Trainers Guide: Foster Parents

The Impact of Suicide on Youth and Families

The Ones We Miss

Developed by NEW Partnership for Children and Families
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The References page in the curriculum cites resources consulted and utilized in the development of the curriculum and training materials.

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A special thanks to Jonah Mowry and his father, Kevin Mowry for permission to utilize the video clip "What's Goin' On…" Jonah and Kevin provided permission to utilize this clip as part of this training. YouTube is the only "authorized" video site to host and play the video and only on Jonah's BlahBlahBlah2145 channel. This video clip must be accessed by linking to YouTube as noted above. Both music and video are copyrighted. Sia has graciously allowed Jonah to use her song with his video as long as it is together on YouTube.
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The Impact of Suicide on Youth and Families: "The Ones We Miss"
(Foster Parent Version)

Course Description:
Providing care for children and adolescents in foster care is both rewarding and challenging. When the challenges include the potential that children in your care may be suicidal, it can be especially frightening. This training is designed to provide foster parents with an introduction to the warning signs, risk factors and protective factors when working with children and youth in care. The "Ones we Miss" addresses children and adolescents at the highest risk, which includes children in out of home care and youth who are bullied. This training addresses how foster parents might recognize warning signs in youth and experience more comfort in asking critical questions and increase potential protective factors for youth.

Course Objectives:

Participants will:

- Understand the phenomenology of suicide and its impact on children and adolescents.
- Understand the warning signs, risk factors, and protective factors of suicide when working with youth and families.
- Gain an understanding of the scope of the problem facing Wisconsin and those working with children in out of home care.
- Develop awareness and understanding of who are the "Ones We Miss", including children in out- of-home care and youth who are bullied.

Notes to the Training Organization and Trainers

Training Time: 3 hours

Target Audience: This training is intended for foster parents. This training is appropriate for foster parents who want to increase their knowledge about the impact of suicide on children and adolescents. There are no prerequisite requirements for this training.

Focus of the Curriculum: This training is designed to help foster parents understand the risk factors, warning signs and protective factors related to suicide in children and youth. In addition, participants will learn about increased risk of suicide for particular groups, including boys, Native American, African American, LGBTQ, bullies, and the bullied, and the impact of children and youth in out-of-home care. Information on some of the prevention and intervention models is presented.

Learning Objectives:

Participants will:

- Understand the phenomenology of suicide and its impact on children and adolescents.
- Understand the warning signs, risk factors, and protective factors of suicide when working with youth and families.
- Gain an understanding of the scope of the problem facing Wisconsin and those working with children in out of home care.
- Develop an awareness and understanding of who are the “Ones We Miss”, including children in out- of-home care and youth who are bullied.

Trainers:

This curriculum is designed to be presented by one trainer. The trainer should have expertise in child welfare work and experience or knowledge in working with child and adolescent suicide. This material is quite difficult to train; consequently it is recommended that trainers have experience and skill in the following:

1. Extensive training experience.
2. Understand group management skills
3. Understand adult learning and learning styles
4. Understand secondary traumatic stress and be able to effectively manage its manifestation in the learning environment
5. Understand the basics of suicide, suicide risk and protective factors
6. Have a comprehensive understanding of the various cultures involved in the training, relevant to suicidality
7. Understand and demonstrate professional boundaries in the training environment
8. Recommended, but not required, professional experience with suicide

Trainers should be aware that talking about suicide can be emotional and difficult. Some participants will likely have experience with a person who attempted or died by suicide, either professionally or personally.

Training Logistics:

Timing
The curriculum is planned for a 3-hour session with one 15-minute break.

Participant Numbers
The curriculum is appropriate for a maximum of 24 participants.

Participant Seating
Participants should be seated in half-moon round tables in teams of four or five to allow small group work.

Room Requirements
Room should be large enough to comfortably accommodate participants and allow room in front for the trainer, equipment, and flip chart stand. Some wall space is needed for displaying flip charts.

Materials and Equipment Requirements

- Laptop
- LCD projector and screen
- Speakers
- Wi-Fi/internet connection for the videos
- Flip chart stand
- Flip chart paper and markers
- Tape
- Video: Richard Cardinal: Cry from a Diary of a Métis Child (1986) produced by the National Film Board of Canada. Available via website: **www.nfb.ca** or 1-800-542-2164
- Video Clip: Jonah Mowry: 'What's going on..' made August 2011 accessible via you-tube at **http://www.youtube.com/watch?feature=player_embedded&v=TdkNn3Ei-Lg**
- Video Clip: Confessions of a Depressed Comic" accessible via Ted.com at **http://www.ted.com/talks/kevin_breel_confessions_of_a_depressed_comic**
- Video Clip: Shane Koyczan: "To This Day" ... for the bullied and beautiful accessible via TED.com at **http://www.ted.com/talks/shane_koyczan_to_this_day_for_the_bullied_and_beautiful.html**

Handouts and Slides

Participants should be given a folder with handouts. A printout of the slides (3 per page with lines for notes, double-sided, stapled) should be included, along with the Idea Catcher, and two Notes sheets

Master Lists of Handouts and Flip Charts

See the **Handouts Master List** at the conclusion of these notes.

There are no flip charts that require advance preparation, as they are utilized during group discussion or can be completed quickly.

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Training Time: 3 hours

IMPACT OF SUICIDE ON YOUTH AND FAMILIES: THE ONES WE MISS
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- Video Clip/Discussion
C. Scope of the Problem in Wisconsin
D. Participant Introductions
E. Agenda and Learning Objectives

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MODULE 1 – INTRODUCTION TO TRAINING

Timing: Approximately **30 minutes**

A. Welcome and Trainer Introductions	5 minutes
B. Training Introduction	10 minutes
C. Scope of the Problem in Wisconsin	5 minutes
D. Participant Introductions	5 minutes
E. Agenda and Learning Objectives	5 minutes

MODULE 1- INTRODUCTION TO TRAINING
TRAINING CONTENT

I. Introduction to Training **(30 minutes)**

A. Welcome and Trainer Introductions (5 minutes)

SLIDES
Title Slide (Slide 1)

Welcome participants to training.
Introduce yourself, providing applicable background experience.

B. Training Introduction (10 minutes)

SLIDES
Confessions of a Depressed Comic **Video Link** (Slide 2)
Video (Slide 3)

Trainer note: Be sure to have internet access in order to play the video. It links directly from Slide 2.

Show the video clip **"Confessions of a Depressed Comic"** using link **(Slide 2)**. Following the video, display **"We need to stop the ignorance…" (Slide 3)** and briefly discuss the impact of the video clip.

Trainer note: You may use "We're All Hiding Something…" video as an alternative to the video in slide 2, depending on the audience (be sure to tie the information in the video into the opening remarks below : **http://www.ted.com/talks/ash_beckham_we_re_all_hiding_something_let_s_find_the_courage_to_open_up**

Suicide can happen in any family. This is a very difficult topic to talk about, hear about, and one that is difficult to research.

As caregivers, it may be difficult to ask the questions that get to the heart of the matter, which is **whether the person in front of you wants to end their life**. They know that telling you means you will do something.

It is difficult for the parent, the spouse, the caregiver, or other family members. Difficult because it is scary, and when you *know*, what do you *do* with that information? Sometimes it feels better to just *not know*, or to believe it is temporary or attention-seeking. After all, how

could that person want to die when they have so much going for them? Perhaps it is paralyzing just thinking about the possibility that someone they love wants to die.

The purpose of this training is to talk about suicide, the warning signs, the risk factors, the protective factors, questions to ask, and what to do when you "know what you know". We will look at specific groups of people that we are missing, the burden of suicide in Wisconsin, the scope of the problem, and how this information will impact your work. We will provide a few tools to take into your work.

C. Scope of the Problem in Wisconsin (5 minutes)

SLIDES
What do we know? United States (Slide 4)
What do we know? Wisconsin (Slide 5)

Display **What do we know? United States (Slide 4)** and share the following information:

Nationally, more men of all ages complete suicide behavior. The most common means of suicide for men in all categories (age and ethnicity) is firearms. **There are 3.6 male deaths by suicide for each female death by suicide. Females, however, attempt suicide 3 times as often as men.** Females are hospitalized more frequently than men due to their methodology, which is by overdose of medication/drugs and cutting. Men's lethal means prohibit the intervention of hospitalization. So, logically one could say that one of the "groups we miss" is men and boys of all ages because of the lethal means they choose.

Suicide is the 10th ranking cause of death in the U.S. for all ages. It is the second ranking cause of death for 15-24 year olds in the U.S. On average, one young person ages 10-24, kills themselves every one hour and 43 minutes. There are an estimated 25 attempts for every death by suicide in the U.S.

Display **What do we know? Wisconsin (Slide 5)** and continue with the following:

In Wisconsin, the picture of suicide mirrors that of the nation. Suicide is the 10th leading cause of death in Wisconsin for all age groups, with the rate of suicide holding steady between 2007 and 2011. Wisconsin's 2011 suicide rate was 13.1, which was higher than the national average (12.7). For every suicide in 2011, there were 11 hospitalizations or emergency room visits for self-inflicted injuries (WISH, 2014).

We also know that 51% of decedents had a mental health problem and 43% were receiving mental health treatment at the time of suicide. Additionally, 24% of decedents had a history of suicide attempts and 34% disclosed their intent to die by suicide to at least one person.

These statistics, however, fail to capture the number of people with suicide ideation and attempts who do not present to the emergency room, are hospitalized, or complete suicide.

D. Participant Introductions (5 minutes)

Go around the room and have participants briefing introduce themselves (ie: name, years fostering etc).

E. Agenda and Learning Objectives (5 minutes)

SLIDES
Learning Objectives (Slide 6)

HANDOUTS
Agenda and Learning Objectives (HO 1)

Review agenda and learning objectives briefly, utilizing **Handout 1- Agenda and Learning Objectives** and **Learning Objectives (Slide 6).**

Cover any additional "housekeeping" such as training/lunch times or self-care.

MODULE 2- THE PHENOMENOLOGY OF SUICIDE

Timing: Approximately **40 minutes**

A. The Burden of Suicide in Wisconsin	
B. Risk Factors, Protective Factors and Warning Signs	
C. Suicidal Behaviors	25 minutes
D. Self-Injurious Behaviors	
E. Children and Adolescents	15 minutes

MODULE 2 – THE PHENOMENOLOGY OF SUICIDE
TRAINING CONTENT

II. The Phenomenology of Suicide (40 minutes)
This module will describe the issue of suicide in Wisconsin, as well as discuss risk factors and suicidal behaviors.

A. The Burden of Suicide in Wisconsin (25 minutes total for A-D)

SLIDES
The Burden of Suicide in WI (Slides 7)
Wisconsin Data (Slide 8)
Who are we missing? (Slide 9)

Display **The Burden of Suicide in Wisconsin (Slide 7)**

"Suicide affects an entire community and,
because it is a complex issue,
it will take a community to work on it."
(Pat Derer, President, HOPES from The Burden of Suicide in WI, 2008)

Suicide rates remained relatively constant from 2007-2011 averaging 724 suicides per year. This adds up to 20,000 years of potential life lost each year. The greatest number of suicides falls between the ages of 45-54 years old. Hospitalizations and emergency room visits for self-inflicted injuries are greatest for ages 15-24 years. The cost of impatient hospitalizations and ER visits averaged over $78 million each year from 2007-2011. In terms of demographics, Whites had highest rate, followed by American Indian groups, Asian, Black, and then Hispanics. Alcohol and drug abuse are second only to depression and other mental health disorders as the most common risk factors for suicide (The Burden of Suicide in Wisconsin, 2007-2011).

Transition to a discussion of youth suicide rates in Wisconsin. Display **Wisconsin Data Slide (Slide 8),** and discuss the following information:

- **Firearms** and **hanging/strangulation** (in relatively even numbers) accounted for **over 80%** of youth suicides.

- **Medication overdoses** and **cutting** accounted for **90%** of **self-inflicted injury hospitalizations.**

- **Binge drinking** and **underage drinking** (highest rate in WI) is highly correlated with suicide attempts.

- 6% of Wisconsin high school students report an attempted suicide in 2013, while the rate for Milwaukee high school students was 14.8% according to the "Youth Risk Behavior Surveillance" summary.

- 13.2% of Wisconsin high school students report seriously considering attempting suicide and 12.1% reported having a plan

- 24.6% of Wisconsin high school students reported feeling sad or hopeless almost every day for at least 2 weeks

Conclusion:
Rates of **suicide mortality, attempts and self-reported risk behaviors** among **youth in Wisconsin** continue to be **unacceptably high**. Those who are using the most lethal methods are not the population that are being seen in hospitals or in-patient settings first. *So who are they?*

Display **Who are we missing? (Slide 9).**

Females are hospitalized twice as many times as males, however male deaths outnumber female deaths by almost a 4:1 ratio. We are missing these men. Hospitalization rates and mortality rates are greater than 50% higher in rural counties. The population of American Indians has the highest hospitalization and mortality rates. This tells us of the seriousness of the issue.

B. Risk Factors, Warning Signs and Protective Factors

SLIDE
Risk Factors, Warning Signs and Protective Factors (Slide 10)

There is **nothing simple about trying to anticipate human behavior**, especially when in a crisis. Tools such as safety contracts may *feel* helpful but they do not always work and sometimes are detrimental.

We **cannot predict suicide with 100% accuracy**, but we have a great deal of information about risk factors, warning signs and protective factors.

Suicide <u>can</u> be prevented - Do you believe that?

<u>Small Group Activity</u>:

Introduce the small group activity by acknowledging that participants already have knowledge about the warning signs, risk factors and protective factors of suicide. Display **Risk Factors, Warning Signs and Protective Factors (Slide 10)**. Hand out flip chart paper/markers.
Ask participants to talk with their team about what they know about suicide, such as warning signs, risk factors and protective factors. Put the list on flip chart paper and hang on the wall. Give them 5-8 minutes.

Trainer note: You do not need to spend much time, if any, processing the accuracy of the answers. The point here is to get the group to begin thinking about these as separate categories and reinforce the fact that they do already know some things about the topic. The Resource Suicide Prevention Resource Center, & Rodgers, P. (2011). *Understanding risk and protective factors for suicide: A primer for preventing suicide.* Newton, MA: Education Development Center, Inc. provides comprehensive information for trainers. You may also want to refer to Handouts 8 -15

Wrap up this section by providing the following information:

Risk factors:
Risk factors affect the likelihood of suicidal behavior. They are characteristics that make it more likely that individuals will consider, attempt or die by suicide. Risk factors indicate that someone is at heighted risk for suicide, but indicate little or nothing about immediate risk.

Warning Signs:
Warning signs indicate an immediate risk of suicide and require immediate intervention. In contrast to risk and protective factors, warning signs are only applicable to individuals.

"Thinking about heart disease helps to make this clear. Risk factors for heart disease include smoking, obesity, and high cholesterol. Having these factors does not mean that someone is having a heart attack right now, but rather that there is an increased chance that they will have heart attack at some time. Warning signs of a heart attack are chest pain, shortness of breath, and nausea. These signs mean that the person may be having a heart attack right now and needs immediate help".

Protective factors:
Protective factors are characteristics that make it less likely that individuals will consider, attempt or die by suicide. Protective factors are not just the *opposite or lack of* risk factors. Rather, they are conditions that promote strength and resilience and ensure that vulnerable individuals are supported and connected with others during difficult times, thereby making suicidal behaviors less likely.

Risk and protective factors are found in individuals, families and communities – they may be fixed or modifiable.

Source: *American Foundation for Suicide Prevention; "Risk Factors and Warning Signs" retrieved from website July 2014*

During this training, we will focus specifically on risk and protective factors to identify and target prevention efforts for high risk groups (or "the one's we miss").

C. Suicidal Behaviors

SLIDES
Suicidal Behaviors (Slide 11)
Ones we miss (Slide 12)

HANDOUT
Definitions (HO 2)

Introduction: *Before we go any further, let us be certain that we share the same understanding of the terminology. Please refer to* **Handout 2- Definitions**. Display **Suicidal Behaviors (Slide 11)**. Review each of the definitions, providing additional information. Share examples as they are relevant.

Suicide:
A deliberate act of self-harm with at least some intent to die that results in death.

Suicide Attempt:
A deliberate act of self-harm with at least some intent to die that does not result in death. Such acts have a wide range of medical seriousness. The risk of completion increases with each attempt. Suicide attempts are a long-term risk factor that represents a chronic situation risk and needs to be taken seriously.

Suicidal Ideation:
Thoughts of attempting suicide. Such thoughts have a wide range of specificity, intensity, and frequency. Suicidal ideation is relatively common. About 34% of those with suicidal ideation go on to make a plan, and 36% make an unplanned attempt. Of those who have experienced suicidal ideation, only 0.05% completes suicide.

It is important to note that suicidal ideation is an unreliable marker for safety. It may be a long-term risk indicator. Substantial numbers of people who make a severe attempt deny having suicidal ideation. An assessment must be made to distinguish suicidal *ideation* and suicidal *intention.*

Suicide Planning:
A severe form of suicidal ideation that includes identifying a method or scenario to attempt suicide.

Display **Ones we miss (Slide 12)** and review the following:

There is a 72% chance that a person who makes a suicide plan will make an attempt. Keep in mind that, based upon 2007-2011 Wisconsin statistics, **34% disclosed their intent to die by suicide to at least one person**, however this means that ***66% did not***.

It is estimated that ***73% who died did not mention intent or ideation during their last contact with a professional***. For those that did talk about it, there is indication that they mentioned it at least 3 times, generally to spouses (60%), relatives (50%), or caregivers (18%).

Note the 18% who mentioned intent or ideation to a caregiver - these include the **children and youth in out-of-home care**. Any thoughts on why that number might be so low? One of the goals of this training is to increase the number of those in out of home care who disclose suicidal intent or ideation by providing their case managers and caregivers information. *Ask participants why children might be reluctant to disclose and what they can do to assist in helping youth overcome this reluctance.*

D. Self-Injurious Behaviors (SIB)

SLIDE
Self-Injurious Behavior (SIB) (Slide 13)

HANDOUTS
Self-Injurious Behavior (HO 3)
Risk and Protective Factors (HO 4)
No More (OOF)

Transition to a discussion of self-injurious behavior.

There are often questions about self-injurious behavior. ***What is it? Is it a risk factor or is it a warning sign?*** This question is most frequently asked by child welfare workers and foster parents on this topic.

Self-injurious behaviors are great cause for concern, confusion, and anxiety for the foster parent. The question has been asked many times; ***how do I know the difference between a suicide attempt and self-injury, or cutting?*** Acknowledge that it is confusing and scary.

Refer to the definition on **Handout 2- Definitions**.

Self-injurious behavior (SIB) is "a deliberate alternation or destruction of body tissue without conscious suicidal intent". They are s*elf-directed acts of self-harm without intent to die.* Broadly, these acts tend to have intrapersonal (e.g., manage emotion) or interpersonal (e.g. communicate distress) motivations and include a variety of behaviors (cutting, piercing, burning) and a have wide range of medical seriousness.

According to Dr. David Mays (2000), self-injurious behavior was originally thought to be associated with only serious mental illness or trauma. Recent findings are different and include that this occurs in high functioning populations and with those who do not have a psychiatric diagnosis.

Here are 4 main types that may help you understand these phenomena.

Display **Self-Injurious Behavior (Slide 13)** and refer participants to **Handout 3- Self-Injurious Behavior.**

1. Severe SIB

These are infrequent acts in which significant amounts of body tissue is destroyed. Severe SIB usually occurs suddenly but with a great deal of damage. It is associated with psychotic states, acute intoxication, encephalitis, schizophrenia, etc. Some examples include enucleation (removing eyeball), castration, and limb amputation. For those who complete severe SIB, some seem indifferent to the act, some have no explanation or the explanation does not make sense, and most are very calm afterwards. The high risk population includes those who have psychosis and are preoccupied with religion and sexuality and suddenly change their behavior (i.e. shaving their head, plucking out eyebrows).

2. Stereotype SIB

This type occurs in a fixed pattern, often rhythmic, such as head banging or finger biting. There is no symbolism to the behavior. It is most common in populations that are institutionalized, developmentally disabled, autistic, or in acute psychotic states. The purpose of the behavior could be done to gain attention, as a response due to under-stimulation, out of frustration, or aggression turned towards self.

3. Socially Accepted/Emblematic SIB

This type includes tattooing, piercing, scarification, etc.

4. Superficial/Moderate SIB

This type of self-injurious behavior has low lethality and little tissue damage. The behavior occurs sporadically or repetitively, and is often a time-limited experimentation among peers. Examples of this SIB include cutting, burning, scab picking, needle sticking, self-punching,

excoriations, or scratching. The SIB may be **compulsive** (nail biting, skin picking, hair pulling), **episodic** (quick, effective release from stress, often impulsive, often in response to anger and anxiety), **repetitive** (little resistance to the act, rumination, identifications as a cutter/burner, qualities of addiction), **counter-dissociative** (the purpose is to reconnect with reality), or **para-suicidal** (ambivalent suicide attempt, attempt to communicate).

This type of SIB has been reported with PTSD, or after rape, combat, and during depersonalization. It may be exacerbated by a dissociative identity disorder, borderline personality disorder, or histrionic personality disorder. It is often seen in prisoners with antisocial personality disorder and persons with Addison's (adrenal disease) or eating disorders.

Self-Injurious Behavior is a common clinical phenomenon. Poisoning and cutting account for 90% of ER visits.

It is more common in adolescent females (worldwide) by nearly a 4:1 ratio. Depression, anxiety, and impulsivity are associated with self-harm in girls (not boys). **Self-harm in adolescents increases proportionately with the consumption of cigarettes, alcohol, or drugs, or having family members who recently self-harmed.** Childhood abuse, substance abuse, PTSD, and Intermittent explosive disorder are also associated with SIB. Girls explain their actions by saying they want to punish themselves or they are trying to get relief from an unbearable state of mind.

Information is widely accessible over the internet. For example, a Google search of self-injury has over 25 million hits (this is a dramatic increase since this training was first introduced in 2010 when google had just over 1 million hits on this topic). A person can watch videos on you-tube of people hurting themselves. So, **ask** your clients about their internet usage, especially around this subject matter. It may give you some needed insight into the behavior.

Again, all of the information above is about the **assessment,** and asking the questions to **gain awareness** or understanding of how the individual may be impacted or may be at risk.

Trainer Note: only do this if time allows.

Provide **Out-of-folder (OOF) Handout "No More".** Explain that this is a blog written by a mother who found her son's bloody t-shirt while looking for something underneath his bed. Read this out loud for participants for full effect (or as an alternative, ask participants to read the handout themselves).

Ask participants to take out **Handout 4 – Risk and Protective Factors** which lists these factors for all individuals. Review the handout with participants. Note that those factors with an asterisk * are consistently indicated across the most up to date literature. It is a review of the material covered, reiterating the protective factors. Try to acknowledge key concepts that they were able to identify on their flip charts, if possible.

E. Children and Adolescents (15 minutes)

SLIDES
Children (Slide 14)
Children- Risk Factors (Slide 15)
Children in Care (Slide 16)
Adolescents (Slide 17)
General Risk Factors for Adolescents (Slide 18)
Protective Factors (Slide 19)

HANDOUTS
Warning Signs and Risk Factors – Children (HO 5)

An article published in Science Daily (Nov. 28, 2011) concluded that thoughts about killing oneself and engaging in suicidal behavior begin much younger than previously thought. New findings reveal that a **significant proportion** of youth make their **first attempt in elementary or middle school**.

The Journal of Adolescent Health cited a study of young people who had attempted suicide. Almost 40% of those studied indicated that they had tried or made their first attempt before entering high school, some as young as 9 years old. There is a sharp increase at 6th grade (age 12), which continues to rise peaking at 8th or 9th grades.

Source: http://www.hhs.gov/news/healthbeat/2012/01/20120117a.html

With young adults who end up having chronic mental health problems, their struggles begin early in life. This is a good place to begin intervention and prevention.

Suicide rates have not increased in last 20 years internationally, but they have in the US. Hanging and use of fire arms were the most common methods by all youth in Wisconsin in 2007-2011.

Trainer note: Examples: Refer to articles such as "Dallas School Staff finds 9-year old Boy Hanging in Bathroom" (1/22/10). Blogs from students and parents after the event commented that the boy was depressed and bullied. He had just returned from an alternative school. Jasmine McClain from North Carolina who hung herself at age 10 reports suggest she was bullied. (11/16/11)

Other factors that influence suicide in children:

- Children with access to guns
- Children with a history of impulsive and aggressive behavior
- Children who are in the 90th percentile of their age group in height – looking more similar to adolescents, but differ from adolescents

Display the **Children (Slide 14)** and refer to **Handout 5- Warning Signs and Risk Factors in Children**.

It is important to note that **children younger than 15 years who die by suicide do not often show signs of depression and do not express suicidal intent.**

Children are less exposed to some types of stressors (no romantic disappointments) and are not as likely to be intoxicated.

There are fewer warning signs for child suicide, but it is often marked by having conflicts with parents and precipitated by disciplinary crisis. The parent/child relationship is important and must be assessed.

Display the **Children- Risk Factors Slide (Slide 15)**. As you receive information about children and youth being placed in your home and during your ongoing care of them, pay particular attention to how some of the following risk factors or warning signs may be manifesting for the child:

- Past suicide attempts or threats
- Depression (risk factor for EVERY group)
- Past violent or aggressive behavior
- Mental illness (disruptive mood dysregulation disorder, bipolar disorder, chronic anxiety and/or alcohol use)
- Eating disorders
- Family history
- Use of certain medications
- Homosexuality/bisexuality
- Cognitive immaturity and impulsivity
- Bringing weapons to school
- Recent experience of humiliation, shame loss
- Bullying
- Victim of abuse or neglect
- Witnessing violence in the home
- Themes of death or depression in reading, conversation or artwork
- Preoccupation with violence on TV, comics video games, internet
- Disciplinary problems
- Vandalism, cruelty to animals, setting fires
- Poor peer relationships

- Involvement with cults or gangs
- Little or no supervision.
- Stressful psychosocial events:
    - Parental divorce
    - Separation from family
    - Death in the family

Reiterate the risk factor of being **separated from parents** and how this may play out in foster care placements.

There was a very interesting 2006 study done in Stockholm, Sweden, National Board of Health and Welfare (Vinnerljung, Hern, & Lindblad, 2006) that looked at suicide attempts and severe psychiatric morbidity among former child welfare clients and found that *"former child welfare clients were 4-5 times more likely than peers in the general population to have been hospitalized for suicide attempts. They were 5-8 times more likely to have been hospitalized for serious psychiatric disorders in their teens and 4-6 times more likely in young adulthood. High excess risks were also found for psychoses and depression among this population. Individuals who had been in long term foster care tended to have the most dismal outcome."*

Conclusions: *"Former child welfare/protection clients should be considered a high risk group for suicide attempts and severe psychiatric morbidity."*

Source: Vinnerljung, B., Hjern, A. and Lindblad, F. (2006), Suicide attempts and severe psychiatric morbidity among former child welfare clients – a national cohort study. Journal of Child Psychology and Psychiatry, 47: 723–733.

Display **Children in Care (Slide 16)**

There was a more recent study conducted in the United States in 2014 that examined the rates of suicidal thoughts and behaviors among preadolescent children (aged 9-11) who experienced maltreatment and subsequent placement into foster care. The results of this study indicate that despite the young age of participants, suicidality was high with an overall prevalence of 26% (the highest type being suicidal ideation). This rate is nearly 5 times the rate of suicidality of the general population at this age. The most common methods that children in this study planned or attempted suicide included cutting/stabbing and choking/hanging. This provides important information about reducing risk by restricting access to these potential methods. Further findings indicate that those who have been physically, sexually or emotionally abused are at greater risk of suicidality than those exposed to neglect only. Children who had experienced physical abuse were 4 times more likely to have made suicidal plans than non-physically abused children. Those who attempted suicide had been in out of home care longer and more lifetime household transitions were associated with almost every index of suicidality. In addition, the number of prior referrals to social services also predicted caregiver reports of suicidality. In a desperate attempt at suicide, some children may engage in provocative behavior in an effort to get others or animals angry enough to kill them. Behaviors that at first seem antisocial may actually be attempts at suicide. These findings speak to the importance of

screening for all children entering foster care, especially when we consider that children entering foster care are 3-10 times more likely to receive a mental health diagnosis. These results have substantial practice implications for mental health and social agencies serving this group, especially when considering placement in foster care or other treatment facilities.

Source: Taussig, Harpin & Maguire; "Suicidality Among Preadolescent Maltreated Children in Foster Care"; Child Maltreatment 2014, Vol. 19(1) 17-26, Sage Publishing

RISK FACTORS FOR ADOLESCENTS

Display **Adolescents (Slide 17).**
What separates those teens who attempt suicide from those who think about it? Substance abuse is a factor, as youth are 12.8 times more likely to die by suicide when under the influence. Teens who attempt suicide feel more severe or enduring hopelessness and isolation. They are generally reluctant to discuss suicidal thoughts.

There are some **general risk factors** for adolescents. Below are the *most commonly accepted*:

Display **General Risk Factors for Adolescents Slide (Slide 18).**

Previous suicide attempt
The first and greatest risk is within 3 months immediately following the first attempt and continues for at least 2 years.

Mental illness
About 90% have a diagnosis of depression, substance abuse or anxiety a year before the suicide. It is estimated that 1 million youths suffer from depression, and 60-80% do not receive help. Substance abuse/use is a risk in teens over age 16 years.

Many parents do not recognize the signs of suicidal behavior. The stressors can be misleading as it could be mental illness causing the stress. The profile of a special risk is a person with depression and impulsive aggression as a reaction to stress, particularly when an additional stressor is introduced.

EARLY in the course of treatment, before learning to cope successfully can be a high risk time. They remain at risk even as they have begun treatment.

Think of how this applies to kids in care. How many have a diagnosis? How does this impact their lifetime risk? How does this apply to parents who have recently been diagnosed and have children in out-of-home care?
There are patterns in suicidal behavior based on the **time of year**. For example, the peak time for young people and college-aged adults is March and April. August is the peak month for the elderly. The rate of suicide drops in December and January for all age groups.

The impact of the **media** can contribute by providing information and creating drama.

Share example of a local or national story. One example is the 11/1/09 story of the teen suicide in Palo Alto "Anguish Over California Teen Suicides Spurs Actions", which was published after a four teens died by suicide by stepping in front of a commuter train during a six month period of time (Leff, 2009).

Source: http://www.deseretnews.com/article/705341292/Anguish-over-California-teen-suicides-spurs-action.html

Imitation

This is referred to as a cluster phenomenon. Often the suicide of a peer influences other youth in the community or school to attempt or die by suicide.

Family history of suicide

Family dysfunction does not seem to influence suicide, but family history of suicide does, which is key to your assessment work with families Suicide is 3.5 times more likely to occur if a first degree relative has been suicidal.

Sexual orientation

Gay and lesbian youth have more ideation, attempts, and psychopathology, but not necessarily more suicide death.

Sexual abuse

A history of sexual abuse contributes to psychopathology but does not specifically affect suicide rates. Note: Physical abuse does increase the risk of suicide in boys.

Incarceration

For youth placed in juvenile detention, the rate of suicide is 57 to 100,00. In comparison, the rate of suicide in adult facilities is 2,041 to 100,000.

Other stressors

- Interpersonal loss
- Disciplinary crises
- Bullying (either being a perpetrator or a victim)
- Failure to communicate with fathers
- Youngsters who are not affiliated with school, work or any institution, could be after a period of absence from school (suspension)
- Males – romantic breakup (which may be their only intimate relationship)

- Being a minority in a upwardly mobile family

All of these stressors may increase isolation. Think particularly about how these stressors impact youth in out-of-home care.

Move into a discussion of protective factors in children and adolescents.
Display **Protective Factors Slide (Slide 19).**

There are three very important factors:

1. Having **friends** (most important protective factor)
2. Having a supportive **parent**
3. Having **school** relationships (being connected)

All of these act as buffers to stress. Think of the youth you care for- do they have these protective factors?

What can you do to strengthen their protective factors? Taking opportunities to influence or reduce stressors may strengthen protective factors.

MODULE 3 – SUICIDE - "THE ONES WE MISS"

Timing: Approximately **55 minutes**

A. Children and Adolescents	5 minutes
B. Native American Youth	15 minutes
C. African American Youth	5 minutes
D. Lesbian, Gay, Bi- Sexual, Transgender, and Questioning Youth	10 minutes
E. The Bullies and the Bullied	10 minutes
F. Summary and Application	10 minutes

MODULE 3 – SUICIDE- " THE ONES WE MISS"
TRAINING CONTENT

III. Suicide- "The Ones We Miss"

We have discussed what suicide is and what it looks like in Wisconsin. We have identified warning signs, risk factors and protective factors.

We are now going to be more specific and look at possible explanations of why the numbers continue to increase, or at best stay the same.

A. Children & Adolescents (5 minutes)

SLIDES
Are these… "Ones We Miss"? (Slide 20)
Girls (Slide 21)
Boys (Slide 22)

Start by showing the **Are these… "Ones We Miss" Slide (Slide 20).** *Note the animation- the slide will end with the **Boys** graphic displayed.* This is the first group we miss.

Suicide becomes a public health problem around the age of 12 years. The rate increases by age, with ages 20-24 seeing the greatest rate (per 100,000).

Frequency of suicidal ideation increases with risky behaviors, such as alcohol use and aggression.

In Wisconsin, suicide is the leading cause of violent death in the state. The counties clustered in the Northern and Western regions of the state experienced the highest suicide rates between 2007 and 2011. Firearms are involved in 45% of those completed suicides.

Discuss and compare the facts about suicide in boys and girls.

Display **Girls (Slide 21)** and discuss the following:

With girls, the ratio of attempts to completions is **4,000:1**. A suicide attempt is **NOT** a statistical risk factor for eventual suicide for girls, but a **depressive episode** is a factor. Girls often do not have a precipitating event and **may kill themselves while recovering from depression**. Panic attacks are a risk factor (intense fear, impending doom). Panic attacks escalate rapidly (10 minutes) and can include cognitive and somatic symptoms.

Display **Boys Slide (Slide 22)** and emphasize the differences in risk factors and suicide completions.

With boys, the ratio of attempts to completion is **500:1**. This is significant when compared to girls. Suicide attempts ARE a statistical risk factor for boys.

Boys often **kill themselves within a few hours of a precipitating event**, while anxiety is at its peak and before thinking through the consequences. Remember, impulsivity is a risk factor. The **precipitating events** can be **legal problems, relationships, or humiliating experiences.** Aggressiveness is a risk factor, too, and a history of physical abuse increases the risk of suicide.

Remember that we talked about the **relationship component**. A romantic break up, especially when this may be their only intimate relationship, can increase risk or be a precipitating event. **Think of this issue with youth in placement.**

B. Native American Youth (15 minutes)

SLIDES
Are these some of the "Ones We Miss"? (Slide 23)
Richard Cardinal Video (Slide 24) Link to video clip
Risk Factors for Native Youth (Slide 25)
Protective Factors for Native Youth (Slide 26)
Richard Cardinal (Slide 27)

HANDOUT
Risk and Protective Factors for Native Youth (HO 6)

OTHER
Video: Richard Cardinal: Cry from the Diary of a Metis Child – play the first 7 minutes

Display **Are these some of the "Ones We Miss"? Slide (Slide 23)**. *Note the animation- the slide will end with the **Native Americans** graphic displayed.*

Display **Richard Cardinal Slide (Slide 24)** and transition to **video clip** from **Richard Cardinal: Cry from the Diary of a Métis Child** (this links directly from slide 24)**.** Introduce the video. Richard was placed in out-of-home care at the age of 4, and had 28 placements up until the age of 17, when he died by suicide. The Métis (MAY-tee) people are an Indian tribe in Canada. Richard left behind a diary that served as the basis for this movie. His death in 1984 spurred legislation to improve the foster care system in Canada for Native children. Participants will only watch the beginning clip of the video (7 minutes).
Prepare participants that the video contains actual pictures of Richard's suicide by hanging. Encourage them to take care of themselves as needed given the sensitive nature of the video.

Play video clip. Stop after interview with the last foster parents and the court process begins (approx. 7 minutes).

According to the Center for Disease Control and Prevention, suicide was the second leading cause of death among American Indian / Alaska Native youth ages 10-24 in 2010, and the eight leading cause of death for American Indians / Alaska Natives of all ages.

American Indian / Alaska Native high school students report higher rates of suicidal behaviors than the general population of high school students.

Reservation reared American Indian/Alaskan Native youth experience higher rates of suicidal ideation (33%) than urban-reared youth (21%), although rates of attempted suicide were not significantly different. (American Association of Suicidality 2010).

In addition to the general risk factors already discussed (prior attempts, alcohol and drug abuse, mood disorders, access to lethal means), there are specific factors that contribute to the alarming rate of suicide among Native American youth.

Refer participants to **Handout 6 – Risk and Protective Factors for Native Youth** and provide the following information:

There are significant risk factors for American Indian/Alaskan Native populations in general that include:

- Historical trauma - attempts to eliminate culture such as forced relocation, removal of children who were sent to boarding schools, prohibition of the practice of native language and cultural traditions, and outlawing of traditional religious practices have affected multiple generations of AI/AN people and contribute to high rates of suicide among them.
- Acculturation - greater adaptation to the mainstream culture reportedly increased psychosocial stress, less happiness, and greater use of drugs or alcohol to cope with the stress of navigating the differences between two cultures.
- Lack of access to and use of mental health services – lack of Native American mental health professionals, rural isolation, self- reliance and embarrassment.
- Alienation - In an analysis of suicide notes to determine motivation, alienation among Native Americans was double that of Whites
- Alcohol and drug use - According to the National Violent Death Reporting System 2003–2009, of AI/AN suicide decedents tested for alcohol, 36% were legally intoxicated at the time of death. There were proportionally more positive test results for alcohol among AI/AN decedents than there were for any other racial or ethnic group.

Display **Risk Factors for Native Youth (Slide 25)**

In addition to the risk factors above, here are risk factors specific to AI/AN Youth:

- Loss of culture
- Loss of language
- Loss of cultural identity
- Family disruption
- Community Violence - AI/AN youth are 2.5 times more likely to experience trauma than non-AI/AN youth
- Contagion - Many suicide deaths occur on reservations where AI/AN youth have considerable exposure to suicide
- Low perceived social support
- Coming from a home without both biological parents
- Family history of substance abuse
- Alcohol and drug use - In 2011, AI/AN had the highest rate of current illicit drug use (13.4%) among those ages 12 or older compared to any other single racial/ethnic group. The overall rate for all racial/ethnic groups was 8.7%.
- Discrimination - Studies of American Indian youth found that discrimination was as important a predictor of suicidal ideation as poor self-esteem and depression.

Depending on the cultural beliefs of a particular tribe and/or how connected to the reservation, being lesbian, gay, bisexual, questioning or "two-spirited" can be a risk factor or a protective factor.

Explain that in many tribes, the elders speak of people who were gifted among all beings because they carried two spirits, that of male and female. They were honored and revered. Two spirited people were often the visionaries, the healers, the medicine people, the nannies of orphans, and care givers.

Trainer note: Research this topic to add to the above description if you are less familiar with the concept of two spirited people.

Display **Protective Factors for Native Youth (Slide 26) and continue to refer to <u>Handout 6 – Risk and Protective Factors for Native Youth</u>**

Culture, tradition, spirituality and family appear to be the most influential protective factors for Native American youth. Prevention efforts should include the family, the youth, and the community.

Healing is continuous, and is not limited to an artificial environment for 50 minutes per week (i.e. counseling). If a teen is really part of his/her community and family and believes that they

are loved, then their "thinking" changes and they have the internal message of "I could never hurt my family or community like that."

How many of you felt that way when you were a teen? Do you remember actually thinking that way?

Think about the children and youth that are in foster care. I wonder who they think really loves them and who they would not want to hurt by taking themselves from them permanently.

Display **Richard Cardinal (Slide 27)** in preparation for large group discussion. Process with the following questions based on the video at the beginning of this section:

1. What were some of the risk factors in Richard's life (keep in mind the risk factors for boys, youth in care and native youth)?

   Examples: multiple placements, loss of cultural identity, family disruption (loss of sibling connections), loss of romantic connection, rural, lack of supervision, physical abuse, etc.

2. What were some protective factors? *key focus

   Examples: connection to family (brother), contact with caregivers (good relationship with foster dad), emotional health (journaling), etc.

3. How could they have been utilized to help Richard?

Bring this topic to a close. Transition to the next "missed" group.

Sources:
National Indian Child Welfare Association (NICWA). (n.d.). *Ensuring the seventh generation: A youth suicide prevention toolkit for tribal child welfare programs.* NICWA- National Indian Child Welfare Association. Retrieved from http://www.nicwa.org/resources/documents/YSPToolkit.pdf
Suicide Prevention Resource Center. (2013). *Suicide among racial/ethnic populations in the U.S.: American Indians/Alaska Natives*. Waltham, MA: Education Development Center, Inc.
American Association of Suicidology, Washington D.C.; www.suicidology.org; 2012 (based on 2010 data)

C. African American Men and Youth (5 minutes)

SLIDES
Are these some of the "Ones We Miss"? (Slide 28)
Risk Factors for African American Youth (Slide 29)
Protective Factors for African American Youth (Slide 30)

HANDOUT
Risk and Protective Factors for African American Youth (HO 7)

Display **Are these some of the "Ones We Miss"? (Slide 28)**. *Note the animation- the slide will end with the **African American** graphic displayed.*

Suicide in African American men is **2.5 times less than** the rate of Caucasian men. It is the third leading cause of death between ages 15 and 24 years. Although African American suicide rates are lower than the overall U.S. rates, suicide affects African American youth at a much higher rate than adults and there has been an increase in this rate.

Why the increase?

Perhaps we are paying more attention to suicide and identifying suicide as a cause of death more frequently. It could be that more are attempting and dying by suicide than in the past. We are seeing the same reasons as white counterparts, including depression, social isolation and hopelessness, relationship conflicts, and sexual identity issues.

2009 data suggests an association of anxiety with suicide attempts in black adolescents, especially social anxiety (social phobia).

The lethal combination of substance abuse and depression may be related to the increase. Those with the highest number of co-occurring disorders are adolescents between 15 and 24 years. We also consider the structural barriers to mental health care, including the lack of health care coverage (25% lack coverage) and disparities in diagnosis and treatment of black adolescents.

There may be attitudinal barriers to seeking help due to a cultural tendency to overcome hardship by trying harder and there is a stigma to seeking help. The preference for community, religious and spiritual forms of support versus use of the formal mental health system can be a risk factor and a protective factor.

The combination of those factors with easy access to guns can contribute to the higher rates. Access to firearms is critical, as there is a higher rate than for whites. Gun-related suicide accounts for 96% of the increase in black youth aged 10-19 years.

One counselor in Atlanta, told the Washington Post that young black men she counsels said they feel isolated from social institutions, such as family, church, and school that could help them. Remember that lacking a sense of culture and community is a risk factor. On the flip side, having these qualities is a protective factor.

Display Risk Factors for African American Youth (Slide 29)

Refer participants to **Handout 7 – Risk and Protective Factors for African American Youth** and provide the following information:

Risk factors include:

- Age: younger than 35 – although this factor isn't specific to "youth only", it is a significant factor in the African American community
- Marital status – being divorced or widowed has been significantly associated with increased odds of suicidal ideation (again, not specific to "youth only")
- Family conflict
- Acculturation – increased acculturation into White society can include loss of family cohesion and support
- Hopelessness, racism and discrimination – perceived racism and discrimination along with social and economic disadvantage
- Access to and use of mental health services – African American youth were substantially less likely than White youth to have used a mental health service in the year during which they seriously thought about or attempted suicide
- Access to firearms (firearms are the predominant method of suicide among African Americans regardless of gender and age)
- Gender and cultural role expectations – this includes the stigma of suicide as the "unforgiveable sin", African American men as "macho" and not taking their own lives, and African American women as always strong and resilient

Display Protective Factors for **African American Youth (Slide 30)**

Protective factors for African American Youth include**:**

- Religion – Orthodox religious beliefs and personal devotion have been identified as protective against suicide among African Americans
- Social and economic support
- Black identity – 2 small studies of African American women found that having a strong sense of African American identity, heritage and history was protective against suicide

- Geographic location - There is a diminished risk of suicide for black adolescents who live in the south, perhaps due to the protective factors of cultural and religious beliefs. This is relevant given where we live.
- Connection to family, community and social institutions - Family support, peer support and community connectedness

Sources:
Suicide Prevention Resource Center. (2013). Suicide among racial/ethnic populations in the U.S.: Blacks. Waltham, MA: Education Development Center, Inc.
American Association of Suicidology, *African American Suicide Fact Sheet*, Washington D.C.; www.suicidology.org; 2012 (based on 2010 data)

D. Lesbian, Gay, Bisexual, Transgender and Questioning Youth (10 minutes)

SLIDES
Are these some of the "Ones We Miss"? (Slide 31)
LGBTQ Youth (Slide 32)
Risk Factors for LGBTQ Youth (Slide 33)
Risk Factors for LGBTQ Youth, cont. (Slide 34)
Protective Factors for LGBTQ Youth (Slide 35)
Hi! I'm Jonah! (Slide 36) Link to video clip

HANDOUT
Risk and Protective Factors for LGBTQ Youth (HO 8)

Introduce the section. Display **Are these some of the "Ones We Miss"? (Slide 31)**. *Note the animation- the slide will end with **LGBTQ** displayed.*

Display **LGBTQ Youth (Slide 32)**.

The lesbian, gay, bisexual and questioning (LGBTQ) population has an **extremely high rate of depression**, **suicidal thoughts**, and **suicide attempts**.

Feelings and experiences are often created by their **environment**, such as:

- Social isolation
- Anger
- Depression
- Repeated stress
- Feelings of inadequacy
- Sexual identity difficulties
- Homelessness (being thrown out or running away)
- Family problems

- Lack of support
- School (high dropout rate)

According to the 2013 Wisconsin Youth Risk Behavior Survey data, compared to high school students who identified as heterosexual, a larger percentage of students who identified as gay, lesbian or bisexual (LGBTQ) reported poor mental health, feelings of severe sadness or hopelessness, suicidal thoughts and behaviors, non-suicidal self-harming behaviors, subjection to bullying, disconnection from their school, and lack of relationships to adults at school.

- Approximately 49% of LGB students reported seriously considering suicide in the past 12 months compared to 11% of heterosexual students.
- 28% of LGB students reported attempting suicide in the past 12 months compared to 4% of heterosexual students
- 14% of LGB students reported suffering injuries related to suicide attempts that required medical treatment compared to 2% of heterosexual students (from *The Burden of Suicide in Wisconsin 2007-2011*)

Let's let this sink in for a few seconds. Emphasize the following:

These youth are **2-4 times more likely to attempt suicide** (SPRC, 2008).

They must cope with developing a **sexual minority identity**, **negative comments and jokes**, and often the **threat of violence** because of their sexual orientation. This is true especially for young people with "cross-gender" appearances, traits, or behaviors. Those behaviors often go unnoticed by school personnel. Many LGBTQ students report that school personnel are perpetrators of homophobic remarks in school. In fact, many LGBTQ students surveyed reported hearing homophobic remarks from school staff (63% in GLSEN's National School Climate Survey). When remarks are made, teachers are less likely to intervene compared to when they intervene for remarks that are racist and sexist in nature. (Espelage, n.d.)

The primary **causes** (as reported by LGBTQ teens) are **negative family interactions, rejection, and being "kicked out".** Nothing is "unconditional" for these youth.

Display **Risk Factors for LGBTQ Youth (Slide 33)**

Refer participants to **Handout 8 – Risk and Protective Factors for LGBTQ Youth** and provide the following information:

Being LGBT is not in itself a risk factor, but social stigma, discrimination, unsafe schools, ineffective providers are all associated with mood, anxiety and substance abuse disorders and suicidal behavior.
What is different for LGB youth is that they tend to have more risk factors and/or more severe risk factors.

Risk factors for LGBTQ Youth include:

- Homophobia
- LGBT Youth's perception of homophobia (whether accurate or not – internalizing negative assumptions about being gay can lead to risky behavior)
- High rates of bullying and violence in schools
- High rates of alcohol/drug use
- High rates of sexually transmitted infections
- High rates of homelessness/"couch surfing"
- Gender nonconformity
- Internal conflict about sexual orientation

Display **Risk Factors for LGBTQ Youth, cont. (Slide 34)**

- Time of coming out/early coming out
- Low family connectedness
- Lack of adult caring
- Unsafe school
- Family rejection
- Victimization
- Stigma and discrimination
- Ethnicity – some ethnic and cultural groups (such as first-generation immigrants) are less accepting of children who do not conform to standard gender roles

Display **Protective Factors for LGBTQ Youth (Slide 35)**

The protective factors that apply to all youth are also applicable to LGBTQ youth, regardless of sexual orientation:

- Family support and acceptance
- Family connectedness
- Caring adults
- Positive role models
- Positive peer groups
- Strong sense of self and self esteem
- Engagement in school and community activities
- Safe schools

Sources:
LGB Youth: Challenges, Risks and Protective Factors: A Tip Sheet for Grantees of the Office of Adolescent Health and the Family and Youth Services Bureau, May 1, 2014
Suicide Prevention Resource Center. (2011). *Suicide prevention among LGBT youth: A workshop for professionals who serve youth*. Newton, MA: Education Development Center, Inc.
Suicide Risk and Prevention for Lesbian, Gay, Bisexual and Transgender Youth; Prepared by the Suicide Prevention Resource Center for the Center for Mental Health Services Substance Abuse and Mental Health Services Administration U.S. Department of Health and Human Services 2008

What about the LGBTQ youth that might be in **foster care**?
Solicit discussion about how youth in care have often changed communities and schools when placed in care, or have moved from placement to placement. They might have been reunified with a family who relocated in their absence. These youth are at a disadvantage. Youth in out-of-home care all have these challenges, but for youth who are LGBTQ, it is compounded.

The role of the child welfare worker is instrumental and critical. Why?

Ask participants whether they ask the question (LGBTQ) of youth on their caseload. Do you discuss this with foster parents, biological parents, or caregivers?

Prepare for **video clip**. Display **Hi! I'm Jonah! Slide (Slide 36)**. The link for the video clip from you-tube is embedded on the slide.

Show video and open the discussion with the group.

Trainer note: You may not have much discussion from the group- that is to be expected. It has been my experience with this material, that there is little feedback. It often impacts participants because these conversations with youth are difficult and often avoided.

You may supplement with a story of an "a-ha" moment working with this population of youth. Example from a participant in a prior training: The participant's client – who had a history of at least 4 suicide attempts – had told his mother that he was gay, and the social worker did not follow up with a conversation with the youth about what it was like for him to be gay.

Also consider adding an example of being successful at having this conversation with a youth, or discuss questions that can be used to open this dialogue. This is a good opportunity to model how these conversations, while awkward for some, can be successful (what worked, how engagement was accomplished, etc.)

E. The Bullies and the Bullied (10 minutes)

SLIDES
Are these some of the "Ones We Miss"? (Slide 37)
Definition of Bullying (Slide 38)
Profile of a Bullied Child/Adolescent (Slide 39)
LGBTQ Youth and Bullying (Slide 40)
Myths (Slide 41)
Risk Factors for Those Involved in Bullying (Slide 42)
Protective Factors for Those Involved in Bullying (Slide 43)
Small Group Discussion (slide 44)

HANDOUTS
The Bullied and the Bullies (HO 9)
Risk and Protective Factors for Those Involved in Bullying (HO 10)
Warning Signs: All Children & Adolescents (HO 11)

Display the **Are these some of the "Ones We Miss"? (Slide 37)**. *Note the animation- the slide will end with **the Bullies and Bullied** graphic displayed.*

Begin the discussion by talking about a current suicide case that would be relevant to this section.

Example: Phoebe Prince, the Irish teen who was bullied by a group of students who were later charged and convicted for bullying behavior. Talk about how bullying experiences led her to take her own life, how so many people knew she was suffering, and how teachers and administrators and fellow students who witnessed the bullying attacks daily did not intervene. The students continued to "harass" her after her death via Facebook and at school functions.

Trainer note: There are many articles about this case on the web. Research prior to training.

Let's talk about bullying, as those who bully and those who get bullied are among the ones we miss.

Display **Definition of Bullying (Slide 38)**. Discuss the definition on the slide:

Definition: Unwanted a*ggressive behavior that is intentional and that involves a real or perceived imbalance of power or strength.* The behavior is repeated, or has the potential to be repeated, over time
There are three main types of bullying, including verbal, social or relational, and physical bullying.

- Physical bullying against a person's body or possessions includes hitting, pinching, shoving, tripping, making mean or rude hand gestures (and similar behaviors), as well as taking or breaking possessions, extorting money, etc.
- Verbal (and written) bullying includes name calling, teasing, taunting, threatening harm, making inappropriate sexual comments, etc.
- Social/Relational involves hurting relationships or reputation, such as shunning, spreading rumors or gossip, mocking, public embarrassment, cyber-bullying, etc.

Source: stopbullying.gov; Bullying Definition, n.d.

According to a recent studies teens report that the top two reasons for bullying are

1. Appearance

2. Actual *or perceived* sexual orientation or gender expression

Additional reasons include looks, body shape and race.

Source: Gay Bullying Statistics, 2009; (Davis and Nixon, 2010) http://www.pacer.org/bullying/about/media-kit/stats.asp;

Discuss the information regarding the prevalence of bullying for children and adolescents.

Approximately 20% of high school students (2009 national study) reported being bullied on school property.

About 10% of children are bullied on regular basis. Bullying impacts some children and youth on a **daily basis**. According to one study for the 2007-2008 school year, 32% of the nation's students ages 12-18 reported being bullied. For those students who were bullied, frequency of bullying was reported as:

- 21% once or twice a month
- 10% once or twice a week
- 7% daily
- 9% report being physically injured
- 4% report being cyber bullied

Source: http://www.sprc.org/sites/sprc.org/files/library/Suicide_Bullying_Issue_Brief.pdf

The nature of cyber-bullying allows it to occur on a 24/7 basis. Between 30-60% of teens report being cyber-bullied, but 85-90% have never told their parents.

LGBTQ youth are bullied **26 times per day**, that is **1 time every 14 minutes**. They hear anti-gay slurs (homo/faggot/sissy). About 31% were threatened or injured in the last school year. About 90% report being verbally or physically harassed or assaulted due to one or more reasons, including their perceived or actual appearance, gender, sexual orientation, gender expression, race/ethnicity, disability, or religion. (This compares to compare to 65% of other students, ages 13-18.)

Research suggests that many bullying incidents are unreported. Students are more likely to report physical abuse, damage to property, and physical threats than bullying that is social/relational. Why do you think that might be? Why is this important to think about?

Display **Profile of a Bullied Child/Adolescent (Slide 39).** There are two main groups of children/youth who are bullied. Discuss the differences between passive and provocative victims.

Passive Victim

Most victims of bullying are passive victims. They present as anxious and unsure of themselves. They are generally passive, submissive, usually quiet, careful, and sensitive. These children may start crying easily. They have poor self-confidence and negative self-images. They have few or no friends. Boys who are passive victims do not fight and are physically weaker.

Provocative Victim

This type of victim is less common. It is more common that a group of students or whole class will be involved in bullying the provocative victim. Provocative victims may try to bully weaker students. These children tend to be quick tempered and try to retaliate, often without success. They are often restless, clumsy, immature, unable to concentrate, and generally considered difficult. They may be hyperactive. As students, they have reading and writing difficulties. They may be disliked by adults or their teachers because of their irritating behaviors.

Trainer note: Revisiting the information on the LGBTQ population is purposeful here. It is important for participants to think about the impact of bullying on LGBTQ youth.

Display **LGBTQ Youth and Bullying (Slide 40).**

In the last section, we spoke about the higher risk of suicide for LGBTQ youth, and we heard from Jonah, a youth who was bullied throughout his school years. *Remember the top two reasons for bullying?* The second reason was the actual or perceived sexual orientation or gender expression.

LGBTQ youth feel they have nowhere to turn. **Four out of five** say they do not know even **ONE** supportive adult at school. Their mental health and education and physical well-being are at constant risk. Remember that these youth **2-4 times more likely to attempt suicide** than heterosexual youth. Often the bullying is so intense that they are unable to receive an adequate education. They are 5 times more likely not to attend school because of feeling unsafe. They are afraid, embarrassed, and ashamed – of being targeted and do not ask for help. These youth are apt to skip school due to fear, threats, and property vandalism, and 28% drop out of school. This is more than 3 times the national average. They are also more likely to smoke, use alcohol and drugs, and engage in other risky behaviors.

Source: http://www.time.com/time/specials/packages/article/0,28804,2095385_2096859_2096805,00.html

We often hear the stories of how being bullied leads to suicide for youth. It is important for us to realize that both victims and perpetrators are at a higher risk for suicide.

Children who are **both victims and perpetrators** are at the **highest risk** (SPRC, 2011). A study completed with middle school students in 2011 indicated that these children are **6.6 times more likely to report seriously considering suicide.**

Source**:** http://www.socialworktoday.com/archive/092011p10.shtml

All three groups are more liked to be depressed – which is a major risk factor. Victims of cyber bullying are at a higher risk for depression than face to face bullying. We know that those who attempt or die by suicide have other serious risk factors, so assessment is imperative.
Media coverage often exaggerates the connection between suicide and bullying.

From a 6th grade girl: "When I saw the cover of my mom's magazine, there was a picture of a pretty girl with words like "bullied to death" or something. I've been bullied too but haven't told anyone. That girl was so much cooler and prettier than I am, and I thought if she had to die maybe I'd have to die too."

Source: http://www.socialworktoday.com/archive/092011p10.shtml

Although bullying behavior and suicide-related behavior are closely related (those involved in bullying are more likely to report suicide related behavior than those who do not report involvement with bullying), suicide is not a "natural response" to being bullied. It is unknown if bullying directly causes suicide-related behavior (as most youth involved in bullying do not engage in suicide-related behavior).

Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, *"The Relationship Between Bullying and Suicide: What we Know and What it Means for Schools" 2014; www.cdc.gov/violenceprevention*

Transition to a discussion about the warning signs of bullying and how this impacts children and youth on their caseload. Begin by discussing the children who have been bullied.

Refer participants to **Handout 9- The Bullied and the Bullies.**

Review the **factors that increase a child's risk of being bullied**. These include a child who internalizes problems (including withdrawal, anxiety/depression), a child with low self-esteem or lack of assertiveness. Aggressiveness in early childhood can lead to rejection by peers and social isolation. (SPRC, 2011)

Think about this- **children who have the highest risk for suicide tend to be bullied, which in turn further raises their risk of suicide**, as well as depression/anxiety and other problems associated with suicidal behavior.

In addition to personal factors, we want to consider family factors, such as the presence of maltreatment, domestic violence, or parental depression. We also consider the dynamics of the school environment, which may include lack of adequate adult supervision and lack of consistent effective discipline (SPRC, 2011).

The handout provides a list of **red flags for all victims of bullying**. These are signs to watch for in children and youth. Being alert to these signs and asking questions as part of assessment can help identify early warning signs.

These include emotional and behavioral changes, such as a child who is acting depressed (not eating, not sleeping, having nightmares, displaying anxiety, or not doing things they usually enjoy). They may display mood swings, including frequent crying. Children who are being bullied may withdraw socially. They may frequently complain of illness or express not wanting to go to school or avoid certain classes. Parents or caregivers may notice that the child is bringing home damaged possessions, or reporting possessions as lost. The child may state that he/she feels picked on or persecuted. They may talk about running away. Parents or school staff may catch bullied children attempting to take or taking something to protect themselves to school (stick, rock, knife, etc.). Bullied children may start to take a different route home from school or refuse to take the bus.

Tips for if you suspect the child is being bullied:

- Ask the child what they think should be done
- Find out what has already been tried and what worked and what did not work
- Seek help from teacher/guidance counselors/ school administration
- Be aware that bullying usually happens in lunchroom, bathroom, school buses, and unsupervised halls. Pay particular attention to these areas.
- Children need help from school staff. Do not encourage them to fight back, but get help instead/tell someone.
- Use role- playing to practice what the child will say to the bully the next time and practice being assertive
- Encourage child to be with friends when traveling in and out of school.

Source: American Academy of Child and Adolescent Psychiatry, Bullying: Facts for Families
http://aacap.org/page.ww?name=Bullying&section=Facts+for+Families

Let's talk next about the children who engaging in bullying behavior, including commons myths, characteristics, and family risk factors. It is important to remember that both kids who are bullied and kids who bully others may have serious and lasting problems.

Display **Myths (Slide 41)** and review the myths about children and youth who bully.

Myths about bullies:

1. They are usually "loners"
   - ✓ The opposite is true, even though the friend group may be small
2. Have low self-esteem
   - ✓ Children who bully often have above average self esteem
   - ✓ Interventions to build their self-esteem are ineffective
3. Bullying is the same thing as conflict
   - ✓ Bullying is aggressive behavior that involves imbalance of power
4. Most bullying is physical
   - ✓ Some is physical, however the most common is verbal (for boys and girls)
5. Bullying isn't serious
   - ✓ It is extremely serious
6. Most likely to happen in urban school
   - ✓ Bullying happens everywhere, every race, every income level, every geographic region
7. Most likely to happen on the bus
   - ✓ More likely on school grounds
8. Most kids who are bullied tell an adult
   - ✓ Estimates indicate that only 25-50% tell an adult
9. Bullied kids learn to deal with it on their own
   - ✓ They cannot learn to deal with this on their own, and it can impact their lives

Refer participants back to **Handout 9**. Children and youth who are engaging in bullying behavior tend to thrive on **control** and **dominating others**. These children have often been victims of physical abuse of have been bullied. Bullying behavior may be linked to the child being depressed, angry, or upset about events at home or school. Children who bully experience suicidal ideation.

Bullies chose targets that fit the profile described above (passive, easily intimidated, have few friends). Children who bully lack empathy and have difficulty following rules. They tend to view violence in a positive way. They can be impulsive, hot- headed, and dominant. Boys who bully tend to be physically stronger than other children. They engage in fighting behaviors, criminal misconduct, and academic misconduct. This is often an attempt to fit in to a peer group.

There are several family risk factors that are more likely for children who bully than non-bullying peers. These include a lack of warmth and involvement on part of parents, overly permissive parenting, a lack of supervision, and use of harsh, physical discipline. The family serves as a model for bullying behavior.

In addition, if school personnel ignore bullying, the intimidating behaviors are reinforced.

Those who are bully/victims (both) often display higher levels of social isolation, depression, and anxiety, especially among girls.

Then there are the **bully/bystanders** who are a new category in this dynamic. These are children who witness bullying and do nothing, or feel that have no power to do anything. They feel helpless or even guilty for not doing anything to stop it.

Let's review the risk and protective factors for those involved in bullying behavior.
A Minnesota Student Survey conducted in 2010 assessed risk and protective factors for three groups of youth involved in bullying: victims, perpetrators and youth reporting involvement as both a victim and perpetrator.
Many of the risk and protective factors for suicidality identified in this study among youth involved in bullying mirror factors found to predict and protect against suicidal ideation and behavior in general populations of adolescents. Because bullying victimization and perpetration are potent risk factors for suicidality among youth, the presence of other known suicide risk factors among youth involved in bullying dangerously elevates the risk for suicidal behavior.

Refer participants to **Handout 10- Risk and Protective Factors for Those Involved in Bullying**

Display **Risk Factors for Those Involved in Bullying (Slide 42)**

Relate risk factors as outlined in Handout 10:

- Bully:
  Physical abuse, sexual abuse, mental health problem, running away from home, carrying a weapon and perceiving oneself as overweight
- Victim:
  Risk factors include physical abuse, sexual abuse, mental health problem, running away from home, perceiving oneself as overweight, participation in religious activities, higher levels of distractibility, disabilities or learning differences, LGBTQ
- Bully-victims:
  Additional risk factors include witnessing family violence, history of physical abuse, cigarette smoking, marijuana use, skipping school due to safety concerns, perceived school and neighborhood safety concerns.
- All three groups(bullies, victims and bully-victims):
  History of self-harm, greater emotional distress, involvement in bullying in any way, especially both bullying others and being bullied (highest risk for suicide related behavior of any groups involved with bullying)

Display **Protective Factors for Those Involved in Bullying (Slide 43)**

Relate Protective Factors as outlined in Handout 14:

- Bullies (only):
  Stronger connections to non-parental adults was an additional protective factor
- Victims (only):
  Stronger connections to non-parental adults, liking school, feeling safe at school
- All three groups:
  Higher levels of parent connectedness, stronger perceived caring by friends

General Protective Factors:

- School connection
- Family Outreach
- Healthy problem coping skills
- Identification of students in need of mental and behavioral health services
- Implementation of effective and inclusive anti-bullying policies, rather than conflict resolution methods

Sources:
Borowsky, Taliaferro & McMorris; Journal of Adolescent Health 53 (2013) S4-S12; Suicidal Thinking and Behavior Among Youth Involved in Verbal and Social Bullying: Risk and Protective Factors; October 22, 2012
Suicide and Bullying: Issue Brief; SPRC Suicide Prevention Resource Center; retrieved from website July 2014
Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, "The Relationship Between Bullying and Suicide: What we Know and What it Means for Schools" 2014; www.cdc.gov/violenceprevention

How is this relevant in your care of children and youth? If a child presents with mental health problems, explore their peer relationships and health/ illness (bullying can cause physical illness, especially if it is chronic and severe).
An informal survey of former foster youth found that half had been bullied because they were in foster care. They reported feeling afraid, angry, sad, and depressed. Children enter out-of-home care due to abuse or neglect, which is often associated with one or more of the parent/child difficulties described for those who either bully or are bullied.
Foster parents have a role in helping to identify and intervene on behalf of child who are bullied and those who engage in bullying behavior. Understanding the risk and protective factors can assist in assessment and intervention.

Refer participants to **Handout 11- Warning Signs: All Children & Adolescents**. Review briefly with participants.

As discussed at the beginning of training, risk factors increase the likelihood of suicide and **warning signs** can be strong indications of need for **immediate intervention**. These are specific behaviors and cues that move beyond risk factors.

F. Summary and Application

SLIDE
Small Group Discussion (Slide 44)

Trainer note: Provide a brief summary, using the following points below and other key concepts and "take-aways" from your previous discussions.

Summary:

Now what do we know? We are missing some young people who are at higher risk for suicide. Review the categories and some facts to support why we need to pay particular attention.

Boys more often die by suicide (4:1 boys to girls in Wisconsin). They are not hospitalized at the rate of girls (who are at least twice the number), therefore may not receive intervention. They use more lethal means (fire arms). We can see signs in school failure and impulse control problems. Boys are triggered by an event, usually around a relationship that is significant to them. Think about the loss of significant relationships for kids who are removed from their homes, or moving to different foster homes. Girls have more protective factors in their relationships with others and are more likely to ask for help or reach out to friends. Boys act impulsively within a very short time after the event.

Native American youth are 5 times more at risk. Discuss other risk factors from the earlier discussion.

Suicides among **African American youth** are increasing.
LGBTQ youth have additional risk factors, and have an extremely high rate of depression, suicidal thoughts, and suicide attempts.

In addition, think back about the characteristics of children who are bullied. How do those fit the children and youth you have placed in out-of-home care? Think of the risk of being bullied for children with disabilities (emotional, physical, intellectual, developmental, and sensory) and think about how risk is increased when you add foster home placement to the mix. How many children and youth on your case load include children with "special needs" of some type? LGBTQ? All of these combined?

Remember how few tell you, or anyone about the bullying. How will you find out?

Small Group Activity:

Display **Small Group Discussion (Slide 44)**.

We introduced six groups: Boys, Native American, African American, LGBTQ, Bullies, and Bullied.

At your table, take a few minutes to discuss:

- Youth you may have on your caseload that you now may be able to identify as "at risk" of suicide
- Talk about specific risk factors
- What protective factors can you utilize in your case planning?

Give the small groups 5 minutes to discuss and then open this up for discussion with the large group. Try to get them to be specific with risk factors and protective factors, along with the impact of the identified six groups for their consideration.

MODULE 4- PREVENTION AND INTERVENTION

Timing: Approximately **25 minutes**, excluding break following the module

A. The Question Model 25 minutes

MODULE 4 – PREVENTION AND INTERVENTION
TRAINING CONTENT

Introduction: We will look at prevention and intervention. Both tie back to the need for assessment. As a foster parent, what is your **role in identifying and assessing risk** of the young people in your care? (Stress the fact that there is a team of people working together and it is not a foster parent's role to identify and assess. When a youth in their care expresses suicidal thoughts the foster parent needs to notify the appropriate person)

A. The Question Model (25 minutes)

SLIDES
The Question Model (Slide 45)
Let's Practice! (Slide 46)
Now, what do you do with what you know? (Slide 47)

HANDOUTS
Justin (OOF)

Trainer note: You will need approximately 15 minutes for the last two activities so move through the lecture piece quickly. It is important for participants to have an opportunity to practice asking the questions so make this the priority if time is short.

Display **The Question Model (Slide 45)**.

Your role is about asking the questions. This can be difficult, but understanding the risks will guide what questions you ask. One approach that is simple and effective includes three simple steps:

1. **Ask the Question(s)**
2. **Listen and Respond**
3. **Act or Refer**

I am going to spend a little time talking about this approach because it is a good place to start thinking about the questions you might want to ask, and then what to do when and if you do get a positive response to suicidal thinking, ideation, or behavior.

1. ASK THE QUESTION(S)

Asking a person about having suicidal thoughts is often awkward. It is a difficult subject. We really do not want the person to be suicidal, and what do we do if they tell us they are?

The truth is that you are probably the best person to ask these questions because you know the warning signs, the risk factors, and the protective factors. You can do this indirectly or directly.

Examples of an indirect approach:

- "Do you ever wish you could go to sleep and never wake up?"
- "You know, when people are as upset as you seem to be, they sometimes wish they were dead. I'm wondering if you're feeling that way too."

Examples of a direct approach

- "Have you ever wanted to stop living?"
- "You look pretty miserable. Are you thinking of killing yourself?"
- "Are you thinking about suicide?"

Use questions that are comfortable to you. It takes some practice and some risk-taking.

If you get a "yes" answer to the question, then what? You <u>have to do something</u>.

Research shows that once a person is asked about suicidal thoughts and they disclose them, they feel **relief**, not distress. Usually, people want to talk about it. There is a myth that exists that asking the question will plant ideas. Asking the suicide question does not increase risk of suicide.

2. LISTEN AND RESPOND

Help begins with the simple act of listening. It can be life-saving. Being a good listener involves giving the person your full attention without interrupting. You can speak when the person is finished. Listening means that you are not rushing to judgment. Listening to someone talk about suicide can evoke personal emotions. You need to tame your own fear so that you can focus on the other person. Listening gives you time for this. Listen first, and then respond.

The goal is simple – that is, to move the person to say "yes they want some help". Put yourself in the situation for a moment. What if it was you and you feeling so miserable and not thinking clearly? Consider being a child who is not able to think it through at all? Would you want those who care about you to stand by and let you kill yourself?

3. ACT OR REFER

The best way to act is to personally see that the individual is connected (face-to-face) to a mental health professional, crisis worker, or police officer. You want to make sure there is no access to firearms or other methods for harm.

We will now spend some time practicing what we have discussed up to this point in the training.

Pairs/Small Group Activity:

Display **Let's Practice! (Slide 46)** and ask participants to take out **OOF Handout - Justin**

Give instructions for participants to get into pairs. Pairs will choose one participant to be Justin and the other to be the foster parent. They will practice using the model with their partner for **5 minutes**. When the time is up, the trainer will instruct them to switch roles and interview again for **5 minutes**. They can provide feedback to the interviewer at the end of the interview.

Let them know that we will process together afterwards, paying particular attention to the questions you used, and what it was like to ask and be asked those questions.

Give them 1-2 minutes to **read the scenario** before beginning the skills practice. Be sure to track the time and call out a one minute warning to give them time to wrap up their interviews. Ask them to provide feedback to the interviewer about the interview for a few minutes, focusing on things that went well.

After the interviews, process together. Ask the participants what was challenging about this particular client. Ask them if what they knew about this particular client was helpful. Ask them if having background about this particular youth was helpful.

Perhaps participants will be able to identify information learned earlier in the training that was helpful in their care of youth.

Next, display the **Now, what do you do with what you know? Slide (Slide 47)** and have a brief large group discussion about the questions.

1. Who do you have on your team?
2. Who makes the decision regarding the "act/refer"?

Process their responses and note that how we respond may contribute to additional risk factors or protective factors. Bring the activity to a close.

MODULE 5- SURVIVING THE SUICIDAL CLIENT

Timing: Approximately **5 minutes**

A. Impact of Suicide on Foster Parents/Families 5 minutes

Trainer note: This section is important for encouraging the self-care and help-seeking of foster parents who have experienced a client who died by suicide or who are suicidal.

MODULE 5 – SURVIVING THE SUICIDAL CLIENT
TRAINING CONTENT

A. Impact of Suicide on Foster Parents/Families

Have a brief discussion on the difficulty of this work and the importance of self-care. If a child or youth they care for displays suicidal behavior, requires hospitalization or dies by suicide it can impact the foster parent/family. Normalize feelings such as denial, self-blame, guilt and anger as well as grief and loss. Stress the importance of working together with the social worker and open communication.

MODULE 6- PUTTING IT ALL TOGETHER

Timing: Approximately **5 minutes**

A. Summary 5 minutes

MODULE 6 – PUTTING IT ALL TOGETHER
TRAINING CONTENT

VI. Putting It All Together

A. Summary (5 minutes)

SLIDES
Putting it all together (Slide 48)

Display **Putting it all together (Slide 48)**. Provide a summary of key information that was discussed during the training, such as:

We have covered a great deal of information today, and you will now have an opportunity to put it all together. We talked about suicide in Wisconsin. We spent some time review the "ones we miss", including the boys, Native American youth, African American youth, LGBTQ youth, and the bullies and the bullied.

We talked about how each of these is exacerbated for youth in care, whether foster care, juvenile detention, or relative care. We reviewed the warning signs of suicide, the risk factors, and protective factors.

ASK: *What are the key protective factors for youth in all categories? (*friendships, supportive adults, and good relationships with parents, culture, of the family and community)

ASK*: If you know all of the above, and are aware of the ones we miss, are <u>you</u> a protective factor? Especially to kids in care?* Refer back to **<u>Handout 4- Risk and Protective Factors.</u>**

You also practiced asking the difficult questions.

In order to support foster parents and other placement resources with information about helping youth at risk for suicide and preventing suicidal behavior among youth in foster care, we have two handouts that you can provide to foster parents and other placement resources: **<u>Out-of Folder Handout - Foster Care Providers: Helping Youth at Risk for Suicide</u>** and **<u>Out-of Folder Handout - Preventing Suicide Behavior Among Youth in Foster Care</u>** and **<u>Suicide: Facts and Warning Signs.</u>**

MODULE 7- CLOSING

Timing: Approximately **5 minutes**, or use time remaining until the end of the training day

A. Closing 5 minutes

MODULE 7- CLOSING
TRAINING CONTENT

VII. Closing

A. Closing

SLIDES
For the Bullied and Beautiful (Slide 49) Link to video clip
Resources (Slide 50)
The One Thing (Slide 51)

HANDOUTS
Evaluation

Prepare for **video clip**. Display **For the Bullied and Beautiful Slide (Slide 49)**. The link for this video is embedded on the slide. Show video.

Display **Resources Slide (Slide 50)** and encourage participants to utilize these sites for current information.

Close with the following summary, or develop your own:

You are not an island. This work is difficult, but you do not have to do it alone. Actually, it is better not to be the "Lone Ranger", especially with this subject matter. I wonder whether this just might be a barrier to asking those difficult questions. Maybe we feel this is just too scary to do alone, and perhaps it is "easier" not to know.

Refer back to the very first small group where they identified warning signs or symptoms of suicide. Point out that we really do know a lot about suicide.

Display The One Thing slide (slide 51).
Ask participants to share "1 Thing" that they will take with them today or something they have learned or an "a-ha" moment. Saying it out loud assists with transfer of learning.

Evaluations
Refer participants to the **Evaluation** form in their folder. Ask them to complete prior to leaving training. Instruct them to leave the Evaluation in the envelope on the registration table. Remind them to sign out.

Thank participants for attending the training.

RESOURCES

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