SUICIDE PREVENTION CARE IN TEXAS

Spotlighting Youth Voices

Texas Institute for Excellence in Mental Health
School of Social Work
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Acknowledgements

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A Brief Introduction

Why Focus on Youth Suicide Prevention in Texas?

The transition to adulthood is a known time of stress, instability, self-exploration (Arnett et al, 2014). Young people experience several major life transitions (e.g., high school completion, entry into college and/or the workforce, evolving peer and romantic relationships, shifts in family roles and expectations) that can be stressful and heighten mental health struggles (Tanner & Arnett, 2016).

Suicide is the second leading cause of death for youth and young adults in Texas. Thousands of young people die by suicide annually in Texas. Youth ages 15-19 in Texas have higher rates of suicide planning and attempts than the national average, with firearms utilized as a common method of suicide (Price & Khubchandani, 2017; Choi et al, 2019). The State of Texas is committed to improving youth suicide prevention (Calabrese et al, 2024).

Many Texas youth struggling with their mental health do not get help. Surveys show high rates of Texas high school students reporting serious thoughts of suicide, feeling sad or hopeless, and/or attempting suicide (Grant et al, 2023; Kennard et al, 2023). Yet, access to mental health care in Texas is lower than the national average. **Young people often express suicidal thoughts differently than adults. Instead of directly saying they want to die, they may show warning signs like irritability, anger, risk-taking behaviors, withdrawal from friends, or sudden changes in behavior (Tundealao et al, 2023; Bertuccio et al, 2022).** Adults (i.e., parents, teachers, coaches, and providers) need to understand these signs, so they can connect young people to support (Lee et al., 2024)

Texas has transformed their statewide suicide prevention efforts and is a leader in reducing risk of youth death by suicide. **Texas centers young peoples' voices to design and implement effective suicide prevention practices and systems across the state.**

Project Goals

The State of Texas Suicide Prevention Coordinator and the Texas Institute for Excellence in Mental Health (TIEMH) at The University of Texas Austin identified a need for better practice tools for adult providers to better support youth and young adults who are: (a) struggling with suicidal thoughts and feelings, (b) recovering following an attempt, and/or (c) navigating grief following losing a loved one to suicide.

Our goal was to collaborate with young people with lived experience to design practice tools for adult providers (defined here as medical doctors, mental health clinicians, or any other professional navigating the care of a young person) that improved their effectiveness in supporting young people with suicidal thoughts, feelings, losses, and other related experiences.

Our activities included:

1. **Built a young adult lived experience consultant team.** We recruited, trained and supported 4 young people to be a part of our project team, co-facilitate workgroups and co-design project products.

2. **Hosted workgroups learning from young people about their perspectives and needs around suicide prevention.** TIEMH hosted workgroups with eight 18-24-year-olds from across the state of Texas.

3. **Developed a Suicide Prevention Guide for adult providers.** The workgroups informed the design of this Prevention Guide. The guide is organized around 6 major themes that emerged from workgroups, and outlines practice strategies based on these themes.

4. **Created a series of informational videos:** TIEMH worked with several workgroup participants to film interviews that aligned with workgroup insights. TIEMH created six videos as alternative and digestible ways to share the Suicide Prevention Guide practices with adult providers.

Methods

Project Leads & Authors

Guide authors and project leaders have experience working in mental health settings as either peer support specialists or therapists (in training and licensed). Project leads also have their own lived experience related to suicide and supporting people in their life.

Young Adult Consultant Team

TIEMH recruited, trained, supported and paid 4 young adult consultants. Consultants used their expertise and lived experience to amplify youth voice and perspective in all project activities.

Virtual Workgroups

TIEMH project leaders co-facilitated virtual workgroups with Young Adult Consultants. Young people (ages 18-24) with lived experience of their own struggles with suicidal thoughts and feelings or had lost a loved one to suicide were eligible to participate in the workgroups. To recruit workgroup participants, the TIEMH team partnered with the State of Texas Suicide Prevention Coordinator, and Young Adult Consultants to distribute flyers to young people across the State of Texas. Eight young people participated across 10 workgroups, with each workgroup discussion consisting of between 3 and 6 participants. All participants were from Urban Texas environments (i.e. Austin, Houston, El Paso). Participants were primarily LGBTQIA-identified-youth, identified as Hispanic or Latino, and were pursuing or have completed post-secondary education.

Workgroups were focused on creating a space for participants to explore what providers do well and where providers had opportunities for growth and change when supporting young people struggling with suicidal thoughts and feelings. Participant discussion originated from lived experience while also thinking critically about the differences in accessibility to suicide prevention care in rural areas, the importance of technology to receive care, and the cultural impact of geographical location in Texas in navigating resources.

Analysis of transcripts of workgroups was led by 2 masters level researchers and 4 youth consultants. The process was guided by a central question of "what do youth who struggle with suicidal thoughts and feelings need from providers". Other workgroup topics such as help seeking behaviors, aspects of healing, and definitions of support specified service experiences within the theme of suicide prevention care. Through continuous evaluation and feedback, the research team collaborated with participants and youth consultants to ensure that developed content and tools matched the described needs and ideas from young people.

Workgroup Themes Inform Guidebook Core Elements

Six major themes emerged as primary gaps in current suicide prevention practices. We translated these themes into Six Core Elements that serve as building blocks for more specific, individualized suicide prevention care. Each Element has a brief chapter that starts with self-reflection questions, details the Element, provides quotes from workgroups that illuminate the Element, and includes activities to challenge reader bias, encourage professional growth, and prompt for discussion. Here are the core elements:

1: How to Talk about Suicide
2: Third Spaces & Alternative Service Opportunities
3: Supporting Family Involvement & Other Supports
4: Technology & Media Literacy
5: Aftercare/Long-Term Support
6: Supporting with the Loss of a Loved One

All Provider-Youth Encounters are Suicide Prevention

Suicide prevention care occurs in every phase of mental health care, from early detection and presence of suicidal ideation, through higher risk moments of potential attempts and aftercare following serious incidents. Prevention can also look like a variety of engagement tactics ranging from asking young people about their support system or how they spend their time to specific assessment of risk using a tool. By regularly and thoughtfully engaging with young people, every provider-young person encounter can be considered suicide prevention care.

The core competencies highlighted in this toolkit emphasize that suicide prevention care goes beyond what happens in session with providers. It includes learning about client lives outside of the office, who they lean on for support, what media they consume, how they spend their time, and much more. **Adult providers play a crucial role in helping young people navigate suicidal ideation while fostering future thinking.**

CORE ELEMENT 1: How to Talk About Suicide

Before You Begin, Reflect:

1. *What does it look like to support a young person experiencing suicidal ideation?*
2. *In what ways do you as a provider open the conversation around suicide and maintain a young person's trust?*
3. *What are some things about suicide that you don't understand?*

The single most important action a provider can take when the topic of suicide comes up while meeting with a young person is to **listen calmly and explore a young person's feelings with genuine curiosity.** Direct service providers (i.e., doctors, nurses, nurse practitioners, therapists, case workers) working with young people are the first line of defense in suicide prevention. For youth to share their feelings related to suicidality, providers must be comfortable with discussing suicidal thoughts and feelings as well as grief and loss with young people – without immediately jumping into a line of robotic risk averse clinical questioning and safety planning. **Young people want their experiences with suicidal thoughts and feelings to be acknowledged and validated by providers who are present and genuinely interested in learning more about the young person's experiences.**

To build trust, **providers must normalize conversations about suicide** with young people and seek to discern when thoughts of suicide may escalate to imminent action and when they will not. This may sound simple, however it is difficult because most adults working with youth want to protect youth. Often youth services staff are trained to ask a series of questions to "assess" suicide risk. **What young people want from adults in their lives is a moment of pause before action.** This requires youth services staff to sit with their own discomfort and anxiety regarding risk and responsibility for ensuring youth safety.

"When I feel treated like a case instead of a person, I shut down."

"I don't need you to fix me right away, I need you to hear me."

Supporting young people experiencing suicidal thoughts, intent, and/or loss can be challenging, but providers must prioritize youth feeling heard through using **validation**, **empathetic listening**, and a **nonjudgemental approach.** When the care experience feels genuine, as opposed to risk averse or for the sole purpose of following ethical and legal guidelines, young people are more likely to trust and open up with their provider. **Too often for young people, suicide exploration feels like part of a routine checklist, not a deep conversation.**

"They didn't know how to actually talk about it... it felt like a checklist. That made me shut down."

"You can tell when someone's just doing their job - that's not the same as caring."

Young people can be apprehensive of disclosing suicidality for fear of involuntary hospitalization or crisis escalation. Many young people perceive that providers rush into crisis intervention strategies and often calling authorities at the first mention of suicide, resulting in a distrust for young people in disclosing suicidal thoughts or actions. Providers must open the conversation and create space and time between disclosure of suicidal thoughts and immediate crisis services through calm and thoughtful exploration, followed by collaborative safety planning.

> *"After my first hospitalization...I got very nervous talking around officials. I was afraid they were going to put me back in."*
>
> *"If the first thing you do is call someone, I won't tell you anything next time. Let me speak without fear."*

Checking in early and often is crucial for effective suicide care prevention, such as pre-established check ins once a month or every 3 months rather than conditional screenings when nearing a crisis. **Providers must consistently monitor and assess risk factors, protective factors, and suicide ideation outside of potentially serious incidents or crises.** This screening process must include explicit conversations regarding suicidal ideation and continuous safety planning, adjusting accordingly to the young person's needs. **Normalizing conversations about suicidality** supports youth in feeling more comfortable sharing when they are experiencing suicidal thoughts and feelings while also decreasing provider discomfort and anxiety.

"People think suicidal thoughts are constant, but sometimes it just comes in waves - and if no one checks in during the quiet, they miss it."

"The best support I ever got was someone checking in weeks later. Like, they remembered me beyond the crisis."

The most meaningful support that providers can offer is **holistic care: seeing young people as complex and evolving individuals beyond their presenting mental health symptoms.** Developmentally, young people are navigating several life transitions while also managing their own mental health care, requiring flexibility and thoughtfulness from providers. While conversations that are explicitly about suicide are important, especially in utilizing tools such as the **Columbia Suicide Severity Rating Scale** (page 14), it is also **necessary to understand who a young person is by learning about their hobbies, interests, social life, work and school and how they spend their time.** Suicidal thoughts and feelings are one element of what a young person is experiencing – which may feel like a priority to an adult service provider. However, suicidal thoughts and feelings may not necessarily be a priority for all young people and discussing them may be difficult because young people do not trust their adult provider. **Young people trust adults who genuinely want to get to know who they are as individuals.**

"Trust doesn't come from one conversation. It's built by showing up over time - even in the quiet moments."

Providers must normalize discussions around suicide with curiosity and empathetic listening - while checking in often and creating distinctions between suicidal thoughts, behaviors, feelings, loss, grief and not inappropriately or immediately treating them as a crisis. Through thoughtful flexibility and non-judgmental exploration, providers can effectively give long-term individualized suicide prevention support to young people. Utilizing tools like the **Harm Reduction Circle** (page 15) can assist with understanding a young person's individual experience in reducing harm and creating safety.

> *"I think we should ask about things beyond just health - like school, hobbies, friends, interests - because that helps encourage future-oriented thinking and planning."*
>
> *"I want to talk about my music. About my goals. Not just if I took my meds today."*

Culturally Responsive & Trauma-Informed Reminder:

Cultural stigma, such as mistreatment, prejudice, and discrimination, plays a major role in how comfortable youth are in seeking mental health care regarding suicide. **Young people from marginalized communities frequently experience disappointing and invalidating treatment from providers,** developing a mistrust in the healthcare system and hesitancy to report suicidal thoughts or behaviors. Be mindful of these potential barriers, learn about the young person's thoughts, experiences, and fears when discussing suicide, and listen to the young person's needs. Remain patient and flexible, adapting to the specific developmental and individual needs of young people without assuming that traditional adult suicide prevention approaches are effective for youth.

An Example to Practice

A young person named Jack comes in for a routine appointment. Dr. Sasha asks questions about his general wellbeing, including *"How's school?"* Jack responds, *"It's fine."* Dr. Sasha continues, asking *"What are your favorite classes? Who do you sit with at lunch?"* Jack responds, *"Um, I like my art class. I eat lunch in the art room every day…"* Dr. Sasha replies, *"That's really cool, do you work on projects or hang with friends in the art room?"* Jack responds, *"Um no, I just, um, people don't seem to like me and well its easier being alone."*

Discussion Questions:

- *How should Dr. Sasha respond? What feels important to opening a dialogue with Jack?*
- *What additional information does Dr. Sasha need to evaluate suicide risk? Why are additional questions needed?*
- *How did Dr. Sasha establish trust with Jack during his appointment? Why was asking specific questions important?*
- *How can Dr. Sasha continue to support Jack after this appointment?*

Columbia-Suicide Severity Rating Scale

In the Past Month...		
Ask Questions 1 and 2	YES	NO
1. **Have you wished you were dead or wished you could go to sleep and not wake up?**		
2. **Have you actually had any thoughts of killing yourself?**		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3. **Have you been thinking about how you might do this?** *E.g. "I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it... and I would never go through with it."*		
4. **Have you had these thoughts and had some intention of acting on them?** *As opposed to "I have the thoughts but I definitely will not do anything about them."*		
5. **Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?**		

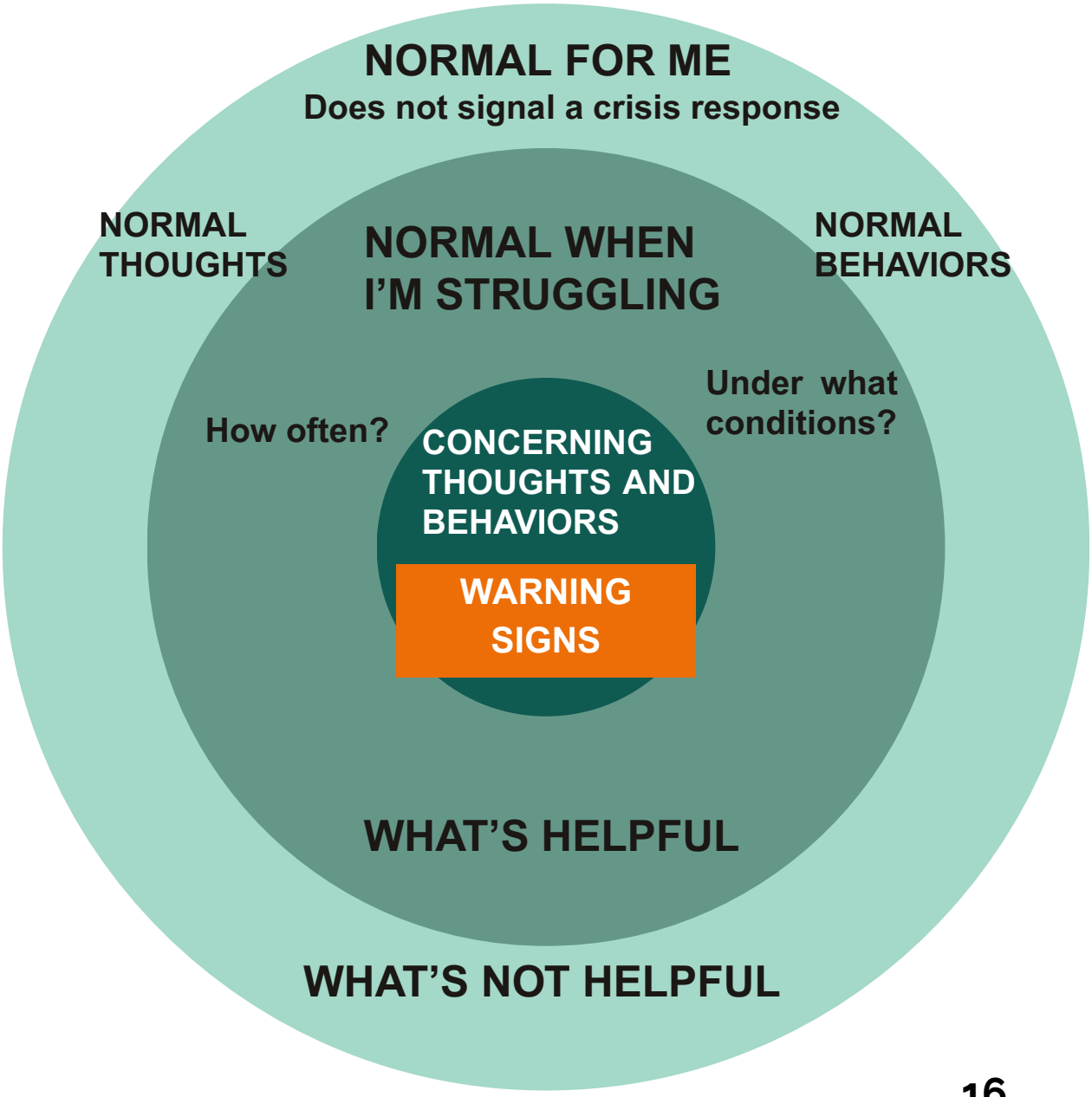
6. **Have you ever done anything, started to do anything, or prepared to do anything to end your life?** *Examples: Took pills, tried to shoot yourself, cut yourself, or hang yourself, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc.* **If YES, ask: Was this within the past three months?**	**YES**	**NO**

Low Risk Moderate Risk High Risk

Harm Reduction Circle

The harm reduction circle can be used to increase understanding and communication when it comes to suicidal thoughts and feelings. This tool empowers young people to normalize and better communicate about their personal boundaries to reduce harm and alarm to create safety.

The circle can be used with providers or loved ones to explore feelings and establish a personal baseline around suicidal thoughts and behaviors. What are normal experiences for some, may be warning signs for others. There is no one size fits all when it comes to suicidal thoughts or feelings and harm reduction.



CORE ELEMENT 2: Third Spaces & Alternative Service Opportunities

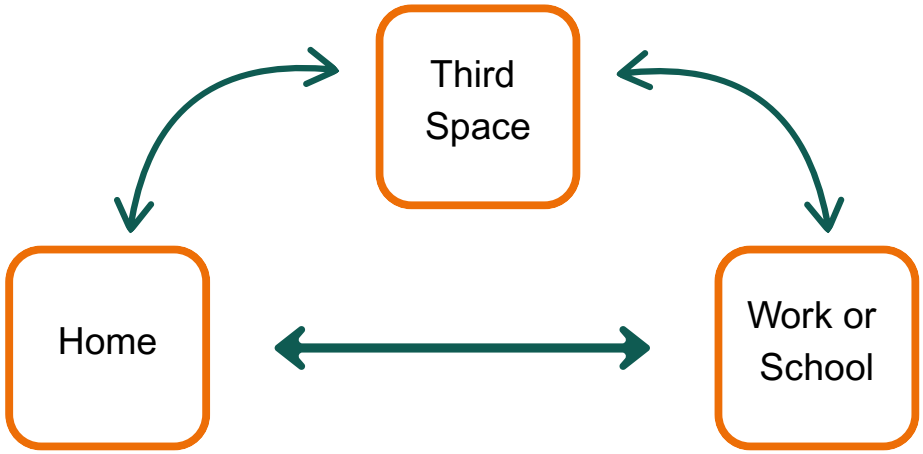
Before You Begin, Reflect:

1. *What does suicide prevention support look like outside of the clinical space?*
2. *What is important to ask young people about their lives to assess for suicide risk?*
3. *How much do you know about your patients? What is important to them?*

While providers often support young people in clinical offices, young people spend most of their lives outside of the office. **A young person's wellness relies on their ability to continue seeking safety and care outside of exclusively clinical spaces.** It is the responsibility of providers to help young people to understand, explore, and navigate what wellness looks like for them on a day-to-day basis – and to connect to communities where they feel safe, can be themselves and belong. To do this, providers need to more deeply know who their young people are, including what they care about, what they are interested in, and what brings them joy.

"Don't come out the gate asking if I want to die. Ask me about my life, my music, my passions. You'll get a better sense of where I'm at."

“Third spaces” are additional physical spaces or communities that young people regularly rely on outside of where they spend most of their time, i.e., home (the “first” space) and school or work (the “second” space). **See Diagram below.** Third spaces include a variety of settings like sports leagues, community centers, an organized or informal group based on shared identities or hobbies, youth centers geared toward specific populations, resource organizations, social events, a local park, and more.



Within a “third” space, young people can find relatability, foster positive relationships, and a community of peers with shared life experiences. Third spaces inspire hope while fostering connectedness, validation and empowerment.

Young people consistently referenced the need to foster fun in addition to healing through an environment that is familiar, consistent, comfortable, and safe. Providers serve a crucial role in helping young people identify third spaces that foster a sense of belonging. By encouraging space for fun and connection, young people can further develop their sense of self while learning to manage their mental health symptoms.

“Mental health is not just therapy. It’s eating, moving, sleeping, praying, connecting.”

"Healing can look like joking around after school or creating music with someone who knows pain like you do."

"Ask me what I do after school, who I hang out with, or what I create. That's where the real stuff lives."

Young people look for connection through shared experience and identity. By engaging in meaningful third spaces, young people can find community through a shared cultural and developmental understanding that may not be as accessible at school, work, home or with providers. In addition to age and generational differences, providers may not share cultural understanding, experiences or interests with their clients. **While still working within a culturally responsive lens, providers should explore and support youth in identifying third spaces in the community to feel seen, appreciated, understood and known.** Offering peer support or additional community resources based on client interests may also help young people begin to build their third space and develop meaningful social connections that support their mental health and wellbeing.

"We need Black spaces. Queer spaces. Religious spaces. Places where we don't have to explain ourselves."

"I felt seen at the LGBTQ center. Nobody asked me to explain why I felt what I felt."

Third spaces are imperative for youth wellness due to the strict limitations of clinical spaces that do not match or accommodate the needs of young people. Clinical offices typically only operate on a 9AM-5PM, Monday through Friday schedule, leaving youth without support outside of office hours. Additional service opportunities could fill this gap by providing more flexible hours or connecting young people to a community with multiple layers of support. If other service opportunities or exploring third spaces feels inaccessible, explore ways to make home safer by considering **Steps to Limit Access to Lethal Means** on page 21.

The rapid increase of technology and social media use for suicide prevention care is a major factor in providing immediate, accessible care when providers are unavailable. **Technology as a third space** can include young people seeking connection with peers through apps like Instagram, Tik Tok, Facebook, Reddit, and more. It also presents several potential dangers and limitations for providers to be aware of. This is expanded on in Core Element 4 (Technology and Media Literacy).

> *"I can be more honest on Discord than in real life. But it also gets dark sometimes. No one's moderating those chats."*
>
> *"Instagram makes me feel seen sometimes, but it also makes me compare my pain to others."*

Suicide prevention goes beyond the clinical sphere. **Providers must be curious about young peoples' lives, relationships, individuality, and needs outside of mental health symptoms, while encouraging engagement in third spaces and alternative service opportunities.** Young people may not know where to start or what to look for, so initiating the conversation and offering additional resources and ideas could make the difference for a client who is struggling. See page 20 for a list of **Examples of Third Spaces & Collaborative Brainstorming.**

Culturally Responsive & Trauma-Informed Reminder:

Young people are looking for relatability (i.e., surrounding themselves with individuals who are like-minded or with similar interests), and understanding through seeking individuals with shared identities and experiences. **Explore what elements of relatability are significant** to each young person and encourage finding third spaces that feel relatable and open to them. It is ethical to also be reflective as a provider in acknowledging personal cultural values and approaching client work with cultural humility and curiosity.

Examples of Third Spaces & Collaborative Brainstorming

Below is a list of examples of third spaces to foster community, access to resources, or joyful engagement. These are meant to be a starting place for collaborative brainstorming with young people about other spaces they may be interested in spending time outside of work/school and home.

- Community centers
- After school programs
- Religious settings
- Local library
- Volunteer groups
- Sports leagues
- Art-based gatherings
- Youth groups geared towards specific populations (i.e. LGBTQ+, Black and Brown youth, young people with disabilities)
- Youth centers that offer access to resources like education assistance or skill-building
- College-based centers or groups
- Activism communities
- Social events
- Online spaces (more in Core Element 4)

Questions to ask young people to encourage discussion:

- How do you like to spend your time?
- What are your interests?
- Are there any communities or identities that are important to you?
- Who do you hang out with?
- What do you like to create?
- Do you have budget restrictions and want to prioritize free spaces?
- What other barriers do we need to consider?

Steps to Limit Access to Lethal Means

As a “first space”, young people spend the majority of their time at home. While exploring third spaces and finding alternative service opportunities that resonate with young people, utilize the steps below to ensure safety at home by limiting access to lethal means.

Step	Behavioral Goal	Considerations
Raise the Issue	Motivate the family to reduce access to lethal means at home	Encourage putting time and distance between suicidal impulse and deadly weapons, such as a gun, to prevent quick and irreversible consequences. While meds are far less likely to result in death, they are the go-to method for most attempts, and some medications are more dangerous than others. Assess how guns and meds are currently stored at home.
Develop a Plan	Store any guns or meds in a secure location that limits client access.	Off-site storage is the safest approach, but if that’s not possible, lock firearms in a gun safe or lock box unloaded and create distance between the keys/combination or disassemble the guns and lock up a key component. Dispose of meds no longer in use. Keep only small quantities of over-the-counter meds on hand and lock others accordingly. Do not lock rescue meds like inhalers or epi-pens. Agree on specific steps and timetables with clients to create an individual plan.
Document and follow-up	Document the plan/next steps and confirm the plan was implemented.	Document the discussion and plan in the medical record. Continue following up in future appointments and adjust the safety plan as needed.

Adapted from Means Matter: CALM Talking Points for Clinicians

CORE ELEMENT 3: Supporting Family Involvement & Other Supports

Before You Begin, Reflect:

1. *Who do young people trust the most when they're struggling with suicidal thoughts?*
2. *How could support people (family & friends) be incorporated into treatment?*
3. *What are your concerns or thoughts about involving family in treatment?*

Meaningful support systems are vital to helping young people feel less alone in their experience with suicidality. **Providers not only need to be curious about young clients' social networks but also must consider how to best involve young people's chosen supports into treatment.** Involving family and other supports intentionally (in partnership with a young person) improves the likelihood that a young person will have support when experiencing suicidal thoughts or feelings, especially outside of a provider's available hours.

> *"Like my friend, she was the main support system... it would have been cool if she could have maybe come in for a session, just so I can say like, 'Hey, whenever I call you like, I need this support"*

Providers must consider the value of involving and working with a young person's identified support system in supporting their mental health and wellbeing. Due to differing social stigmas, cultural norms, and rhetoric around suicide, providers should not make assumptions about who a young client may choose to be their support person.

Providers must explore **WHO** a young person wants involved in their mental health care and **HOW** they want them involved. This includes reviewing and obtaining client consent for sharing information with young person identified supportive adults as well as discussing boundaries regarding information sharing with institutions and supportive adults (i.e., what can be shared under what conditions). An example of **Consent for Release of Information** is available on page 26. **Providers must recognize that the social networks of young people are constantly evolving** (to be expected during this developmental phase), and partner with young people to identify who is best to involve in their mental health care as needs, priorities and goals evolve.

> *"I don't want to be forced to talk to someone just because they're my parent."*
>
> *"I wish there was something like family therapy but for you and your friends...like, safe spaces where we could talk things through with someone helping."*

Young people do not always know that involving additional people in their mental healthcare is an option, particularly if their experience in mental health care is limited. **Providers have a responsibility to explain (and re-explain on a regular basis) how family involvement can benefit young people, and what family involvement might look like in ongoing care.** This also includes helping young people navigate difficult conversations with loved ones and sharing tools to educate families on mental health signs, symptoms, and coping strategies.

"I have this intense fear that they're [caregivers] going to not take it well, or it's going to ruin the relationship somehow... it would have been super helpful if I could identify those people, but also if they [providers] went over how to have that conversation."

"Checking in on mental health is not really a big thing... so especially for families that haven't grown up in the U.S... it's important to tell them that it should be a normal thing."

Young people may not want their parents/primary caregivers involved in their mental health care. Young people may prefer other supportive adults to be involved in their mental health care, including partners, siblings, friends, chosen family, roommates, etc. **Providers must be flexible in how they define family and deeply explore which adults in a youth's life are most supportive and why.** Fear of having information shared with unsupportive parents/primary caregivers (without client consent) can deter young people from considering family involvement in their mental health care. **It is important for providers to partner with young people about what they want shared and how they want it shared with their supportive adults,** and to follow-through on information sharing with supportive adults that aligns with the youth's priorities and desires. Providers also MUST explain how information sharing with supportive adults and institutions youth are connected to might change based on level of crisis. For example, if a young person is under 18 and experiencing acute suicidal ideation, the provider is mandated to inform the parent/primary caregiver under most circumstances.

"... Sometimes I don't know how to have these talks because when I have these talks, I blow up, and sometimes people take it the wrong way because they care about you, and they don't know what to do with that info."

Young people's relationships are constantly changing, and providers must be prepared by remaining flexible about who is involved in a young person's mental health care, and how they are involved. **Checking in regularly (i.e., quarterly) about information sharing preferences, updating consent documents, and re-establishing safe supports is crucial** to ensure the most up to date information and sharing preferences are followed. If a crisis does arise, this allows for minimizing unauthorized information sharing and/or potential harm.

"Things change, and no one checks back in unless you hit crisis mode again."

"When my mom was in the loop, I felt more supported... but only because she understood what was happening."

Providers must honor a young person's preferences regarding which supportive adults they want involved in their mental health care. Family involvement does not exclusively mean blood-related relatives. Key supports might include: a teacher, a friend, a family member, additional professional support, or another community support person they felt comfortable sharing their suicidal thoughts and feelings. This support and sharing will look different depending on who the support person is and what is appropriate to share with them. For a young person who is over 18, a friend, roommate, or partner might be a preferred key support over a family caregiver. While for a young person under 18, the provider may need to connect with an involved primary caregiver at times and with information that the youth wants shared with their caregiver. For additional guidance in establishing preferable support people and methods of reaching out, see page 27 **Supplemental Tool for Involving Support People in Safety Planning.**

Culturally Responsive & Trauma-Informed Reminder:

Different cultures have different perspectives around mental health struggles, particularly suicidality. Providers must be aware of potential cultural stigma young people face when involving family in care and the extra weight they carry when having to be educators on the topic. Approach each young person's level of safety with curiosity and empathy while remaining open minded regarding their choice in support people.

Consent for Release of Information

Client Name: _____ DOB: _____

I give my permission for [PROVIDER] to use or disclose information from my mental health records with the person(s) or organization(s) listed below. I understand that such records may contain health information about psychiatric, drug and/or alcohol diagnosis and treatment as well as referrals and written and verbal communication with staff related to mental health interventions.

If consent is not withdrawn, this consent will be in effect for six months from the date signed. If major changes in services are proposed, a new consent will be required.

Name / Organization: _____
Phone: _____
Email: _____
Relationship: _____
Information to be Released: _____
Date of Next Review: _____

I understand that my consent is voluntary and may be withdrawn at any time. I understand that my consent will expire six months from the date of my signature.

_____	_____	_____
Client Signature	Client Printed Name	Date
_____	_____	_____
Provider Signature	Provider Printed Name	Date

Supplemental Tool for Involving Support People in Safety Planning

Traditional safety planning includes deciding who a young person could call in times of crisis but following through on reaching out for help may feel more nuanced in practice. Establishing different tiers of engagement may be helpful to lower the barrier for young people when reaching out for help, minimizing the amount of decision making needed in the moment. List support people below in order of priority as a supplement to traditional safety planning.

Support Person #1

Name: Relationship:

Purpose for Reaching Out: *(ex: safe person to talk to, distraction, connection to additional resources, etc.)*

Preferred Communication: ☐ Call ☐ Text ☐ Email

Drafted Script/Message:

Support Person #2

Name: Relationship:

Purpose for Reaching Out: *(ex: safe person to talk to, distraction, connection to additional resources, etc.)*

Preferred Communication: ☐ Call ☐ Text ☐ Email

Drafted Script/Message:

CORE ELEMENT 4: Technology & Media Literacy

Before You Begin, Reflect:

1. *How has the use of technology changed since you were a young person?*
2. *Why is it valuable? What are the drawbacks?*
3. *In what ways is technology relevant to suicide prevention care?*

Young people are increasingly using virtual tools and engaging with digital communities when experiencing depression, anxiety and suicidality. Today, **research indicates that roughly 50% of adolescents spend 5 hours a day on social media while 12% spend over 10 hours** (Gillespie et al., 2024). Most young people (and adults) rely on the internet and social media for information about mental health distress and treatment options and/or coping strategies, as well as for avenues to connect to others with similar struggles and to share their experiences for validation, helpful advice and a sense of not feeling so alone in one's experience with suicidality. Increasingly, artificial intelligence (AI) platforms are resulting in youth engaging with AI chatbots around their mental health and coping strategies.

Adult providers must recognize that young people are actively and frequently engaged in leveraging digital spaces for their mental health needs. Familiarize themselves with the potential value and benefits as well as the limitations and dangers of these tools for suicide prevention. **Explore how each individual young person is using digital tools, such as texting or social media to support their mental health with openness and curiosity.** Avoid asking youth to fully refrain from using digital tools. Instead explore pros and cons of digital tools and communities for supporting youth mental health and wellness.

"It's easier to talk in a group chat than to a teacher."

"If I text my friend a '.' [period], that means check on me."

"It's easier to text about this stuff than say it out loud."

Technology, the internet and social media are constantly evolving and often difficult to keep up with for adults in general. Adult providers can dismiss the potential benefits of digital tools and communities when they are not familiar with them. Adults working with youth must prioritize becoming familiar with new social media and AI platforms that youth are engaging with. **A way for adult providers to become familiar with digital tools, communities and platforms is to explore their functionality together with young people.** When young people bring up digital tools and communities, it is critical to **keep an open-mind and ask open-ended non-judgmental questions to youth exploring** how the tool works, how youth feel that they are benefitting them, and potential dangers youth foresee and safeguards that are or could be in place to protect youth. The next page describes commonly used digital tools, communities, applications and platforms.

Common Digital Tools, Communities, Applications & Platforms

Type	Examples	Examples of Use	Potential Concerns
AI Chatbots	ChatGPT Copilot Claude	• Ask questions • Validation of feelings • Advice seeking	• Incorrect information • Could encourage suicidal action • Privacy & personal information risks
Social Media	TikTok Snapchat Instagram Youtube	• Connecting with peers • Information gathering • Entertainment	• Negative effect on self-esteem • Cyberbullying
Interactive Gaming	World of Warcraft	• Entertainment • Social connection through shared interest	• Inappropriate exposure to violent and sexual content • Cyberbullying
Online Communities & Chatrooms	Reddit Discord	• Validation of feelings • Information gathering • Community building	• Could encourage suicidal action • Cyberbullying
Streaming Platforms	Twitch	• Entertainment • Social connection through shared interest	• Exposure to inappropriate content • Privacy risks
Platforms for Community Connecting	Campfire Phoenix	• Joining groups to connect with people in community (e.g., PokemonGo groups)	• Broad access to personal location • Personal safety risks

Through the internet, smartphones and social media, **young people from all over the world can quickly and easily connect and bond over shared identities, life experiences and interests, and mental health distress and suicidality.** Young people now can find community and belonging in digital spaces that would not have been possible in the past. Young people are actively searching for connection with others in digital spaces based on personal experiences and struggles, e.g., chronic illnesses, disabilities, and niche interests. Digital spaces are an example of third spaces detailed in Core Element 2 (Third Spaces & Alternative Service Opportunities).

"I found other people like me in a Discord [chatroom] space. That helped."

"Checking in doesn't have to be deep. Just knowing someone notices helps."

"Sometimes I just need to scroll and feel numb for a while."

Young people increasingly use AI tools to seek nonjudgmental support with suicidal thoughts or feelings. **Providers must explore mental health benefits and drawbacks among youth using artificial intelligence (AI) for mental health support.** AI chatbots are NOT mental health professionals. Publicly available and free AI chatbots (e.g., Gemini, ChatGPT, Claude) are not trained in mental health and suicide prevention evidence-based practices. **AI chatbots are not held to the same ethical standards of mental health professionals.** AI chatbots are not regulated, monitored or designed to provide mental health support – and although are found to be helpful to some youth, they also pose real risk to youth mental health and safety.

"If you're looking for advice there, I would say definitely steer away from that [AI use], because there's just a lot of unknowns there. It doesn't always give you the same advice. It doesn't always give you great advice."

"The AI will be telling them to do dark things, or like agreeing with them in that state of mind."

"However, I have noticed that it [AI tools] can keep you ruminating on it. It can be really great but it can also get you trapped in a little bit of a cycle."

Digitally-delivered mental health treatment (referred to as "telehealth") has expanded access to those who live in rural areas, have limited access to transportation, and/or have a disability. Young people have increasing access to online counseling (e.g., Talkspace, BetterHelp) and peer support (e.g., peers.net). **Mental health care access outside of one's physical location via digital platforms increases connections to providers who share identities (e.g., racial, ethnic, cultural, sexual, gender), life experiences (e.g., divorced parents, poverty, incarceration, homelessness), interests and values.** Research shows evidence-based mental health care can be delivered effectively online with similar positive impacts to in-person care.

When discussing telehealth with youth, explore potential safety concerns, especially around suicide prevention practices in the event of a crisis. Co-develop safety plans that leverage both the physical and virtual world that includes who to connect with in-person and virtually when in crisis. **Often online mental health providers cannot provide crisis support, and instead provide a general crisis line for their clients to access crisis supports.** If you are an adult provider supporting youth experiencing suicide, review your agency's protocol for suicidality with youth (and their family members) to ensure youth have access to timely, effective crisis care.

Lead with curiosity when exploring young people's use of digital spaces for navigating suicidal thoughts and feelings. **Explore what digital spaces feel important/relevant to young people, why they may or may not be helpful, and how they engage with these spaces with a nonjudgmental perspective.** It is unrealistic to assume that young people are going to stop utilizing digital tools and spaces for navigating their mental health and wellness. Use harm reduction strategies instead of a digital "abstinence" based approach to explore youth's **intentions and motivations for using digital spaces and accessing digital communities.** For additional guidance within these conversations, see page 34 **Considerations for Digital Awareness**. Explore why, when, and how young people are using digital tools, especially AI chatbots, for navigating suicidal thoughts and feelings. Develop clear safety plans that include in-person supports, and virtual tools and communities when appropriate and relevant, to provide effective suicide prevention care.

> *"...just acknowledging that it is a part of our everyday life. I think that's really important with every resource, is that you acknowledge it's not the best, but having that conversation gets in front of it."*

Culturally Responsive & Trauma-Informed Reminder:

Youth engagement with digital tools and spaces for navigating mental health and wellness is normal and developmentally appropriate. Adult providers should not police or restrict digital tool/community use but be open to exploring the benefits and risks to youth who are experiencing suicidal thoughts and feelings. Remain curious about the way youth utilize digital tools and spaces. **Use of digital tools, including social media for navigating suicidal ideation may be a method of survival, particularly for disabled, queer, or culturally marginalized youth.**

Considerations for Digital Awareness

Technology will always be part of young people's lives and will only continue evolving rapidly. Below are additional suggestions to empower providers and young people in engaging in conversations around technology use, media literacy, and digital awareness.

Encourage Limited Screen Time

Talk about ways to limit screen time through built-in tools like timers or doing other hobbies that don't involve a screen. It's unrealistic to expect young people to completely eliminate screen time, but diversify the way young people consume information and allocate their attention.

Get to Know the Apps

With so many options and more getting developed every day, have a candid conversation with young people about which apps they prioritize as part of their digital diet, and don't assume everyone uses the same ones. Understand the purpose of these apps in particular and how the young person engages with them without judgement.

Remember Technology is Not Going Anywhere

Young people will use technology, including social media and AI tools. The goal is not to completely discourage the use of tech tools, but foster a culture of open conversation and harm reduction, so that young people understand potential dangers of using technology for suicide prevention and engage with it thoughtfully.

Remember the Permanency and Inaccuracy of the Internet

It's important to educate young people about their digital footprint and how what they post online and send electronically can have lasting impacts. Conversely, information found online or through AI tools may not be reliable or true, so encourage young people to bring in what they learn from online tools into sessions to discuss together.

An Example to Practice

A young person named Lola comes into the office for a regular, routine visit. Lola discloses experiencing suicidal thoughts in the past few weeks and the development of a plan without any further intent or attempts. The doctor asks more questions about how Lola navigates being in crisis and Lola explains how they use AI tools when they need someone to talk to, and especially when other support people are not around. They describe feeling validated, cared for and more stable after engaging with AI.

Discussion Questions:

- What other questions should the doctor ask Lola about their use of AI? How could they explore the need that AI fulfills from a nonjudgemental perspective?
- What psychoeducation feels important to discuss regarding the potential dangers and benefits of AI?
- Which harm reduction tactics may be the most feasible at this point for Lola? How could they collectively work to implement them?

CORE ELEMENT 5: Aftercare/Long-Term Support

Before You Begin, Reflect:

1. *How can supporting a young person develop over time?*
2. *In what ways do you currently set up clients for long-term success?*
3. *What are long-term challenges that affect a young person's wellness after a serious attempt?*

Suicide care should not end directly after a suicide-related event. **Rather, effective, developmentally attuned suicide care involves long term support for young people and their loved ones.** Basic suicide care recognizes one's acute needs leading up to and during a crisis, while more informed, holistic suicide care also includes strategies to address the long-term impact of serious suicidal ideation or attempts. Providers must be devoted to delivering consistent care throughout a young person's journey of navigating suicidal thoughts and behaviors (before, during and after a crisis). **Holistic suicide care practices must extend beyond the initial support immediately following a crisis.**

"Make what we're dealing with right now more manageable, but also not coming at it from one of the extremes."

"Healing has just been that I'm constantly choosing to, you know, to stay alive, that that's something I'm focusing on."

Young people and adult providers may experience a shift within their relationship following a crisis. **Both individuals experienced a traumatic event that demands processing through reflection, sharing insights and healing together.** Post-crisis is a time to rebuild relationships and re-establish trust for both young people and providers. Part of the healing and trust building processes requires a provider to honor that the crisis event was part of the process – and one that they together are learning from.

Providers must collaborate with young people in taking the new information they learned from the event together to revise wellness plans grounded in realistic expectations, rather than fear-based and reactive decisions, and prioritize young people's preferences, lifestyles, culture and community. Prevention planning should be adaptive to evolving needs, circumstances and developmental changes of each individual young person. See pages 40 and 41 for a **Long-Term Safety Planning Template.**

"I felt like somehow that shifted therapy completely for me where it was like they no longer wanted to bring stuff up because they were worried I was going to try something..."

"I want 'I'm not going to treat you with kid gloves, and I'm not going to treat you like you're made out of glass because the reality is, you were a resilient person', but we have to look at what thoughts and feelings are causing this behavior...' it felt like they were almost scared of me, like scared to talk to me."

Re-centering care to a future focus instead of a focus on preventing past crises from happening again is a key shift in long-term suicide care. Sometimes providers focus on managing suicidality and not on supporting youth in looking towards the future. Many young people consider suicidal thoughts or behaviors as a "back up plan" to manage intense emotions and discomfort, due to the lack of confidence, motivation, or skillset to handle life challenges. Creating short- and long-term plans to equip young people with learned skills and self-assurance will help them to face future joys and obstacles**.** Through a strength-based approach, providers and youth can brainstorm protective factors and positive visioning for the future, such as building positive relationships or fostering excitement towards a specific goal.

"This is not a backup plan, for when future things go bad, and it shouldn't be... I realized I would always be like, 'well, things go bad. I'll just die'... but then I didn't die, and on that I was like, 'oh wow! Just bad, and I don't know what to do.'"

"Anytime I'm actually able to just like, sit down and actually think about my future, I know that there's some healing that has happened."

"A gap that I thought of was like life skills. Because I'm thinking about how we said, we're not even thinking about the future."

Service plan goals must balance intervention and prevention, while centering future goals. Building relationships, confidence, self-esteem, coping strategies, and a greater understanding of triggers/activators support a young person in both preventing a crisis and handling future challenges and successes. Long-term care goes beyond 30-day programs or brief crisis intervention. **Youth require patience and time to adjust, and for providers to remain flexible yet consistent to meet their vacillating, developmental needs to prepare them to better handle future suicidality.**

Several factors affect a young person's long-term risk for suicide, including the presence of comorbid mental health diagnoses, substance use disorders, or lack of meaningful social supports. Young people may also lack strong emotional regulation skills and increased impulsivity to handle all of these factors in addition to chronic suicidality. Important systemic challenges include access to insurance and medical aid, financial support, housing instability, interactions with the justice system, and sociopolitical stigma regarding seeking mental health care. Without exploring these considerations, long-term care will be less effective. For accessible care without the urgency of a crisis line, see pages 42 and 43 **Warm-Lines for Additional Support.**

"For me, it's being able to look back at how I was in the past and realize that things don't upset me or trigger me in the same way as they would have."

"I think it has a lot to do with having more good days than bad days but also having the bad days... like okay, if I handled this differently, there's been some progress there."

Long term suicide prevention requires young person's supports. Review Core Element 3 (Supporting Family Involvements & Other Support) to learn more about incorporating supports in care.

Culturally Responsive & Trauma-Informed Reminder:

Developmentally appropriate long-term care must consider other sociocultural factors specific to young people. Examples include young people navigating drastic shifts in relationships, lack of potential financial support, instability of housing or career, extra responsibilities of attending school, family, social and other expectations in addition to managing their mental health. Be thoughtful about pacing treatment and maximize small wins that youth and young adults can celebrate while juggling other social factors at the same time.

Long-Term Safety Planning Template

Date of Creation:
Check in Point: 3mo 6mo 9mo 12mo

Step 1: Warning Signs (list 3)

Step 2: Internal Coping Strategies - things I can do to on my own without contacting another person (list 3)

Step 3: People and Social Settings that provide distraction (list 4 with addresses)

Step 4: People Whom I can ask for help during a crisis (list 3 with phone number)

Adapted from Stanley-Brown Safety Plan Worksheet

Long-Term Safety Planning Template

Date of Creation:
Check in Point: 3mo 6mo 9mo 12mo

Step 5: Professionals or Professional Services I can contact during a crisis (list 3 with phone numbers or emails)

Step 6: Making the Environment Safer - plan for lethal means safety (list 2)

Additional Reflection Questions for Long-Term Safety Planning:

- What are your current short-term goals? How do you know when you're successful? Why is this a goal?
- What are your current long-term goals? How do you know when you're successful? Why is this a goal?
- Has anything in this safety plan changed since its creation?
- What has worked? What has not worked?

Adapted from Stanley-Brown Safety Plan Worksheet

Warm-Lines for Additional Support

Below is a list of warm-lines available for the state of Texas and nationally. For clients that need additional professional support without calling a crisis hotline, warmlines are a useful tool for providers to discuss with young people.

Warmline	Phone Number	Hours of Operation
HOPE Family Health Warmline	(844) 755-4673	M-F 12p-10p (CT) Sat 9a-2p
**NAMI Bexar County Warmline	(210) 939-9999	Daily, 8a-11p (CT)
S.E.A. Center Warmline	(713) 970-4483 (713) 970-4481 - Spanish	M-F, 9a-5p (CT)
Y.W.C.A. Greater Austin Warmline	(512) 548-9922	M-Th 8:30a-8p (CT) F 8:30a-5p, Sat 12p-4p (CT)

** Indicates warmlines with a chat option available and all warmlines are available in Spanish

Adapted from NAMI National Warmline Directory

Warm-Lines for Additional Support

Below is a list of warm-lines available nationally for specific populations. For clients that need additional professional support without calling a crisis hotline, warmlines are a useful tool for providers to discuss with young people.

Warmline	Phone Number	Hours of Operation
LGBT National Help Center Provides free & confidential peer-support, information, and resources	(888) 843-4564	M-F, 4p-12a (ET) Sat, 12p-5p
LGBT Youth Talkline Provides free & confidential peer-support, information, and resources (25 years old and under)	(800) 246-7743	M-F, 4p-12a (ET) Sat, 12p-5p
Teen Line Provides support, resources and hope to any teen who is struggling	(800) 852-8336	Daily 6p-10p (PT) Text TEEN to 839863
Your Life Your Voice Provides “Ways to Get Help” with call, text, and email options	(800) 448-3000	24/7

Adapted from NAMI National Warmline Directory

CORE ELEMENT 6: Supporting with the Loss of a Loved One

Before You Begin, Reflect:

1. *What protocols are currently in place with your organization in response to completed suicides?*
2. *What is your role as the provider in supporting individuals with the loss of a loved one?*
3. *What aspects of supporting clients through grief are lost in suicide care?*

Facing the loss of a loved one is tremendously painful, and loss from suicide is a unique form of grief that requires an informed and thoughtful approach from youth service providers. After losing someone to suicide, people often grapple with unanswered questions, guilt or blame, questioning signs they did not see in their loved one or what they could have said or done differently to prevent the loss. Some even experience anger at the person who died by suicide, looking for answers and/or struggling to process the loss. **Providers must validate any feelings that a young person is having following a loss related to suicide.**

"It's not about what you can say, or what you should say as much as it is, just letting them say what they want to say... and letting them take the lead on what going back to normal or feeling not horrible looks like"

Suicide grief is highly stigmatized. To support young people with suicide grief, providers must understand and acknowledge the ways in which grief is an ongoing process, and that people experience and express grief in different ways. While some may express their struggles outwardly, others may conceal or separate their own struggles in the wake of profound loss. **Providers must check-in with young people about how they are feeling following a suicide-related loss.** Simply asking about, providing time/space to share, and reinforcing that you are there to listen are all simple but important strategies a provider can use to support a young person process their grief and loss. For guidance on neutral, nonjudgemental language around suicide, see page 48 **Language Matters: Talking About Suicide.**

> *"...It's not gonna fix the pain. It's not going to make the person come back. It's not going to make it go away. So having more space to just exist and not have to have it figured out."*

Suicide grief can have a communal effect. **The loss of a peer, classmate, acquaintance or community member can deeply impact young people**, regardless of their personal closeness to the person. Loss can provoke questions, feelings or fear around one's own mortality, or lead to experiences of hopelessness or suicidal thoughts in young people. Survivors of loss may have to manage additional responsibilities in supporting others through their grieving processes in addition to managing their own grief and mental health. **Providers must recognize and validate grief processes in young people, including those who may be unaware of how a loss is affecting them. Using a nonjudgmental approach to exploring loss is key to providing trauma-informed care.** To assist young people with recognizing physical effects of grief, see page 50 **Physical Symptoms of Grief Checklist.**

"I know a lot of people who are family and like survivors of grief, of people that they have lost. They don't necessarily always turn to mental health professionals the same way that someone going through and experiencing suicidal ideation and thoughts and feelings would."

"They feel kind of swept to the side that they're so focused on taking care of this individual that they don't realize themselves. That is also a process that is just as scary."

Grief is an ongoing process. Providers have a responsibility to regularly check in on young people who have experienced a loss related to suicide and support young people in connecting to appropriate care if their mental health struggles are getting in the way of their daily activities and overall wellbeing. For more guidance on supporting a young person navigating grief, see page 49 **Survivors of Suicide Loss: Understanding the Grief Process**. **Talking openly with young people about suicide, grief and loss reinforces that you are a safe adult to talk to when help is needed.**

"The community wants to know you're there to help them but like try not to be performative about it... I've felt like all of the resources that they provided on campus, there was just- like they left it up there out in the open. They're like 'well, here's this. Bye! We'll never talk about this ever again."

"I think there needs to be more people available just to have an open door if anybody does need to talk about it, because I was one of those people."

Culturally Responsive & Trauma-Informed Reminder:

Different cultures and religions have varying beliefs around suicide that may influence how a young person may navigate intense emotions within the grief process. Providers should be aware of and encourage young people to discuss cultural perspectives and attitudes about suicide that may feel distressing or soothing. Embracing their cultural identity through remembrance and mourning can be an opportunity to uplift cultural creativity and collective healing within ceremonies, traditions, and other meaningful acts. Ask the young person about what feels important to them regarding mourning a loss and listen for opportunities to welcome grieving through cultural identity and practice.

Language Matters: Talking About Suicide

When talking about suicide, it is important to use words that are **neutral, factual, and free from judgement or shame** about accessing care or navigating mental health conditions. The goal is to encourage open and safe conversations that lead people to seeking help.

Suicide Death

Suicide is the result of complex factors and should not be discussed as a "successful" event or as being "completed". For example, the word "commit" implies that suicide is a criminal or immoral act.

Safe Words: Died by suicide

Words to Avoid: Successful suicide, completed suicide, committed suicide

Specific Populations

Be mindful when discussing populations that may be at risk for suicide, highlighting the factors that can contribute to higher risk rather than identifying a population as inherently high risk. Some words carry negative meanings and increase stigma.

Safe Words: Populations with higher rates of suicide, factors that may increase a person's risk of suicide, economic and social risks of suicide.

Words to Avoid: High-risk populations, vulnerable or susceptible people, the burden of suicide

Suicide Attempts

It is important to not portray suicide as a positive or negative. For example, referring to a suicide attempt as "unsuccessful" or "incomplete" implies that dying is the preferred outcome.

Safe Words: Attempted suicide

Words to Avoid: Incomplete suicide, suicidal gesture, unsuccessful suicide, failed attempt, nonfatal suicide

People Impacted by Suicide

Use language that emphasizes the person and avoids labeling. Different people identify with different terms, so focus on generally accepted safe terms.

Safe Words: Person bereaved by suicide, survivor of suicide loss, survivor of suicide attempt, person with lived experience

Survivors of Suicide Loss: Understanding the Healing Process

Survivors of suicide loss embark on the complex process of moving through the grief and learning to find a new normal - a process that takes time. Informal and formal supports are crucial during this time. Informal supports include family, friends, and faith communities while formal supports include survivor support groups, counseling, or other professional services.

Below are more considerations for walking with a young person through the healing process:

Feelings of grief may come on suddenly:

Survivors of suicide loss may have several good days in a row, then hear a song or see their loved one's favorite flower and may experience overwhelming feelings of grief. When this happens, encourage focusing on positive memories and asking more about their relationship.

Holidays, birthdays, & anniversaries are often difficult:

The first year after the person passes, holidays or birthdays can be extremely difficult, making continuous long-term support even more significant. Consider brainstorming a new tradition or celebration with family while still honoring a young person's loved one.

Survivors of suicide loss often feel bad about feeling good:

The first time a survivor laughs after their loved one dies can feel like a betrayal. Remind young people that survivors deserve to live happy lives too and celebrate the positive moments throughout grieving.

Friends and Family may not offer support:

Sometimes people closest to survivors do not know what to say and do not call or offer support. Encourage young people to lean on the people who are willing and able to support.

Physical Symptoms of Grief Checklist

Some survivors of suicide loss are unaware of the ways that grief can show up emotionally and physically. Below are examples of physical symptoms of grief to ask young people that may open the conversation to talking about suicide and loss.

Trouble Sleeping

Insomnia and difficulty falling asleep
Excessive sleeping
Vivid dreams or nightmares about the loss
Persistent exhaustion unrelieved by rest

Fatigue & Gut Symptoms

Decreased capacity for physical activity
Feeling physically “heavy” or weak
Difficulty completing routine tasks
Significant changes in appetite or stomach pain

Muscle Pain or Tension

Chest tightness or heaviness
Difficulty breathing or racing heart rate
Headaches or migraines
Neck, shoulders, and back tension
Generalized aching without a cause

Cognitive Symptoms

“Brain fog” or difficulty focusing
Memory lapses or forgetfulness
Waves of overwhelming sadness, anger, or guilt
Confusion
Difficulty making decisions

Resource List for Providers to Share with Young People

- **Tiny Lantern** - A peer and community-based resource for supporting folks in our lives that may be suicidal, as well as examining the beliefs and structures that keep suicide taboo.

- **Project LETS** - Provides anti-carceral peer support services that advocate for community liberation, political education, and alternatives to the mental health system

- **Fireweed Collective** - Offers mental health education and mutual aid through a Healing Justice and Disability Justice lens

- **Kiva Centers** - A peer-run organization dedicated to community building and systems changing

- **Project YES** - A very easy, quick, and youth-centered guide to managing suicidal thoughts, feelings, or other mental health struggles

- **Safety Plan App** - Made by the US Dept of Veteran Affairs (VA), this is a downloadable app to continuously develop & adjust an individual safety plan with additional resources to learn more about suicide

- **Seize the Awkward** - A campaign that promotes finding help or being supportive to someone struggling, even if you show up imperfectly - includes access to real stories, additional resources, and youth-centered language

- **Trevor Project** - Nationally-recognized organization that provides crisis services, peer support, and public education regarding suicide prevention, specifically for LGBTQ+ youth

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Thank You

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