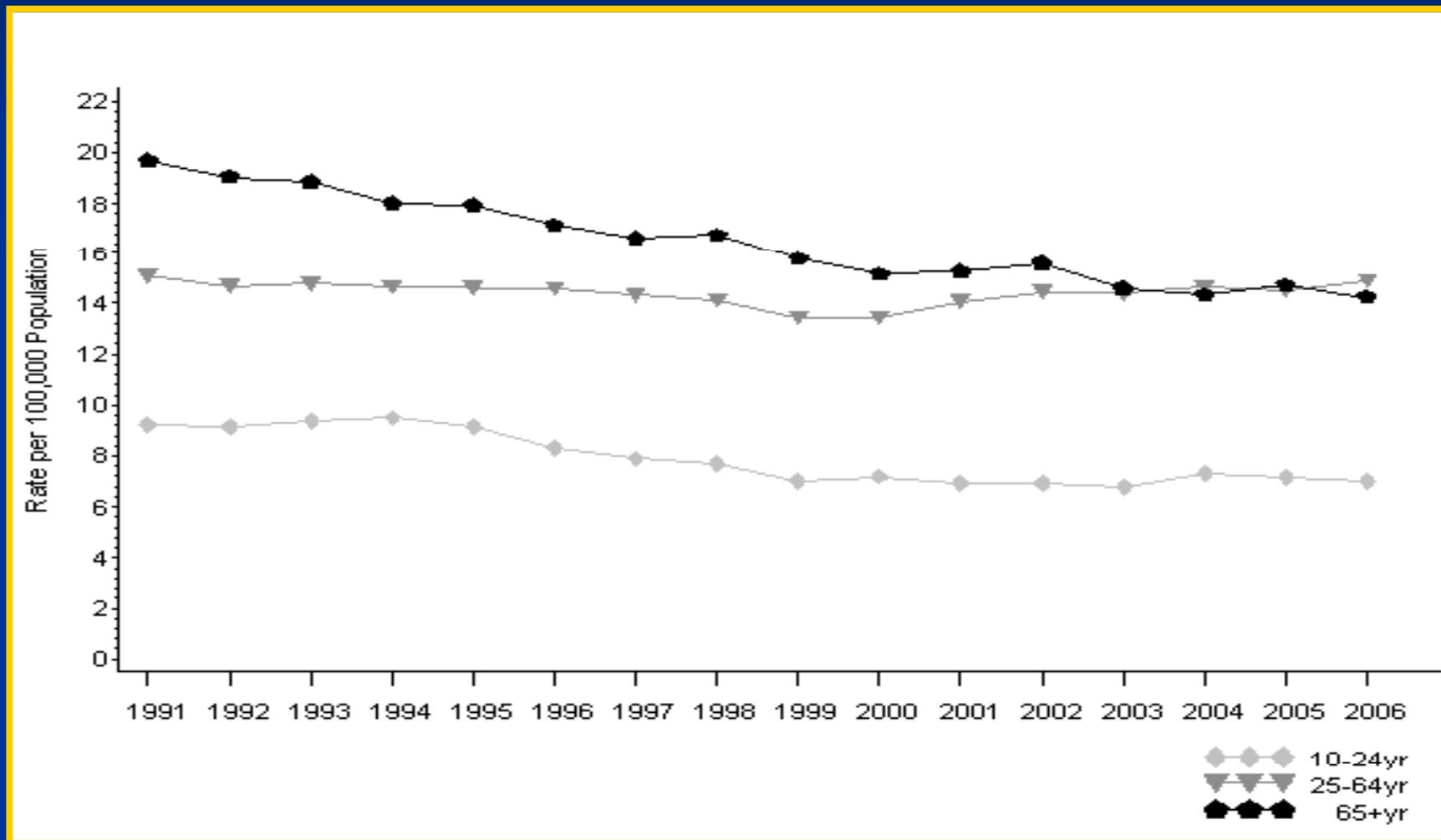
# Adolescent Suicide: Scope of the Problem

- The typical profile of an adolescent nonfatal suicide attempter is a female who ingests pills; the profile of a the typical suicide completer is a male who dies from a self-inflicted gunshot wound.
- Most adolescent suicide attempts are precipitated by interpersonal conflicts. Often, the intent of the suicidal behavior appears to be to effect change in the behaviors/attitudes of others.
- For every completed youth suicide it is estimated that 100-200 attempts are made.
- Firearms remain the most commonly used suicide method among youth, accounting for approximately 50% of all completed suicides.

**Source:** American Association of Suicidology, 2006

# Adolescent Suicide: Scope of the Problem

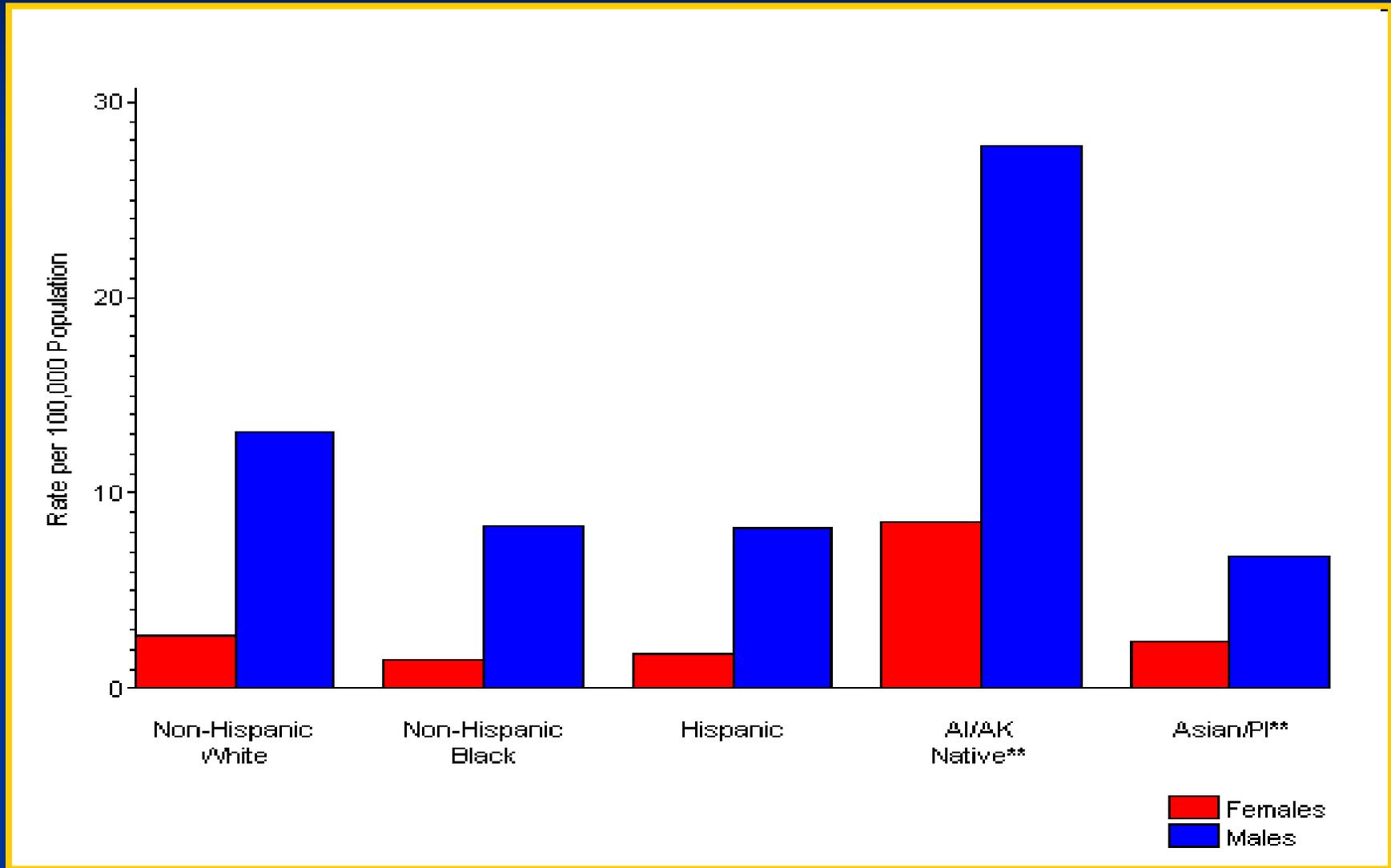
## Trends in Suicide Rates\* Among Both Sexes, by Age Group, United States, 1991-2006



**Source:** National Center for Injury Prevention and Control, Centers for Disease Control (2012).

# Adolescent Suicide: Scope of the Problem

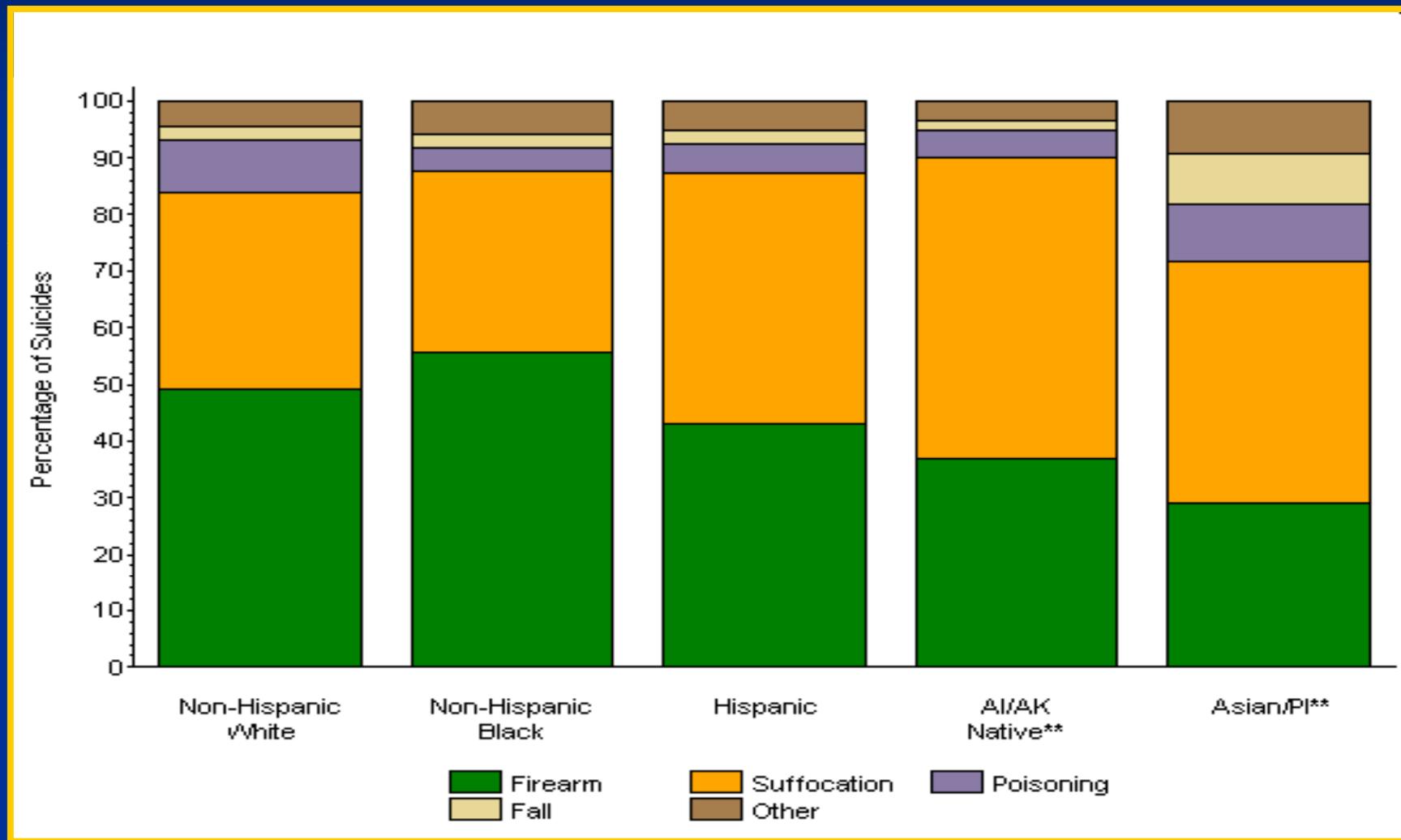
Suicide Rates\* Among Persons Ages 10-24 Years, by Race/Ethnicity and Sex, United States, 2002-2006



Source: National Center for Injury Prevention and Control, Centers for Disease Control (2012).

# Adolescent Suicide: Scope of the Problem

Percentage of Suicides Among Persons Ages 10-24 Years,  
by Race/Ethnicity and Mechanism, United States, 2002-2006

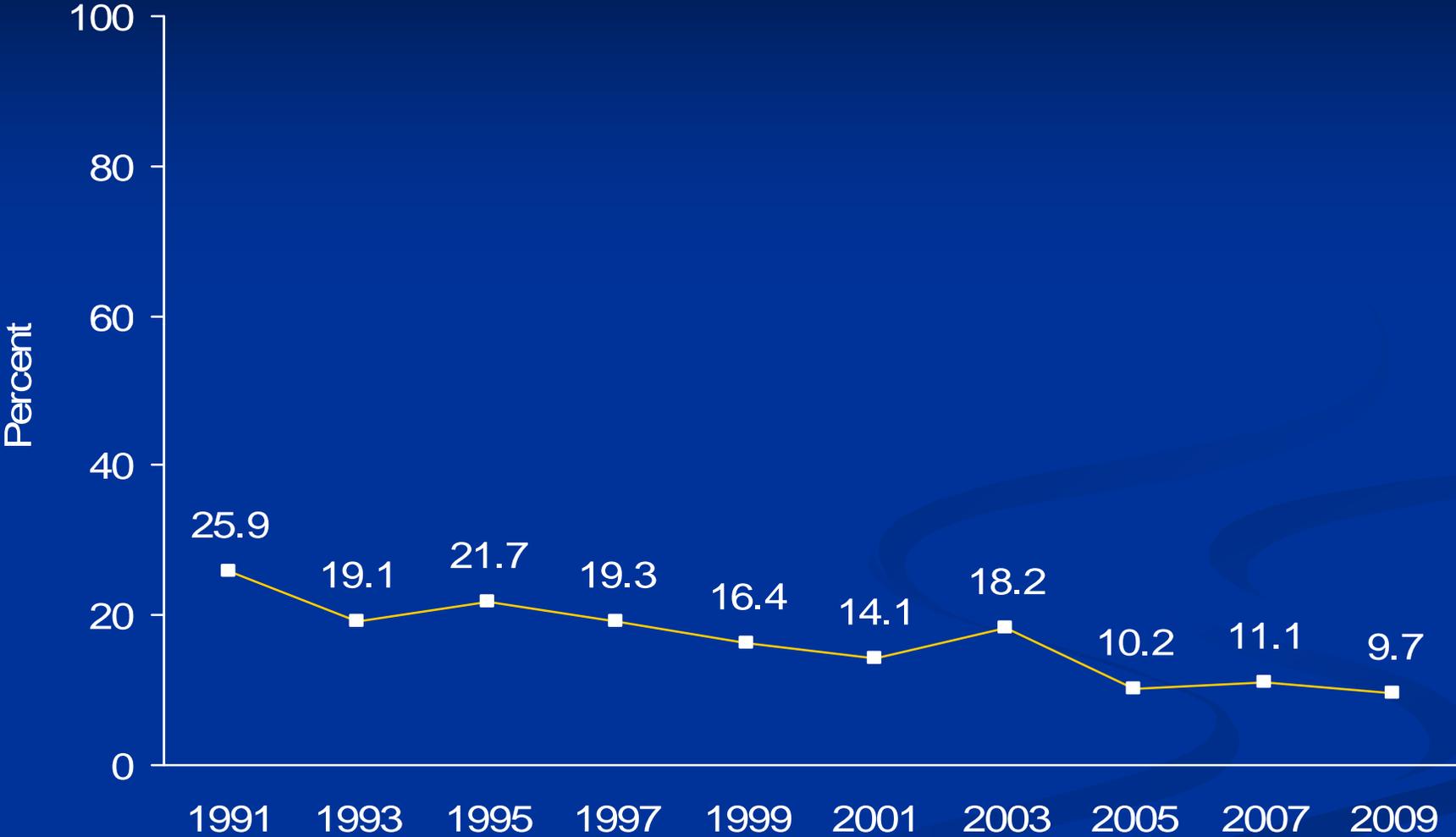


Source: National Center for Injury Prevention and Control, Centers for Disease Control (2012).

# The Youth Risk Behavior Surveillance System

- School-based survey of teenagers conducted biannually by the U.S. Department of Health & Human Services/Centers for Disease Control
- 9<sup>th</sup> – 12<sup>th</sup> grade students
- Anonymous
- Self-administered, computer-scanned questionnaire or answer sheet
- Representative sample of U.S. high school student population
- Total sample size in 2009 = **16,410**
- The YRBSS is our best source of information concerning adolescent lifestyle and behavioral factors which contribute to risk of illness, accident or injury

# Percentage of High School Students Who Rarely or Never Wore a Seat Belt,\* 1991 – 2009†

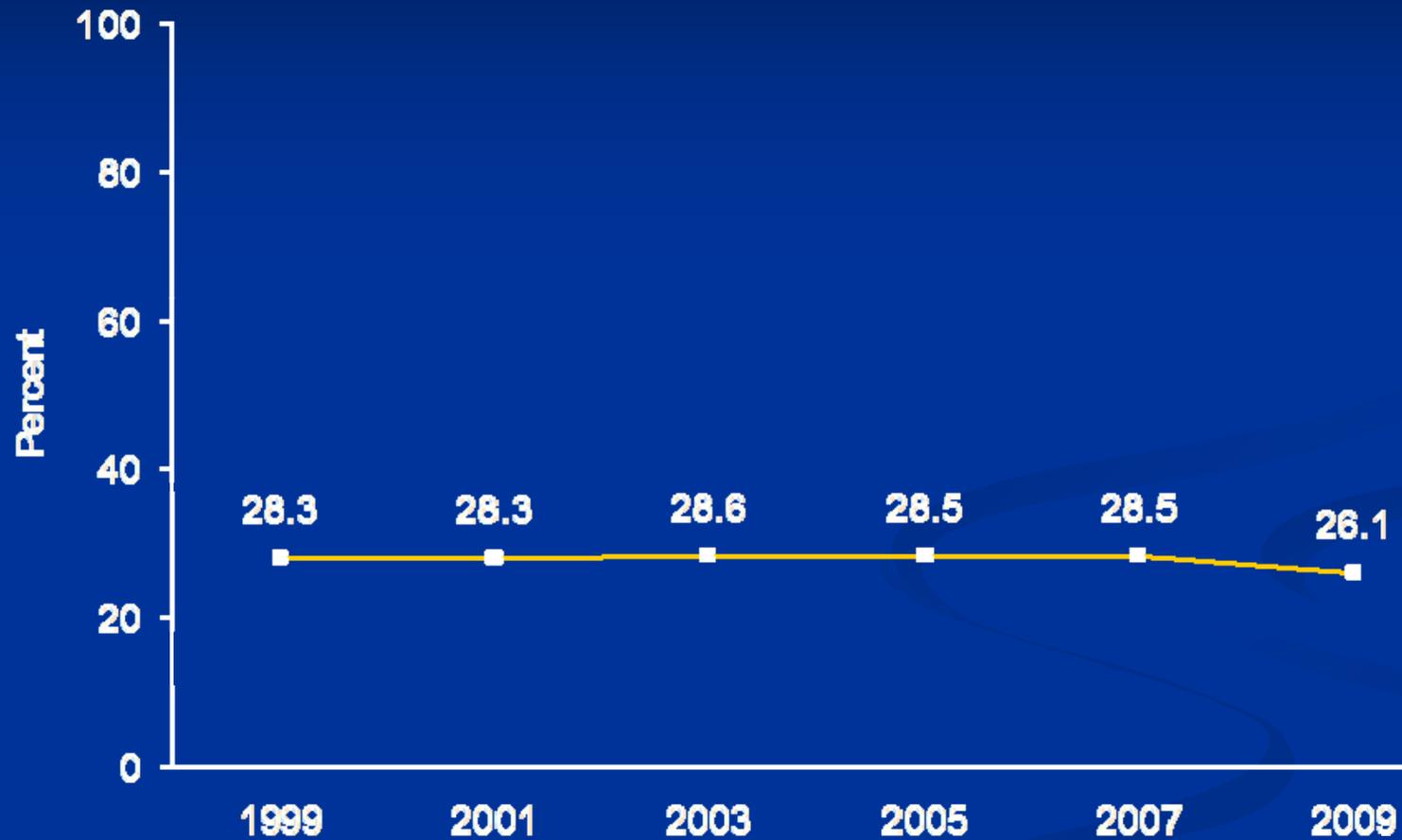


\* When riding in a car driven by someone else.

† Decreased 1991–2009,  $p < 0.05$ .



## Percentage of High School Students Who Felt Sad or Hopeless,\* 1999 – 2009



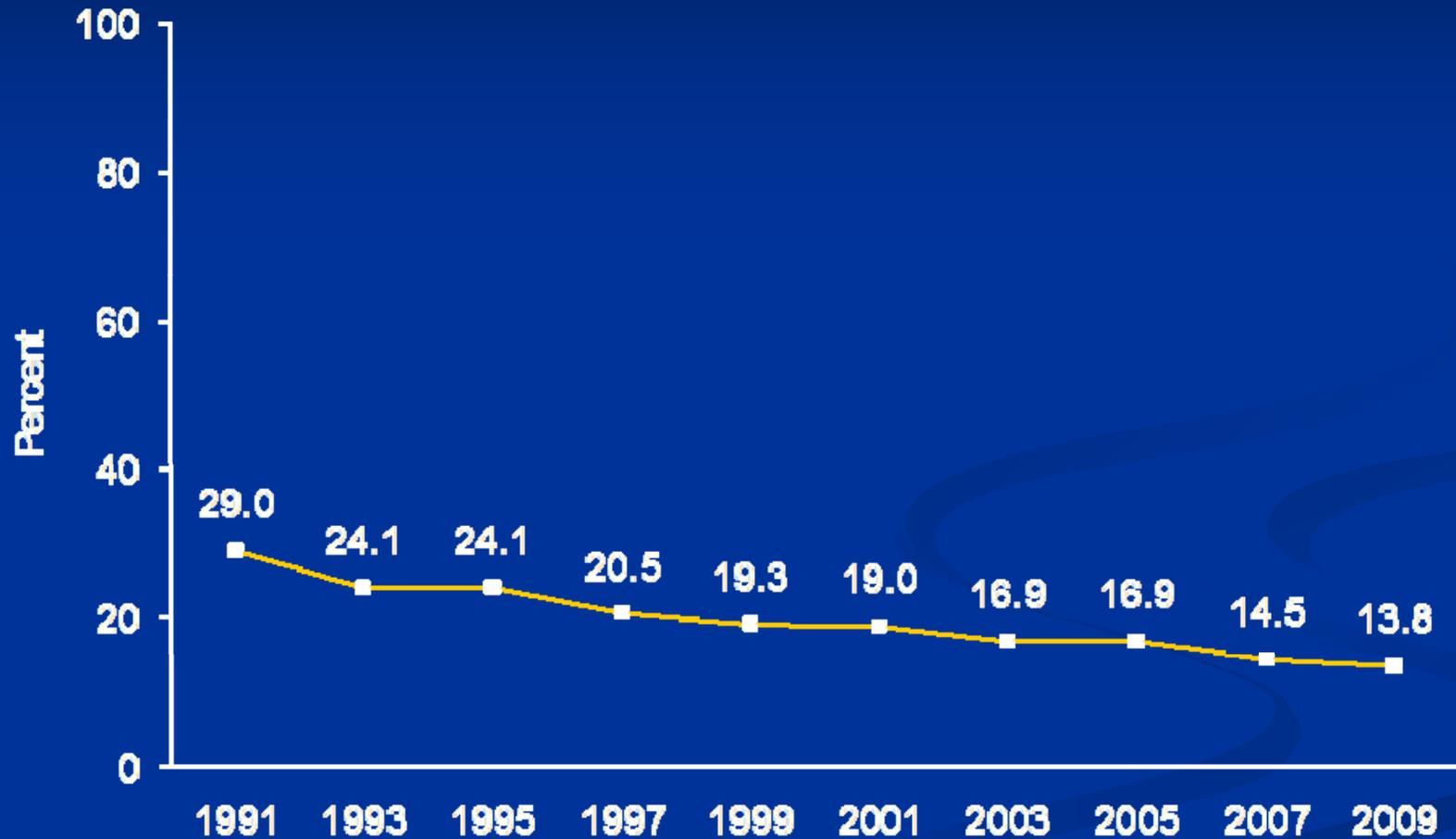
\* Almost every day for  $\geq 2$  weeks in a row that they stopped doing some usual activities during the 12 months preceding the survey

<sup>1</sup> No significant change over time

*National Youth Risk Behavior Surveys, 1999 – 2009*



## Percentage of High School Students Who Seriously Considered Attempting Suicide,\* 1991 – 2009



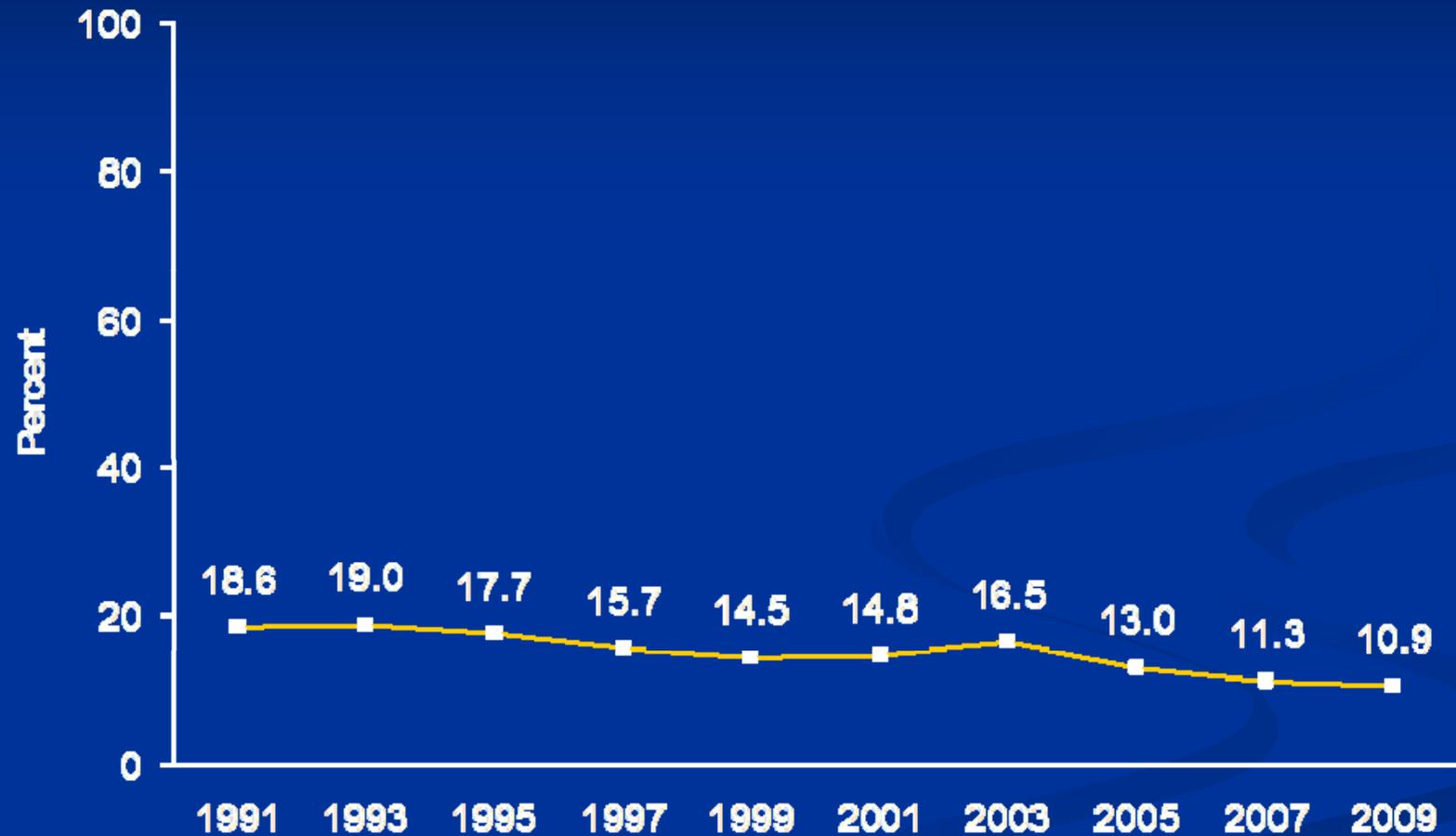
\* During the 12 months preceding the survey

<sup>1</sup> Significant linear decrease and quadratic change,  $P < .05$

*National Youth Risk Behavior Surveys, 1991 – 2009*



## Percentage of High School Students Who Made a Plan About How They Would Attempt Suicide,\* 1991 – 2009



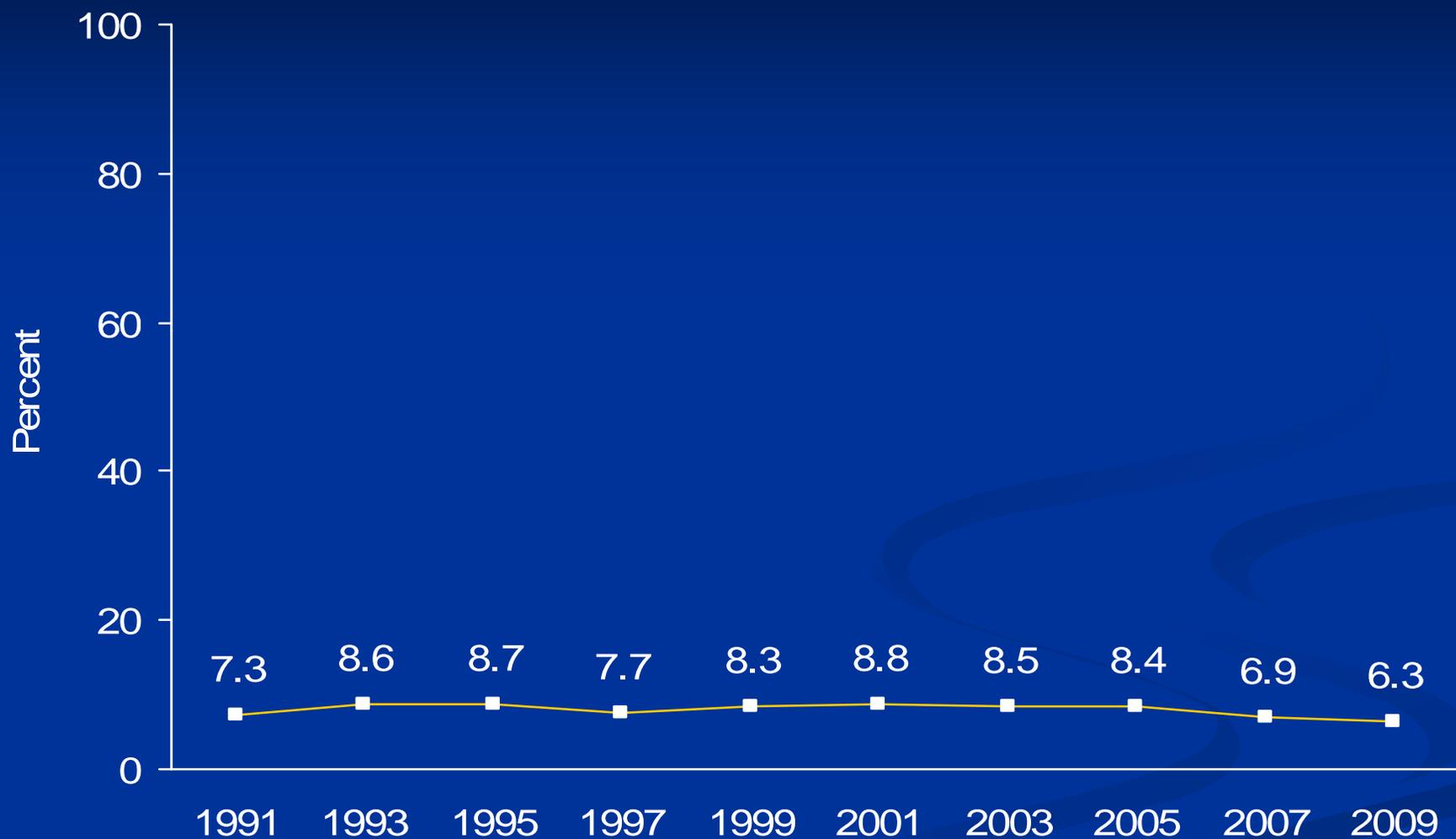
\* During the 12 months preceding the survey

<sup>1</sup> Significant linear decrease,  $P < .05$

*National Youth Risk Behavior Surveys, 1991 – 2009*



## Percentage of High School Students Who Attempted Suicide,\* 1991 – 2009†



\* One or more times during the 12 months before the survey.

† No change 1991–2001, decreased 1991–2009,  $p < 0.05$ .

*National Youth Risk Behavior Surveys, 1991–2009*



# What Conclusions May We Draw Concerning Adolescent Suicide?

- Adolescent suicide is a major public health problem
- We know a great deal about the risk factors and underlying causes of adolescent suicide, which can guide prevention efforts
- Prevention efforts should focus upon training in the warning signs of adolescent suicide and strategies to link at-risk kids with professional help, to reduce the incidence of suicidal behavior

# Risk Factors— *Warning Signs* —for Adolescent Suicide

- Psychiatric illness such as depression, especially when accompanied by substance abuse
- Significant family instability / turbulence
- Poor coping skills, impaired problem-solving, impulsivity
- Social / interpersonal isolation
- Low self-esteem, hopelessness, helplessness, ruminative worry
- Recent stressful event
- Intense psychic pain
- Exposure to model of suicidal behavior
- History of prior suicidal behavior
- Access to lethal means

# Risk Factors— *Warning Signs* —for Adolescent Suicide

## ■ Psychiatric illness

- Findings of psychological autopsy studies:

Most Common Psychiatric Diagnoses		
	Male	Female
Mood disorder (depression)	50%	69%
Antisocial/conduct disorder	43%	24%
Substance abuse	38%	17%
Anxiety disorder	19%	48%

- Among suicide completers, 70% used drugs frequently, 50% have positive blood alcohol findings at time of death, 75% fit criteria for drug/alcohol abuse criteria

**Source:** American Association of Suicidology, 2006

# Risk Factors— *Warning Signs* —for Adolescent Suicide

- **Parental or family problems**
  - Family history of suicidal behavior
  - Parental mental health disorder
  - Severe conflicts with parents
  - Parental divorce
- **Poor coping skills**
  - Impulsivity
  - Aggressive/explosive behavior pattern
  - Avoidant coping strategies
  - Poor problem-solving

# Risk Factors— *Warning Signs* —for Adolescent Suicide

## ■ Poor reasoning

- Cognitive inflexibility—tunnel vision where the “solution” of suicide seems to be the only way out
- Pervasive hopelessness
- Profound pessimism
- Inability to see transient nature of current problems

## ■ Social/interpersonal isolation

- Poor or negative network of support
- Lonely, isolated, insecure attachments with others

## ■ Low self-esteem, hopelessness, helplessness

- Profound sense of shame, inferiority

# Risk Factors— *Warning Signs* —for Adolescent Suicide

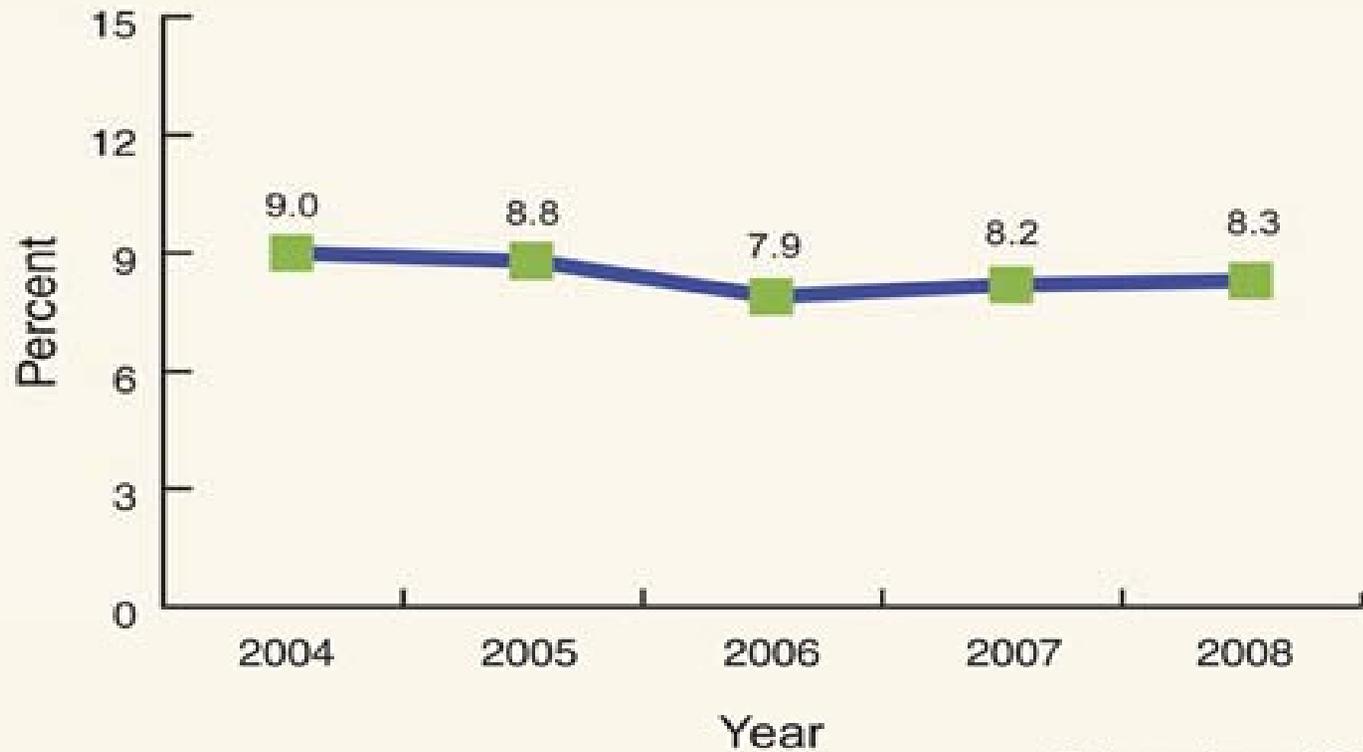
- **Intense psychic pain**
  - Often triggered by recent stressful events such as interpersonal losses, disciplinary/legal crisis or other painful life changes
- **Exposure to model of suicidal behavior**
  - Experts estimate that approximately 5% of youth suicides are linked to media coverage of suicidal behavior
  - Suicide clusters within schools are a serious public health threat, triggered by a model of suicidal behavior
- **Access to lethal means**
  - Controlled studies indicate statistical link between incidence of youth suicide and gun ownership in the home

# What is it to be suicidal?

- To be suicidal is to be in a temporary, transient state of mind—think of it as a “psychiatric fever”
  - Like a fever it is short-lived in nature—it typically resolves in a matter of days
  - The condition itself needs to be contained while the underlying cause is identified and treatment initiated
- The suicidal state of mind typically has the following features & characteristics:
  - Loss of fluid, flexible problem-solving capabilities
  - Intense psychic pain
  - Due to tunnel-vision and the loss of cognitive flexibility, the idea of suicide is viewed as a “solution”
  - Adolescents are susceptible to suggestibility and, when in this state of mind, are more likely to be influenced by a model of suicidal behavior than are adults
  - Typically, this temporary state of mind lifts within a period of just a few days and the person regains their customary ability to problem-solve

# Depression in Adolescence

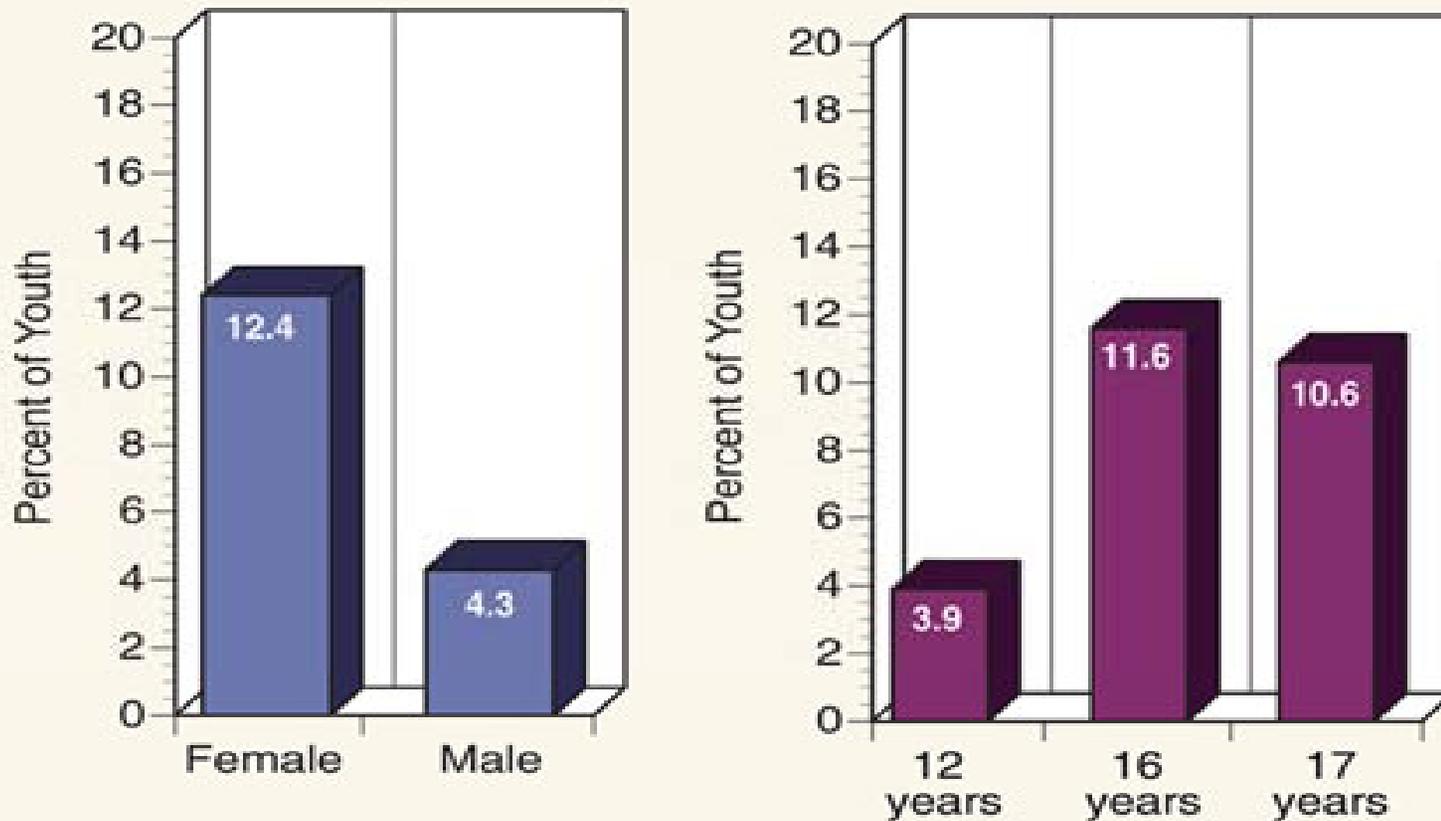
**Prevalence of Depression Among U.S. Youth Ages 12–17 (2004–2008)**



*Data courtesy of SAMHSA*

# Depression in Adolescence

## Prevalence of Depression Among U.S. Youth by Sex and Age



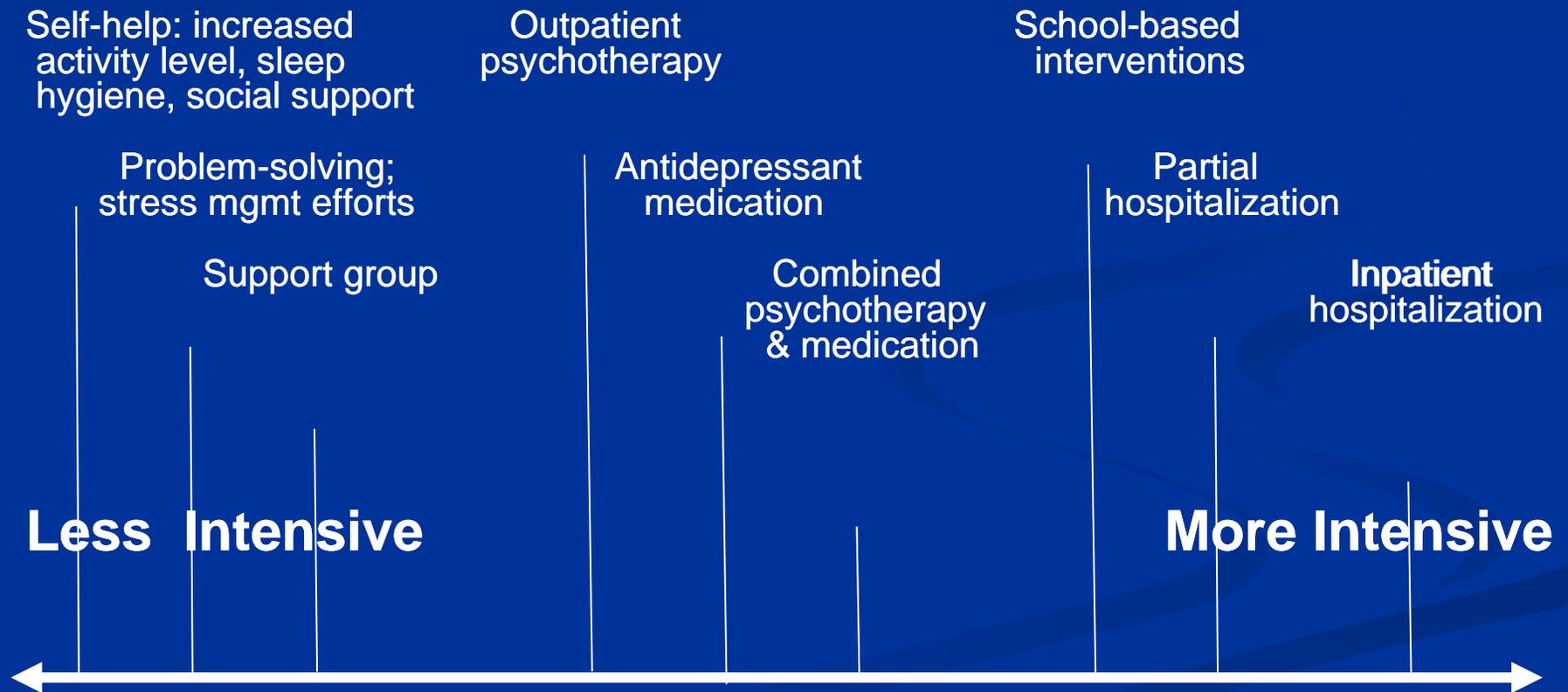
Data courtesy of SAMHSA

# Signs & Symptoms Of Depression In Adolescence

- Depressed or irritable mood
- Irritability, short temper, agitation
- Loss of interest in activities, apathy
- Reduced pleasure in daily activities
- Inability to enjoy activities which used to be sources of pleasure
- Change in appetite, usually a loss of appetite but sometimes an increase
- Change in weight (unintentional weight loss or unintentional weight gain)
- Persistent difficulty falling asleep or staying asleep ( insomnia )
- Excessive daytime sleepiness
- Fatigue
- Difficulty concentrating
- Difficulty making decisions
- Memory loss (amnesia) episodes
- Preoccupation with self
- Feelings of worthlessness, sadness, or self-hatred
- Excessive or inappropriate feelings of guilt
- Acting-out behavior (missing curfews, unusual defiance)
- Thoughts about suicide or obsessive fears or worries about death
- Plans to commit suicide or actual suicide attempt
- Self-injury
- School refusal
- Excessively irresponsible behavior pattern

# Treatment of Depression in Adolescence

## Continuum of Treatment Interventions



# Management of the Student Who Is At-Risk for Suicidal Behavior

Student comes to attention of gatekeeper



- Notice
- Engage
- Talk



Student seen by in-school mental health professional



Preliminary suicide risk assessment conducted:

*TIME or IS PATH WARM ?*

# Who Are “Gatekeepers”

*If you are attending  
this presentation  
you are a  
gatekeeper!*

# What Should A Gatekeeper Do When Concerned About A Student?

- Role of Gatekeeper is *not* to function as a mental health professional
- Role of Gatekeeper is to:
  - Observe students
  - Encourage students who are struggling to access help
  - Serve as conduit to professional help, for those students observed to be at risk
- Gatekeepers can play an essential role in providing a safety net for at-risk students.

# What Should A Gatekeeper Do When Concerned About A Student?

A Simple Mnemonic To Provide a Safety N.E.T.

■ Notice

■ Engage

■ Talk

# What Should A Gatekeeper Do When Concerned About A Student?

## ■ Notice

- Know the warning signs of adolescent suicide & symptoms of depression
- Be observant for signs of distress
- Be prepared to approach students in distress

<i>Do...</i>	<i>Try Not To...</i>
<ul style="list-style-type: none"><li>✓View yourself as part of a team working to identify warning signs of depression and/or suicidal risk</li><li>✓Maintain a <u>watchful eye</u> over students to promote safety and early intervention</li><li>✓Observe all students for signs of distress or deterioration in functioning</li><li>✓Pick up on cues suggestive of inner turmoil, pain, hopelessness</li></ul>	<ul style="list-style-type: none"><li>✓Be reluctant to acknowledge distress or behavioral changes among students</li><li>✓Assume that the student will come to someone else's attention</li><li>✓Be reluctant to get involved</li><li>✓Shrug-off signs of distress</li><li>✓Keep morbid drawings/writings or other warning signs a "secret"</li></ul>

# What Should A Gatekeeper Do When Concerned About A Student?

## ■ Engage

- Take the initiative to approach students who show signs of distress
- Engage students in a concerned, friendly, supportive manner

<i>Do...</i>	<i>Try Not To...</i>
<ul style="list-style-type: none"><li>✓Approach the student of concern</li><li>✓Express your concern for the student: "Are you okay? Everything alright?"</li><li>✓Explain basis for your concern</li><li>✓Display warmth, encouragement</li><li>✓Express your concerns and observations in matter-of-fact manner</li></ul>	<ul style="list-style-type: none"><li>✓Put the student on the defensive</li><li>✓Take on responsibility for counseling the student by giving advice or agreeing to hold information in confidence</li><li>✓View referral of the student to the school social worker or other appropriate resource as a "betrayal" of the student's trust</li></ul>

# What Should A Gatekeeper Do When Concerned About A Student?

## ■ Talk

- The student may need to talk with someone beyond the initial gatekeeper— *be prepared to refer the student an in-school mental health provider*
- Personally link the student with a school social worker, psychologist or other appropriate resource

<i>Do...</i>	<i>Try Not To...</i>
<ul style="list-style-type: none"><li>✓ If you notice signs of distress or emotional pain, persuade the student to accept additional help—<i>talk</i> to them</li><li>✓ Ensure that the student is personally introduced to the receiving mental health professional within the school</li><li>✓ Share all pertinent information, observations and concerns with the receiving mental health professional</li></ul>	<ul style="list-style-type: none"><li>✓ Simply give the student the name of an in-school mental health professional without personally ensuring linkage</li><li>✓ Predict the interventions which might follow after evaluation by the mental health professional</li><li>✓ Give the impression to the student that he/she is “in trouble” or that further referral is punitive in nature</li></ul>

# Gatekeeper Overview:

## Provide a Safety N.E.T. For Students

<h1>Notice</h1>	<ul style="list-style-type: none"><li>■ Be aware that you may be the only adult who notices warning signs of possible suicide risk</li><li>■ Know warning signs of depression and / or suicidal risk</li><li>■ Keep a watchful eye over all students</li></ul>
<h1>Engage</h1>	<ul style="list-style-type: none"><li>■ Engage students of concern—inquire about their well-being, express concern</li><li>■ After approaching the student, if you observe indications of troubles with mood, outlook on life or other warning signs, persuade the student to meet with an in-school mental health professional</li></ul>
<h1>Talk</h1>	<ul style="list-style-type: none"><li>■ Persuade the student to speak further with an in-school mental health professional.</li><li>■ Ensure that the linkage of the student of concern with an in-school mental health professional occurs—personally escort the student or introduce the student to the mental health professional.</li></ul>

# For The Receiving Mental Health Professional: Suicide Risk Assessment

## Approaches to the assessment of suicide risk: The TIME suicide assessment interview

- Thoughts
  - Have you ever thought of hurting or killing yourself? If so, when?
- Intent
  - Do you have a suicide plan?
  - Do you plan to make an attempt on your life?
- Method
  - How would you do it? What preparations have you made?
  - Is there a date or time in mind?
  - Have you told anyone about this plan?
  - Have you written a note? Do you plan to write a note?
- Experience
  - Have you previously tried to hurt or kill yourself?
  - When did this occur? What did you do?
  - Did you see a doctor or nurse for any injuries?

# For The Receiving Mental Health Professional: Suicide Risk Assessment

## Risk Assessment Mnemonic: *IS PATH WARM?*

<b>I</b>	<b>Ideation:</b> Suicidal threats or preoccupation
<b>S</b>	<b>Substance Abuse:</b> Increased alcohol or drug use
<b>P</b>	<b>Purposelessness:</b> No reason for living; no sense of purpose in life
<b>A</b>	<b>Anxiety:</b> Fear, agitation, sleep disruption
<b>T</b>	<b>Trapped:</b> A sense that there is no way out
<b>H</b>	<b>Hopelessness:</b> Losing hope that things will ever get better
<b>W</b>	<b>Withdrawal:</b> Pulling away from friends, family and society
<b>A</b>	<b>Anger:</b> Rage, uncontrolled anger, revenge-seeking behavior
<b>R</b>	<b>Recklessness:</b> Engaging in risky behaviors
<b>M</b>	<b>Mood Change:</b> Dramatic mood changes, especially depression

**Source:** American Association of Suicidology, 2006

# Interventions With Students Who Are At-Risk for Suicidal Behavior

Preliminary suicide risk assessment conducted:

*TIME or IS PATH WARM ?*

*Are there indications of active suicidal ideation, plans or other risk factors?*

## No apparent risk

Evaluation by school clinical staff indicates no suicidal warning signs or risk factors warranting follow-up



- Parents may be notified of concerns prompting eval & outcome of eval
- Student may be monitored

## Some concerns

Evaluation by school clinical staff indicates no clear risk but areas of concern warrant outpatient referral



- Parents are notified
- Outpatient referral recommended
- Student monitored

## Moderate risk

Evaluation by school clinical staff indicates no imminent threat but further rapid eval is indicated



- Parents are notified of eval
- Require student to be evaluated on outpatient basis

## Immanent risk

Evaluation by school clinical staff indicates high degree of risk for immanent suicidal behavior



- Parents are notified of eval
- Referral to emergency room for immediate eval is arranged

# Now *You* Can Help to Provide a Safety N.E.T. For Students

<h2>Notice</h2>	<ul style="list-style-type: none"><li>■ Be aware that you may be the only adult who notices warning signs of possible suicide risk</li><li>■ Know warning signs of depression and / or suicidal risk</li><li>■ Keep a watchful eye over all students</li></ul>
<h2>Engage</h2>	<ul style="list-style-type: none"><li>■ Engage students of concern—inquire about their well-being, express concern</li><li>■ After approaching the student, if you observe indications of troubles with mood, outlook on life or other warning signs, persuade the student to meet with an in-school mental health professional</li></ul>
<h2>Talk</h2>	<ul style="list-style-type: none"><li>■ Persuade the student to speak further with an in-school mental health professional.</li><li>■ Ensure that the linkage of the student of concern with an in-school mental health professional occurs—personally escort the student or introduce the student to the mental health professional.</li></ul>

*Thank you for attending this  
gatekeeper training session to help  
prevent adolescent suicide.*

*The Safety N.E.T. for at-risk students is  
now stronger, thanks to your  
participation!*

# Sources

- American Association of Suicidology
- National Adolescent Health Information Center
- National Center for Injury Prevention and Control / Centers for Disease Control
- Youth Risk Behavior Surveillance System / Centers for Disease Control
- Youth Suicide Prevention School-Based Guide, Florida Institute of Mental Health / University of South Florida

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