Suicide Prevention Guidelines

§22.1 – 272.1 Code of Virginia

Board of Education
Commonwealth of Virginia
Richmond

2003 Revision

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Background

The 1999 General Assembly passed Senate Bill 1250 (S. Newman) directing the Board of Education, in cooperation with the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Health, to develop guidelines for licensed school personnel to use in contacting parents or, if conditions warrant, the local or state service agency when they believe a student is in imminent risk for attempting suicide. These guidelines were to include (1) criteria to assess the suicide risks of students, (2) characteristics to identify potentially suicidal students, (3) appropriate responses to students expressing suicidal intentions, (4) available and appropriate community services for students expressing suicidal intentions, (5) suicide prevention strategies which may be implemented by local schools for students expressing suicidal intentions, (6) criteria for notification of and discussions with parents of students expressing suicidal intentions, (7) criteria for as-soon-as-practicable contact with parents, (8) appropriate sensitivity to religious beliefs, and (9) the legal requirements and criteria for notification of public service agencies. The guidelines were disseminated to school personnel in October 1999. This revised version of the guidelines was developed in response to the recommendation of the Virginia "Youth Suicide Prevention Plan" (House Document 29, 2001) to include criteria in a revision for following up with parents of students expressing suicidal intentions after initial contact has occurred.

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Executive Summary

Youth suicide is a significant problem which recently has received much attention. With the recent advances in understanding of the causative factors and the parameters of the problem along with the identification of effective intervention strategies, parents and professionals are now able to implement measures that can reduce rates of suicidal behavior in children and youth. These guidelines, which were mandated by the 1999 General Assembly, identify those actions that should be taken by school personnel when they suspect a student is at risk for suicide. A major component of the identified measures focuses on procedures to follow for contacting parents, or if conditions warrant, the local or state service agencies when educators believe a student is in imminent risk for attempting suicide. Guidelines for assessment strategies and related practices such as suicide prevention techniques are covered.

I. Introduction

Suicide accounts for more than 30,000 deaths per year in the United States. Nationally 2,000 to 3,000 adolescents take their lives each year. Virginia statistics for the most recent years show that teenage (15-19 years of age) deaths related to suicide range from 53 to 57 per year (Centers Disease Control, 1995).

Data from the 1997 Youth Risk Behavior Surveillance Survey (YRBS), conducted by the Centers for Disease Control, included 16,262 high school students in the United States, and found that 1 in 5 students (24.1%) had seriously considered attempting suicide in the previous year. In 1994, 2,270 youths died from suicide (National Center for Health Statistics, 1994). Considering that medical examiners underreport suicides by 25 percent to 50 percent (Jobes, Casey, Berman, Wright, 1991) and that 100 to 200 suicide attempts occur for each youth suicide completion (National Center for Health Statistics, 1994), there may actually have been as many as 4,500 youth suicides and 900,000 youth suicide attempts in 1994 (King, 1999, p. 159).

Noting the data on the incidence of suicide in children and youth and its increasing rate in several age groups (Centers for Disease Control, 1995), the 1999 General Assembly passed Senate Bill 1250 (Newman), which requires the Board of Education, in cooperation with the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Health, to develop guidelines for licensed school personnel to use when contacting parents, or, if conditions warrant, the local or state service agency when they believe a student is an imminent risk for attempting suicide (see Appendix A for a copy of changes in the Code of Virginia related to SB 1250). To implement the General Assembly's mandate, the Virginia Department of Education (VDOE) impaneled representatives from the aforementioned agencies along with several practitioners from local school divisions to develop the guidelines.

Besides these guidelines, which appear in sections II-III of this study, various related practices, suggestions, and reference literature were developed. These materials can be found in the appendices. Of particular value for many school-based clinicians will be the cases found in Appendix E. The general principles for responding to a suicidal child, which are included in Appendix B, serve as the foundation for the guidelines and the appendices focusing on assessment.

II. Guidelines for Obtaining and Conducting an In-School Assessment and Follow Up

Below are listed the guidelines and suggestions for school personnel to follow when suspecting that a student is at risk of attempting suicide.

A. Reporting Concerns

All licensed school professionals bear a responsibility to identify and report students at risk of suicide. Some school personnel, such as building administrators and teachers, do not by training and job responsibility possess the skills to professionally assess imminent danger with regard to suicidal ideation. The latter are expected to report any direct communication from a student that indicates a suicidal intent to licensed school professionals, who by training and job responsibility, possess the skills to professionally assess imminent danger. Details for making the report under various conditions (e.g., school counselor is on sick leave) should be included in each school division's crisis management plan.

B. Conducting an Assessment

Licensed school professionals who by training and job-related duties are responsible for assessing imminent risk of danger related to suicidal ideation include school counselors, school nurses (Registered Nurses and Licensed Practical Nurses), school psychologists, and school social workers. Appendices C and D contain information to help trained mental health professionals with assessment of suicidal risk.

C. Making Contacts

The school personnel identified above who are responsible for conducting this assessment are also responsible, subsequent to this assessment, for ensuring that a contact is made to parents or the Department of Social Services (DSS) as deemed appropriate within the parameters of this statute.

III. Guidelines for Notifying Concerned Parties

Below are listed specific guidelines and suggestions for notifying parents or social services when a child is in imminent danger of suicide.

A. Identification of Available and Appropriate Community Services for Suicidal Children

Each school division will develop and maintain a current local and state-level resource list of public and private assessment and treatment facilities appropriate for school-age children. Such facilities provide the services of licensed mental health professionals who are qualified to assess and provide appropriate crisis intervention for school-age children with suicidal intent. This list should include information on location, contact procedures, costs, and other considerations that facilitate the referral process for parents and departments of social services.

B. Parent Notification Timelines and Procedures

If a student is determined to be at imminent risk of suicide (Appendix D contains information on determining imminent risk and Appendix E has examples of using these guidelines), then the licensed school professional who completed the assessment shall immediately call at least one of the student's parents/guardians. When contacting the student's parent or guardian, the licensed school professional should:

- provide his or her name and position in the school,
- state that in his or her professional judgment the student is at imminent risk of suicide,
- assure the parent or guardian that the student is currently safe,
- state the legal requirement for the call, citing the § 22.1-272.1. of the Code of Virginia,
- ask the parent whether he or she is aware of the student's mental state,
- ask the parent whether he or she wishes to obtain or has obtained mental counseling for the student,
- provide names of community counseling resources if appropriate,
- offer to facilitate the referral, and
- determine the parent's intent to seek appropriate services for the student.

Parents who opt for supportive interventions outside the professional mental health arena, such as religious-based interventions, should provide at a minimum a plan that will include a safety plan and an issues-based intervention procedure that will keep the child safe and will address the precipitant issues.

The licensed school professional shall document the phone call or attempted phone call to the parent or guardian. The documentation shall include the time and date of the call, the parent's or guardian's response, and any required follow up.

If the licensed school professional is unable to contact either parent or guardian by the end of the school day, then he or she shall follow the school's crisis management plan for seeking treatment for a student without the parent's authorization.

A student who is at imminent risk of suicide must remain under adult supervision until a parent or other authorized individual accepts responsibility for the student's safety.

C. Issues of Abuse and Neglect

If a student indicates that parental abuse or neglect is the reason for contemplating suicide, parental contact should not be made. The licensed school professional should ensure that the local or state social services agency is notified immediately in a manner consistent with school reporting guidelines. The notifying person must emphasize that immediate action is necessary to protect the child from harm.

If parental contact is made and, in the course of this contact, relevant issues of abuse or neglect are discovered (e.g., a parent acknowledges the child's suicidal intent but indicates no intent to act for the well-being of the child), the licensed school professional should ensure that the local or state services agency is contacted immediately. School reporting guidelines should be observed when making the agency contact. The notifying person must emphasize the fact that immediate action is necessary to protect the child from harm.

D. Department of Social Services Notification Timelines and Procedures

If the licensed school professional suspects or has knowledge of abuse or neglect, he/she ensure that the Virginia Department of Social Services(1-800-552-7096) or Child Protective Services unit of the local department of social services is contacted in accordance with scool reporting guidelines. The child must be kept safe and secure until the local department of social services, child protective services worker, or other authorized individual accepts responsibility for the safety of the child.

The report should include the following:

- his or her name and position in the school,
- the name and identifying information of the child, and
- the legal requirement for the call, citing § 22.1-272.1 of the Code of Virginia.

Other appropriate information regarding the abuse or neglect issues - such information may include:

- specifics as to reported abusive behavior or incidents,
- significant recent changes in school attendance, performance, or behavior,
- when such changes were noted and their duration, and
- an offer to facilitate an appropriate mental health referral.

An important consideration regarding this aspect of the process is that a high degree of cooperation and responsiveness is called for on the part of schools, departments of social services, and treatment providers such as community mental health centers (SUPTS. MEMO NO. 27, issued on March 1, 2002, contains recommended procedures for developing protocols between school divisions and local service agencies for handling suspected child abuse and neglect reports). The investigation of alleged abuse or neglect is often an involved process. Child protective service workers will be called upon to begin the process of investigation with a child who is very likely to be difficult to interview. It is expected that emergency treatment will be sought jointly by school and social services personnel prior to the completion of such an investigation. Local school systems are encouraged to coordinate with departments of social services and treatment providers on the integration of this process into their school's crisis management plan.

Upon completion of this process, the licensed school professional shall document the phone call to the department of social services. The documentation shall include the time and date of the call, the individual contacted, the response plan agreed upon, and any required follow up. A student who is at imminent risk of suicide should remain under adult supervision until an authorized individual accepts responsibility for the safety of the student.

IV. Guidelines for Following Up an Intervention

Recommended practices for following up include:

The licensed school professional who initiates the referral makes direct, personal contact (by telephone, letter and/or a visit, depending on family circumstances) with at least one custodial parent and/or guardian to help make an initial assessment of the child's status and to invite the parent/guardian to attend a follow up meeting with the school's student assistance team or its equivalent. The direct contact should emphasize the following:

- The meeting is intended to be a constructive, collaborative effort to ensure the best interests of the child are met;

- The importance of the parent/guardian's involvement in the meeting, and that they will receive written confirmation of the meeting time and place;

- The follow up is a team effort that includes school personnel, the parent/guardian, the child, and the child's mental health provider if appropriate, and;

- The follow up will focus on determining needed interventions to help the child,

including the identification of actions to be taken to create a "safety net" around the at-risk child.

It is recommended that written confirmation of the meeting should be accompanied by the brochure entitled **What Every Parent Should Know About Preventing Youth Suicide**. This brochure, which provides information about teen depression and suicide, is available from the Virginia Department of Health.

Suggestions for conducting the follow up meeting are provided in Appendix B.

V. Conclusions

There are few losses as painful as the death of a child and few deaths are as difficult to comprehend and accept as self-inflicted death. It is no wonder then that the topic of childhood suicide generates so much concern. Childhood is typically viewed as a time of anticipation and promise. How is it then that a choice is made to end this possibility of growth and cancel the hope for the future? The answers are neither simple nor satisfactory. The task of all professionals involved in and dedicated to the education of children is to help prevent whenever possible such sad and unnecessary loss of life. Observance of the guidelines covered in Sections II and III, and related prevention practices, such as the ones outlined in Appendices F and G, will increase the likelihood that all the students with us today in classrooms will return for another day of school.

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Bibliography and Suggested Readings

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Appendices

Appendix A

Code of Virginia

1. That the Code of Virginia was amended by adding a section numbered 22.1-272.1 as follows:

§22.1-272.1. Responsibility to contact parent of student at imminent risk of suicide; notice to be given to social services if parental abuse or neglect; Board of Education, in cooperation with the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Health, to develop guidelines for parental contact.

A. *Any person licensed as administrative or instructional personnel by the Board of Education and employed by a local school board who, in the scope of his employment, has reason to believe, as a result of direct communication from a student, that such student is at imminent risk of suicide, shall, as soon as practicable, contact at least one of such student's parents to ask whether such parent is aware of the student's mental state and whether the parent wishes to obtain or has already obtained counseling for such student. Such contact shall be made in accordance with the provisions of the guidelines required by subsection C.*

B. *If the student has indicated that the reason for being at imminent risk of suicide relates to parental abuse or neglect, this contact shall not be made with the parent. Instead, the person shall, as soon as practicable, notify the local department of social services of the county or city wherein the child resides or wherein the abuse or neglect is believed to have occurred or the state Department of Social Services' toll-free child abuse and neglect hotline, as required by §63.1-248.3. When giving this notice to the local or state department, the person shall stress the need to take immediate action to protect the child from harm.*

C. *The Board of Education, in cooperation with the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Health, shall develop guidelines for making the contact required by subsection A. These guidelines shall include, but need not be limited to, (i) criteria to assess the suicide risks of students, (ii) characteristics to identify potentially suicidal students, (iii) appro priate responses to students expressing suicidal intentions, (iv) available and appropriate community services for students expressing suicidal intentions, (v) suicide prevention strategies which may be implemented by local schools for students expressing suicidal intentions, (vi) criteria for notification of and discussions with parents of students expressing suicidal intentions, (vii) criteria for as-soon-as-practicable contact with the parents, (viii) appropriate sensitivity to religious beliefs, and (ix) legal re quirements and criteria for notification of public service agencies, including, but not limited to, the local or state social services and mental health agencies. These guidelines may include case studies and problem-solving exercises and may be designed as materials for in-service training programs for licensed administrative and instructional personnel*

2. That the Board of Education, in cooperation with the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Health, shall develop, publish and distribute the guidelines required by §22.1-272.1 to the local school divisions by October 1, 1999.

3. That, notwithstanding the effective date of this act, no person shall be required to comply with the parental contact requirements set forth in §22.1-272.1 until the guidelines of the Board of Education are developed, published, and distributed to the local school divisions.

Appendix B

Responses to Students Expressing Suicidal Intentions

Responding to the Suicidal Child

Regardless of the age or particular precipitating circumstances, the following principles are appropriate when working with a child with suicidal tendencies.

Trust Your Suspicions

If you are worried about a child, act to address your concerns rather than adopting a wait-and-see policy.

Communicate Your Concerns to the Child

Talking about the possibility of suicide will not push a non-suicidal child into self-destructive behavior. Avoiding talk may allow a suicidal child to continue in his or her perceived isolation and thereby energize suicidal thoughts. Once we have begun such communication with a child, we should also endeavor to keep this communication open.

Avoid Withdrawing or Denial

When thoughts of suicide are expressed, avoid withdrawing and denying feelings and intent, or responding in moralistic tones. Seek and accept all information the child is able and willing to provide about suicidal concerns.

Stay In Proximal Contact

If you think the possibility of suicide is imminent, do not leave the child alone. Insure that adult supervision is maintained until the child's safety is assured.

Follow Your School Crisis Plan

Know and follow your school's crisis plan regarding children who are at risk of suicide. Key elements to attend to are the child's well-being, appropriate parental involvement, and adherence to established guidelines consistent with § 22.1-272.1 of the Code of Virginia.

Follow Up

Suicidal intent by a child is a crisis event that presents both danger and opportunity. When the danger subsides, the opportunity to explore and resolve the issues that caused the crises should not be missed. A follow up meeting should be held. The meeting should have the following objectives:

- Ascertain the child's status (e.g. What's going on with the child now? Is he/she seeing someone for mental health treatment or counseling? Did the parents/guardians follow up with recommendations given at the time of the intervention?);

- Facilitate an exchange of information including recommendations by the therapist about what to do in school to assist the child, strategies for handling make-up work, needed academic accommodations, assistance for parents/guardians, and possible referrals to community-based teams; and,

- Establish the identities of service providers, future meeting dates (if needed), and action plans.

A follow up meeting should be held even if the parents/guardians are not cooperative or refuse to be involved, or in cases of suspected neglect or abuse by the parents/guardians. Written meeting notes should be maintained about parental/guardian involvement, and allegations of abuse and or neglect. Confidentiality of records and parents' rights to access the records must be maintained in accordance to state law. School officials should check with the school board attorney or other appropriate legal counsel for guidance on this matter.

Finally, one note:

- By definition, an abused or neglected child is one whose parents/guardians refuse to provide care necessary for the child's health (Sections 16.1.228 and 63.2-100 of the Code of Virginia). Those parents/guardians who fail to provide care should be reported to local social services, and the parent/guardian shall be notified about any report by letter delivered in an effective manner.

Appendix C

Characteristics to Identify Potentially Suicidal Students

The literature on suicide, and specifically childhood suicide, identifies several characteristics of individuals who may be considered at risk. The following list reflects these commonly identified characteristics:

PERCEPTION OF UNENDURABLE AND INESCAPABLE PAIN

Individuals contemplating suicide often report a perception of unendurable and inescapable pain. From the individual's point of view, there seems to be no way to cope with this pain outside of ending his or her life. This becomes a particularly troublesome issue in adolescence. The troubled adolescent is often alone or relies on a relatively ineffective peer group for problem-solving strategies. Issues are sometimes further complicated by the use of mood-altering chemicals to avoid pain, which further impairs problem-solving capabilities.

Children may verbalize seeing their particular situation as hopeless and note that they see no practical way to solve the problem or alleviate the pain.

HOPELESSNESS AND HELPLESSNESS REGARDING SELF OF A SIGNIFICANT LIFE SITUATION

Suicidal individuals often evidence an affective response towards their problems of hopelessness and helplessness. When the pain is seen as unendurable and inescapable, the individual may feel overwhelmed and come to believe that no positive resolution to his or her problems is attainable.

AMBIVALENCE REGARDING SUICIDE

Children contemplating suicide often evidence ambivalence about wanting to live or die. The typical view that ending life is wrong or unacceptable becomes less fixed. The individual moves towards a view of suicide as an alternative. In a situation in which one can do nothing, suicide is at least an alternative over which the individual can exercise some choice and control.

PERCEPTION OF SUICIDE AS A SOLUTION

Rigid and restricted patterns of thinking and problem solving may be present in a child who is at risk for suicide. Problem-solving attempts may be met with apathy or belief that there is nothing that can be done. A cognitive perception of suicide as a solution that results in the ending of pain can appear as a reasonable alternative. In this scenario, suicide is not conceived as an act that ends life but one that ends pain. For many children the permanence of this decision is not clearly assimilated into the cognitive process. For others it is seen as a necessary condition to a workable solution such as a response designed to punish or manipulate a loved one.

PHYSICALLY/PSYCHOLOGICALLY DISTANCING SELF FROM OTHERS

Some individuals contemplating suicide may communicate intent. There may also be a psychological or social effort to move away from others. As suicide is more seriously considered, there is generally some attempt to inform others of this impending decision. At the same time a progressive distancing from others occur as people becoming less and less critical to the individual's perception of his or her existence.

OTHER CONSIDERATIONS

Berman and Jobes (1995) define the following types of adolescents who are more at risk of suicidal behavior:

- the depressed adolescent readily diagnosed using research-based criteria;
- the substance-abusing adolescent, who may turn to drugs or alcohol to anesthetize depression;
- the borderline or schizotypal adolescent, who has a history of rage or impulsivity, and interpersonal instability;
- the antisocial, acting-out or conduct-disordered adolescent, whose behavior signals a lack of alliance with or allegiance to healthy objects and systems;
- the marginal, isolated loner, who exists on the fringes of a peer system separate from a peer system, or in groups of marginal others (e.g., with other runaways);
- the rigid, unofficial perfectionist, the "star" who thinks irrationally when threatened with not achieving exceptionally high levels of performance;
- the psychotic adolescent whose behavior is governed by either command hallucinations or an intense panic in anticipation of a self-perceived decompensation; and,
- the in-crisis adolescent whose stress-provoked behavior is driven by impulsively and irrationality.

Though suicide rates for children in elementary schools are not as high as suicide rates for adolescents in middle and high schools, even young children are capable of suicidal behavior. Contributing factors to depression in young children, which is often associated with suicidal thoughts, are:

- perfectionism,
- over achievement,
- lack of appropriate social skills,
- membership in minority groups (not just racial) who feel discriminated against, and
- significant or chronic failure at important tasks such as academics or athletics.

Other warning signals for younger children may include:

- being accident-prone (reflective of a lack of personal care or covert gestures or attempts),
- deep and prolonged grief over any loss significant to the child,
- overwhelming guilt, and
- swift, dramatic improvement after a period of depression (with the lifting of heavy depressive symptoms, the child has more energy to act on any suicidal thoughts).

(Silbert & Berry, 1993)

Appendix D

Criteria to Assess the Suicide Risk of Students

The following guidelines are meant to support the trained mental health professional in assessing the imminent danger of suicide as presented by a student. While most assessment criteria are applicable to K-12 students, some distinctions are drawn between younger (elementary school) students and older (middle and high school) students. The trained professional is cautioned to use his or her clinical judgement in applying these guidelines to individual students. Judgements as to whether to apply "younger" or "older" assessment criteria to individual middle school students should be based on the professional's knowledge and experience with that student. A further important cautionary reminder is that when in doubt regarding the assessment of imminent danger, it is always best to err on the side of caution to insure the safety of the child.

SPECIFIC CRITERIA – OLDER CHILDREN (MIDDLE AND HIGH SCHOOL)

Communication of Intent

Suicidal ideation may be expressed through statements such as "'I wish I were dead, gone, or not around anymore." Students also might say, "you'd be better off without me" or "No one would care if I were gone." School personnel should take such statements, or any statement of suicidal intent, seriously.

Suicidal thoughts also may be expressed in a student's writings or artwork, and should also be taken seriously by school personnel. Themes of death present in a student's artwork, writings, and verbal statements are also factors that are cause for concern.

Students who may not be verbalizing suicidal ideation in direct ways such as overt statements may verbalize seeing suicide as a solution or as a way to end a state of turmoil, unhappiness, or pain.

A student who suddenly gives away personal possessions or refers to the person or persons who should receive such possessions when he or she is gone should be considered at significant risk. The writing of a will or a directive about what is to be done after the person is no longer alive should also be viewed with concern.

Gender

Adolescent females are significantly more likely than adolescent males to have thoughts about suicide and to have attempted suicide. Adolescent females are one and a half to two times more likely than adolescent males to report experiencing suicidal ideation and three or four times more likely to attempt suicide (King, 1997, and Centers for Disease Control, 1998). Adolescent males are 4 to 5.5 times more likely than adolescent females to complete suicide attempts (King, 1997, and National Center for Health Statistics, 1998). While adolescent females complete one of every twenty-five suicide attempts, adolescent males complete one of every three attempts (Karolus, Kirk & Shatz, 1990).

History of Expressed Thoughts or Attempts

A child with a family history of suicide or one who has threatened or attempted suicide in the past is at greater risk of successfully completing a suicide attempt. The risk is increased if a child previously attempted suicide and little clinical intervention occurred (i.e. parents or family minimize the suicide attempt or the child did not receive any mental health services.) A history of suicide in the family may lead young individuals to think of suicide as a reasonable way of coping with problems (Marcus, 1996). Adolescents who attempted suicide are eight times more likely than adolescents who have not attempted suicide to attempt suicide again (Lewinsohn, Rhodes, & Seeley, 1993). One-third to one-half of adolescents who kill themselves have a history of previous suicide attempts (Hawton, & Catalan, 1987).

Plan

An expressed workable plan indicates a much higher risk than vague or unworkable notions of how to commit suicide. Access to a lethal means, particularly a firearm, combined with a history of previous suicidal attempts or ideation reflects high risk and suggests the need for immediate intervention. Similarly, the purchase of a weapon, a rope, or any other potentially lethal or suspicious article should be a matter of concern.

Among the factors that contribute to the heightened completion rate of suicide for teenagers is greater access to lethal weapons (e.g., firearms), to drugs and alcohol, and to motor vehicles. Guns are the most frequently used method for completing suicides among adolescents (Marttunen, Aro, & Lonnquist, 1992). In 1994, guns accounted for 67% of all completed adolescent suicides. (Centers for Disease Control, 1994). A gun in the house increases an adolescent's risk of suicide. Regardless of whether a gun is locked up or not, its presence in the home is associated with a higher risk for adolescent suicide (Brent, Perper, Allman, Moritz, Wartella, & Zekllenak, 1991).

Support Systems

The lack of appropriate support systems or the ability to communicate with or access such support increases the risk of imminent danger. It is important to explore the availability of support systems for children and their ability and willingness to access such support (e.g., parents, friends). Refusal to use these systems signifies a cutting off of communication and makes the intent more serious (Corey, Corey, & Callahan, 1998).

Loss

Significant losses such as loss of social position, another person, love, or self-esteem may trigger the sense of hopelessness or unendurable pain and thereby increase the potential for imminent danger. Adults must be aware that children and adolescents experience their own losses and define which losses are significant. The pain and difficulty sometimes associated with these developmental stages may seem unimportant to adults. However, to the child, his or her pain and worries may seem all encompassing and permanent.

Similarly, a student who has experienced a major loss and whose grief appears to be marked and long lasting may be at risk for depression or possible suicidal ideation. Students, who have experienced other significant losses such as the break-up or rejection of a romantic relationship, rejection by peers, unstable living, economic conditions, or other student may be at risk of suicidal behavior.

Substance Abuse
Mood-altering chemicals tend to lower inhibitions and increase the likelihood of exhibiting personally or socially sanctioned behavior. They further distort cognitive processes and increase impulsivity. Engaging in alcohol or drug use and abuse are significant risks, especially if a significant change in substance use occurs, or if the substance use is a marked change in behavior for a student.

History of Impulsive Behavior
Children who have an established pattern of impulsive behavior are more likely to act on immediate impulses, especially in times of stress and confusion. Adolescence is an impulsive age. School records such as discipline referrals may often reflect such impulsivity.

History of Mental Illness
Children with a history of emotional difficulties may be lacking in appropriate support systems, coping skills, and problem-solving skills. When thoughts of suicide are apparent in these children, the risk is increased. Special considerations regarding prior mental illness include:

- relation to present state,
- relation to other imminent danger factors, and
- co-morbid characteristics of substance use and depression.

Psychiatric illness or substance use are both high-risk factors. A student diagnosed with a mood disorder, particularly a major depressive or bipolar disorder, is at greatest risk of engaging in suicidal behavior. Children with borderline personality disorders, chronic depressive episodes, and schizophrenia are a particularly high risk.

Recent Uncharacteristic Behavioral Change
Marked changes in behavior may indicate a student who is at risk. A student, who suddenly has plummeting grades, appears to be distancing himself or herself from peers and adults exhibits emotional outbursts, inappropriate and unprovoked anger, frustration, mood liability, or other maladaptive behavior change may be at risk.

B. SPECIFIC CRITERIA – YOUNGER CHILDREN (ELEMENTARY SCHOOL)

The criteria listed above for older children also are generally applicable to younger children. The list below highlights differences that the professional may encounter when evaluating younger children.

Communication of Intent
Children may express thoughts of suicide or even attempt suicide. A child who attempts suicide should be assessed as high risk and not be left alone.

Attention should be given to drawings that depict scenes of physical harm directed at the child and especially self-inflicted harm. Children may express thoughts of wanting to die or join a dead loved one in heaven.

Gender
Gender is not a determining factor for suicide attempts by children in elementary school. Suicidal behavior appears more commonly in boys than girls under 12 years of age, although there is no difference in degree of severity by gender. Typically, at this stage in life young boys and girls do not differ in their preference of methods.

History of Expressed Thoughts or Attempts
Along with considerations highlighted above for older children, previous suicide by a family member is a significant consideration for young children who may see such behavior as an acceptable model and not comprehend the finality of such an act.

Plan
Having a plan places a young child at a high risk for a suicide attempt. There are many explanatory variables for the low suicide rate in children. Unlike middle and high schools, elementary school children do not necessarily have access to self-destructive means. Their planning skills are not as matter-of-fact and the time left alone and unsupervised at this age is minimal (Gover, 1991). Therefore, a young child who has developed a workable plan for suicide is a serious risk.

Jumping from heights is the most common method in 6 to 12-year-olds. Other methods used to attempt suicide by elementary school children include:
- carbon monoxide gas,
- firearms (depending upon accessibility),
- ingestion of poison,
- stabbing,
- drowning,
- running into traffic, and
- burning

(Pfeffer, 1986)

Support Systems
Relationships within the family have the greatest impact on young children. The family is the primary social network for children and provides the background for building a sense of self and a sense of belonging (Young, 1998). Children are very dependent upon this support system and any significant change or disruption, not explained appropriately to the child, can cause serious problems. Family characteristics that increase the likelihood of imminent danger for elementary school children include divorce and separation and a history of drug and alcohol abuse.

Familiar factors that greatly influence the probability of suicide are:
- parental separation,
- divorce,
- poor adaptation to a single parent family,
- family history of psychopathology (especially parental suicide behavior),
- parental depression, and
- drug abuse and violent physical or sexual abuse by parents.

(Capuzzi, 1994)

Loss

Grief and bereavement are issues that are closely tied to family accord. The likelihood of imminent danger varies depending upon the psychological connection and how close the child was to the deceased. Pfeffer (1986) illustrates the complex relationships between parental death, parental depression, suicidal ideation, and childhood suicidal behavior. A child may respond to parent's deteriorating psychological state, and act out suicidal impulses expressed by the parent. Grief not appropriately addressed with children can place them at a high risk of danger. Suicidal verbalizations and gestures may be a direct result of not understanding death and wanting to join a loved one.

Substance Abuse

Substance abuse is not a prevalent problem for the younger children, but this does not suggest that they do not have access to mood-altering substances. In relation to suicidal thoughts and attempts, it is usually the parent who is abusing the substance.

The parent's abuse of alcohol, for example, leads to neglectful behavior toward their child, which puts the child at risk for suicidal thoughts and behavior. If a child is abusing alcohol, it should be considered a definite warning sign for possible suicidal behavior.

History of Impulsive Behavior

Children who are impulsive and are highly suggestible are at risk for suicide (Young, 1998). Impulsive behaviors exhibited by young children may come in the form of bullying and stealing.

History of Mental Illness

Young children with any diagnosable psychological problems should be thoroughly and repeatedly assessed by clinicians for potential suicide. In time, these children may begin to feel isolated and out of control. Depression may go unnoticed (Young, 1998). Childhood depression that eventually leads to suicidal thoughts or attempts can exhibit itself in the form of anger and rebellion. Adults may associate depression only with feelings of sadness and dependency and fail to recognize a child who may mask it with behavior that disrupts the family and school environments. A cautionary note: while many suicidal children show signs of depression, the majority of depressed youth are not suicidal, but merely searching for support to help deal with their problems (Cappuzi, 1994).

Appendix E

Case Readings

The cases below are fictitious but represent of typical presentations of child suicide issues. They are presented here for the benefit of the licensed school professional to supplement the guidelines established for § 22.1-272.1. of the Code of Virginia.

A. Elementary School Cases

Susan

Susan, an eight year-old child, was referred to the guidance counselor by her third-grade teacher, Ms. Johnson. The guidance counselor was informed that Susan continues to talk and fails to follow directions during class time. (Susan's mother was informed of this behavior on Susan's last report card.) Near the end of the day, Ms. Johnson caught Susan passing out birthday cards to her friends during a spelling test. Ms. Johnson was "fed up" and decided Susan needed to be disciplined. Susan was to write a note home to her mother, describing her behavior in the classroom. The note was to be signed by her mother and returned the next day. Susan wrote:

Dear Mom,

I am writing to you because I was being bad in class. I was told to stop talking by Ms. Johnson, but I didn't. I passed out my birthday invitations during class. I am very sorry. I can't help the things I do. I can't do anything right. All I want to do is die. Maybe if I were dead, things would be different. Please forgive me.

Love,
Susan

The teacher describes Susan as being happy and outgoing among her peers. She stated that she has never seen Susan sad or depressed and can't figure out why she would hurt herself. Because school will be letting out in the next fifteen minutes, Ms. Johnson is wondering if Susan is in any immediate danger.

To determine the seriousness of this situation, the guidance counselor met with Susan to discuss her note. Susan admitted that she talked and passed out birthday invitations during class. When asked if she was thinking about hurting herself, Susan hesitated, shook her head "No". She said that she did not want to hurt herself at all, but was really worried about her upcoming party. Susan then started to cry. Susan stated that her mother would cancel her birthday party if she were to get in trouble again for misbehaving. Susan reported that she was very sorry and begged for another chance.

Case Interpretation - Susan

Based on the given information the assessment of imminent danger is low. Susan knew that if her negative behavior were to continue she would be punished. Susan was caught passing out birthday

invitations and was probably scared that her party would be cancelled. The note home to her mother was a way to get out of trouble.

Susan has also been described as happy and outgoing and has never been seen as sad or depressed. There are no serious indicators present beyond the note, which may be interpreted as low-risk based on information obtained in the interview.

Jamie

Jamie is a fifth-grade student at Oak Elementary School. After the recent death of her mother, Jamie had been coming to school late. Jamie reported that her father has to go to work early and that she has the responsibility for getting herself and her six-year-old brother off to school.

Within the past month, Jamie had lost considerable weight. She had withdrawn from her peers. She took little or no interest in fun activities. Jamie also has difficulty concentrating on her schoolwork and rarely turned in homework assignments. Despite several notes and calls home, the father had yet to respond to the teacher's messages regarding Jamie's behavior.

Mrs. Williams, Jamie's teacher, referred her to the guidance counselor. During recess, Jamie ran out of the playground into ongoing traffic. According to Mrs. Williams," It was a blessing that Jamie did not get hit."

When confronted with this situation, Jamie broke out in sobs. She stated that she missed her mother and wanted to be with her in heaven. According to Jamie, "Life is not worth living anymore." When asked whether she had talked with her father about her thoughts and feelings, Jamie responded that she tried, but he just doesn't seem to care and doesn't listen to her anymore.

Case Interpretation - Jamie

Based on the given information, there were many warning signs that this child was in immediate danger. Jamie had no interest in pleasurable activities, her schoolwork had declined, she was verbalizing suicidal thoughts, and her running into traffic may well be interpreted as a gesture or an attempt to take her own life.

There were also warning signs regarding neglect. She had taken the role as caregiver for her younger brother and reported her father is withdrawn and unresponsive to her. It may well be that due to the recent death of his wife, the father was in a state of depression and, therefore, had trouble attending to his children's needs.

Juan

Juan was a slightly overweight 11-year-old boy. He generally showed average academic abilities. Juan was the youngest of three children; his two older sisters are in high school. Juan's parents were divorced three months ago. He lived with his mother and visited his father on weekends.
Juan's teacher noticed a drop in his academic performance and a lack of motivation since the divorce. He seemed to daydream more than usual and was beginning to show an uncharacteristic disrespectful attitude in his voice when responding to his teacher. The teacher had referred Juan to the school counselor because of this change in behavior.

Upon talking to Juan the guidance counselor learned that Juan's mother worked at the local sewing factory; and since the divorce had been working a considerable amount of overtime. When his mother worked overtime, Juan either stayed alone for several hours or was cared for by his teen-age sisters. Because the sisters have after-school jobs, this child-care system was somewhat sporadic. Juan's mother had also started seeing a man, George, who worked in the same factory. On some occasions

Juan goes out with his mom and George, but just as often he stayed home and watched videos that his mom had rented for him. Juan's father was distant. He spent most of his time watching sports on TV and conversing very little with Juan. He was bitter about the divorce and made negative comments to Juan about his mom.

Prior to the second meeting between Juan and his counselor, Juan's teacher made an immediate referral because of an incident that occurred on the playground. The teacher found Juan sitting by himself crying. When asked what he was doing, Juan said that if he could make himself "go away" maybe everything would be better and that his parents would get back together.

The counselor met with Juan and continued the discussion about the home life, divorce, and his feelings. Juan admitted he had lost interest in school and after-school activities and had been feeling sad most of the time. When asked what he meant about making himself "go away" Juan said that he thought everyone would be better off if he weren't around. When asked how could he make himself go away, Juan replied that his sister's magazines have stories about kids killing themselves. He had not read these stories but had heard his sisters talking about them. Juan had no clear idea how he would try to kill himself but he thought that this might be a way to get his parents together and make things normal again.

Case Interpretation - Juan

Juan was a student with genuinely serious concerns but is not at imminent risk. He was experiencing a significant loss and manifesting behavioral changes often associated with depression. Juan does not have a clear plan for suicide and was more focused on reuniting his parents than ending his life. Juan did have a support system, though somewhat unstable, which can be accessed. Juan was a candidate for a suicide contract and immediate involvement in individual or family counseling. Though not a requirement of § 22.1-272.1 of the Code of Virginia, Juan's parents should be contacted to initiate appropriate support.

B. Middle School Cases

Keesha

The school social worker was asked to see Keesha, an eighth-grade girl, by her teacher. Keesha was upset about friends abandoning her and about her reputation. In the past two months she had become sexually active. Peers were making suggestive comments and calling her names in the halls at school. Keesha's boyfriend had abandoned her for another girl and was one of those initiating tales of her sexual behavior. She displayed flat affect as she talked about feeling very sad. The social worker asked if she had experienced any recent thoughts about harming herself. In response, Keesha pushed up the sleeves of her sweater revealing many scars and fresh cuts on both forearms. She had been mutilating herself for several weeks. When asked if she intended to hurt herself further, she looked down and refused to answer. Keesha said her parents were unaware of the self-injurious behavior and would not be open to seeking counseling for her. The school social worker reassured her that parents generally want to hear about their children's problems and want to help even when the problems are difficult to talk about. With Keesha's somewhat nervous agreement, the social worker arranged for her parents to come in for a conference. Keesha revealed her injuries in that setting and arrangements were made for an intake appointment at the community mental health center.

Case Interpretation - Keesha

Based on the given information, there were many warning signs that Keesha was in immediate danger. She displayed flat affect. She was experiencing significant loss (boyfriend, reputation, innocence - perhaps) and had made several gestures toward suicide in the past few weeks and was likely to continue or escalate this behavior. Contacting Keesha's parents was indicated.

April

April was a 12-year-old sixth grader. She had been in her school system since kindergarten without incident. She consistently scored above average in every academic area. April had never been in trouble – until recently. About two months ago her grades plummeted from A's and B's to D's and F's. A quite different attitude replaced her normally cheerful, helpful classroom demeanor.

She became hostile and confrontational, and often spoke out inappropriately in class. Her teachers had to call home almost daily. During these conversations teachers said that her parents had reported they were noticing similar behavior as well as clingy toddler-like antics.

She was an only child and only grandchild. Ms. Seay, April's math teacher, was informed that April's mother was due to have another baby next month. Ms. Seay sent April to the counselor's office because April was openly and cheerfully telling classmates good-bye and giving some small belongings away. When she was questioned her about this she stated "I'm going to kill myself this afternoon." After chatting for a few more minutes she was asked her about her reasons. She responded "I'm going to kill myself because my family hates me." When questioned about her plan she thought and said "I don't really know but maybe I'll think of something". It was suggested that a call home might be helpful. April smiles brightly and welcomed the idea. She then exclaimed that she needs to go to her locker because she knows her Mom will be right there and she wanted to be ready. "I really need to be ready. I feel much better. Mom may even have time for us to go to the mall," April chirps.

Case Interpretation - April

April was an example of attention-seeking suicidal behavior. This was evidenced most clearly by her statements after she met with the counselor. She was very eager to have anyone listen to her. She was "chatty" which indicated a light mood. She welcomed whole-heartedly the idea of the counselor calling her mother. She was more focused on her mother rushing down to pick her up than her "family hating her." She thought that her mother would take her to the mall, which indicated April does not see the severity of her threat. Her negative behavior increased in severity as the due date for the new baby approached. She was probably jealous of the new baby and worried that she could not be special once the new sibling arrives. The counselor should meet with April's parents and April, and discuss family roles and the importance of special times just for April and mom. However, the threat of suicide should not be ignored due to the fact that this child was clearly and inappropriately seeking attention. April will need some support in adjusting to the new baby and resolving her feelings about the changes going on at home.

Kenny

Kenny was a seventh grader at Clark Middle School. Since entering Clark at mid-term, Kenny had been polite but shy. He had yet to establish a solid base of friends. Kenny's academic performance had recently dropped dramatically.

Kenny lived with both parents. He was a latch-key student. He had one stepbrother who went to live in another city. Kenny had not been involved in extracurricular activities at school.

His teacher reported that recently Kenny had begun to be aggressive and to have difficulty getting along with his classmates and his teachers. The teacher had also seen him hanging out in the cafeteria with a group of students who had been suspended for possession of drugs. The teacher referred Kenny to the school counselor after several episodes of sleeping in class and refusing to do his work.

When Kenny finally opened up and started talking, the counselor found out that Kenny was extremely angry with his parents. He said that they did not like his new friends. During the past few weeks he had had several angry confrontations with his parents. Kenny said that he really missed his stepbrother as he was always there for him to talk to.

The counselor scheduled another session with Kenny later in the week and then called the parents. The parents seemed angry that the counselor was getting involved and made excuses about not being able to come to school to talk.

Before the next scheduled counseling session, his teacher abruptly sent Kenny to the counselor. Kenny had just gone into a fit of rage in the classroom calling his teacher an inappropriate name and threatening to sling his desk out of the window. In the counselor's office Kenny raged and blurted out, "If all of you guys keep after me I'll kill my parents and myself too!" When asked how he would do that, he responded, "I've thought about that several times this week. I'll just use my father's gun in his drawer. The bullets are there, too!"

Case Interpretation - Kenny

Based on this information that included recent family change, changes in behavior, impulsive behavior, accessibility to guns, a verbal statement of a specific plan, and diminished support system, Kenny's situation was seen as one of imminent danger. Parent contact was indicated. If during this contact the parents displayed disinterest or refused to seek appropriate intervention for Kenny, then contact with the Department of Social Services is indicated.

C. High School Cases

Justin

Justin recently turned 15. It was almost the end of his ninth-grade year. He was an average student, a hard worker, and played several sports. Justin's mother phoned the school counselor and requested an appointment for him. His mother expressed concern over recent changes she was seeing in her son. She reported that Justin's girlfriend of almost a year broke up with him to date an older friend of his. Since that time Justin didn't want to leave his bed. He ate little, did not play outside, and was beginning to refuse to go to school. He had become withdrawn and looked sad.

In the interview, the counselor informed Justin about the call from his mother and assured him that it was only because she was worried about him that she called. After some initial hesitation, Justin reported that he felt very sad inside. He reduced to tears as he admitted that he often cried and cannot stop.

Justin reported a general lack of energy and disinterest in usually fun activities. His biggest concern was that it wasn't manly to feel this way, but he said that he can't help it. Justin sighed and stated, " It had been two weeks but the hurt just won't stop." When asked if he had thought about hurting himself, he said that he had thought about it. "I could have gotten a hunting rifle from my cousin,

but my mom came home looking forward to seeing me and I just couldn't do that to her. . put her through that." He continued "I just wanted this hurt to stop, I can't go on like this." He told you that he'd wanted you to help him but he doubted that you could.

Case Interpretation - Justin

Justin was clearly in distress over a significant loss; however, he was reaching out for help. He was in touch with his feelings and knew that they cannot continue in this capacity. He had identified a strong reason for living. His suicidal thoughts should be taken seriously, but he was not in imminent danger. Though not a requirement of § 22.1-272.1 of the Code of Virginia, the counselor should discuss a suicide contract with him and obtain a commitment from him. Parental involvement had already begun and should continue along with Justin's involvement in counseling.

Calvin

Calvin was a 17-year-old Caucasian male. He was 5'11" and weighed 160 pounds. Calvin lived with both parents in their home in a suburban neighborhood. Calvin's father was a construction worker and his mother was a waitress. Calvin had attended school in the same public school system since kindergarten. At the age of 15 Calvin was injured by a self-inflicted gunshot wound to the shoulder while out hunting. The following information came from a telephone conversation between the counselor and Calvin's mother: Calvin had told his mother that he had accidentally tripped over a tree stump, which had caused the gun to go off. He was treated and released from the hospital a day later. While there, a psychiatrist saw Calvin and suggested that he might benefit from counseling. This incident occurred after the death of a grandparent to whom Calvin felt particularly close. Upon returning to school, Calvin was seen on a supportive basis by his school counselor as his parents chose not to pursue counseling outside of the school. The counselor continued to monitor Calvin for the next three months at which time the counselor and his teachers agreed that he appeared to have settled back into school and was doing well both emotionally and academically.

Calvin was re-referred to the school counselor following an incident between Calvin and his former girlfriend. The two were talking when Calvin suddenly rammed his fist into the wall and began crying uncontrollably. Concerned about his hand, the teacher first sent Calvin to the nurse with another student and then asked Calvin if he would like to talk with his counselor after seeing the nurse. Calvin said that he would. While Calvin was at the nurse's office, his friend John spoke with the teacher concerning Calvin. John told the teacher that the day before, he had asked to borrow Calvin's car. Calvin agreed to the request and then told John he didn't have to worry about returning the truck because he (Calvin) wouldn't need it anymore. At this point the teacher relayed the above information to the counselor.

Calvin entered the guidance office with a bandaged right hand and swollen eyes. When asked what was going on, he replied "too much." When questioned further, Calvin said that his girlfriend had left him and his mother wanted a divorce from his father. When Calvin was asked how this made him feel he said, …" sad, just very sad." Calvin said he was so mad that he wanted to get back at everybody and make people sorry for hurting him so badly. When asked how he might do that, he replied that he would shoot himself and make them wish he were still around. When asked if he really wanted to kill himself, he reported that he still had his shotgun and said "I messed it up the first time, I won't mess it up again." He then became withdrawn and refused to answer further questions.

Case Interpretation - Calvin

Calvin evidences several significant indicators of imminent danger. He had a previous attempt, a workable plan, significant loss, and was distancing himself from others, and making gestures of farewell. Calvin's parents have failed to follow up on previous recommendations for counseling, but obviously did not attempt to prevent the previous school-based counseling. His parents should be contacted regarding the current imminent danger. If during this contact the parents displayed disinterest or refused to seek appropriate intervention for Kenny, then contact with the Department of Social Services is indicated.

Candy

Candy was a 15-year-old 10th grader. She attended a rural high school. Candy was slight in built, very pretty, and somewhat shy. She was the only child of an older couple. Candy usually made the honor roll, with an occasional C in math. Because she was shy, Candy had never had a boyfriend. Some boys had expressed an interest in "going" with her, but she had never responded to their advances. Candy was not closely connected to any peer group. She evidenced difficulty making friends.

Recently a new student named Joe came to the school. Joe, who was 17, transferred from a city school. Joe immediately took an interest in Candy, and with a great deal of charm and persistence quickly gained her interest in return. Candy found Joe easy to talk to and she didn't feel shy around him. They started "going" together and soon Candy had fallen head over heels in love.

After about three months of an intense relationship, Joe told Candy that he could not go with her anymore. He was now going with Rachel, a pretty, popular basketball star in his English class.

Candy was distraught. A number of teachers noticed a change in her. She appeared depressed, listless, and withdrawn. Candy often put her head down during class. She was referred to the school counselor by one of her teachers because of this change in behavior.

Acknowledging that she had no close friends, it appeared to be a relief for Candy to talk to the counselor. She quickly poured out her story about Joe. As tears flowed down her face, Candy told how important Joe was to her life and commented that she wished she were dead. Candy told the counselor that without Joe "there was nothing to live for." When asked if she had thought about taking her own life, Candy responded that she didn't think she could ever do that but that she understood why a person would in her situation.

The counselor sensed that Candy may be suicidal and further explored thoughts about taking her life. Candy responded that sometimes she felt that it would be the easiest solution, but what she wanted more than anything was to get Joe back. Candy also reported that talking with the counselor was a great relief and she wanted to talk more. She also wondered if the counselor could help her talk with her mother about this as they rarely talked about such things.

Case Interpretation - Candy

Candy was clearly in distress. She had a limited support system and had suffered a significant loss. She did not, however, express a clear desire or intent to hurt herself. Candy had no behavioral or emotional history that would increase the risk of imminent danger. Candy also had found viable support in her meeting with the school counselor and indicated strong interest in continuing these meetings and initiating parental involvement. A suicide contract is indicated as a safe precaution. Parental contact is not mandated under § 22.1-272.1 of the Code of Virginia, but it is advised and, in fact, was requested by the student.

Appendix F

Suicide Prevention Strategies: Creating a Supportive Environment

Introduction

It becomes increasingly important for school personnel to consider the social and emotional climate of a school as a mitigating factor for suicide prevention.

Suggestions for creating a supportive, proactive climate for suicide prevention include the following:

- fostering a school climate that is safe, secure, and comfortable for all students,
- developing activities and extracurricular programs that are inviting and inclusive,
- training and supporting staff members who help and encourage students,
- insuring service staff members are accessible to students,
- providing a regular forum in which staff members discuss students who are displaying worrisome behavior or experiencing stress,
- conducting faculty/staff gate-keeper training to identify students who are potentially at risk,
- conducting appropriate peer gatekeeper training for all students,
- cultivating relationships with public and private organizations for assessment and referral of students in crisis, and
- providing on-going support groups for students in known risk categories such as (a) students returning from psychiatric hospitalization or suicide attempts (b) students in recovery from substance abuse (c) students who are court-involved (d) students reacting to family trauma such as separation, divorce, or death of a family member.

Appendix G

Warning Signs

Seeking Help

The American Psychiatric Association recommends that parents seek professional help if their child experiences serious mood changes in which the duration is longer than a couple of weeks. Some of the identified warnings are as follows:

- withdrawal from friends and family,
- inability to concentrate,
- talk of suicide,
- dramatic change in personal appearance,
- expressions of hopelessness or excessive guilt,
- self-destructive behavior (examples: reckless driving, drug abuse, and promiscuity),
- preoccupation with death, and
- bequeathing favorite possessions.

Further warning signs include:

- impulsivity such as violent actions, rebellious behavior, or running away,
- inappropriate responses (e.g., rejection) to praise or reward,
- frequent complaints physical symptoms such as headaches and fatigue,
- verbal hints in statements such as: "I won't be a problem for you much longer" or "I won't see you again."

(American Academy of Child and Adolescent Psychiatry, 1997)