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# *Self-Harm and Suicide Awareness and Prevention in Childhood and Early Adolescence: A Brief for Elementary School Educators and School-Based Professionals*

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When children talk about death, communicate a wish to die, or hurt themselves—when they engage in suicidal thoughts and behaviors (hereafter referred to as "STBs")—school adults may feel stunned and disoriented. Rates of reported STBs in children are rising (Burstein et al., 2019), elevating the need for up-to-date information meant to ensure educators are prepared to respond in the best possible way.

This Brief, a complement to the more detailed resource, "Self-Harm and Suicide Awareness and Prevention in Childhood and Early Adolescence: A Resource for Elementary School Educators & School-Based Professionals," is designed to provide elementary school personnel with critical knowledge and resources to help them recognize and assess the warning signs of STBs, and to respond in such a way that harm may be reduced, and children are kept safe.

## *Talking about STBs*

One way school professionals can develop confidence in preventing and responding to STBs among young children is to familiarize ourselves with terminology and practice our ability to name challenges in front of us.

- **Suicidal Ideation.** Thinking about, considering, or planning death by suicide. Suicidal ideation comprises suicidal thoughts.
- **Suicide Attempt.** A non-fatal, self-directed, potentially injurious behavior with intent to die. A suicide attempt may not result in injury.
- **Non-Suicidal Self-Injury.** Injuries inflicted to the body without suicidal intent (e.g., cutting, scratching, burning self; pulling one's hair out; hitting self).

**Avoid** phrases such as *"committed"* suicide, *"failed"* or *"successful"* suicide attempt. These terms can convey judgment and perpetuate stigma.

**Use** non-judgmental phrases, such as *"died by suicide"* or *"non-fatal suicide attempt"*.

## *Risk Factors and Warning Signs*

Although more research is needed to understand suicidal thoughts and behaviors in children, we know that certain experiences place children at risk. Without adults to help them cope, Adverse Childhood Experiences (ACEs), such as abuse, neglect, exposure to violence, or other unresolved trauma can impact children's mental, emotional, and physical development and increase the risk of suicide (Hughes et al., 2017).

Environmental and social factors also contribute to toxic levels of stress. Chronic stressors such as poverty, discrimination, community violence, environmental racism, and other social injustices affect overall well-being. Oppression and experiences of marginalization contribute to disproportionately high rates of suicide and mental health conditions in BIPOC youth (Trent et al., 2019) and LGBTQ+ communities (Johns et al., 2019).

**It is important to remember that no single risk factor is known to cause suicide; most children who die by suicide have several risk factors.**

| **Risk factors** are characteristics or conditions that increase the chance that someone would consider suicide (American Foundation for Suicide Prevention). Risk factors include… | **Warning signs** are indicators that someone may be considering suicide right now. Warning signs include… |
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| • Trauma, including emotional, physical, and/or sexual abuse; neglect or domestic violence.<br>• Peer-related problems, including experiencing bullying or bullying others.<br>• Familial rejection, including due to sexual orientation or gender identity.<br>• Personal or family history of mental health conditions or suicide.<br>• Recent loss or separation. | • Dramatic changes in mood or behavior, including impulsive or risky behaviors.<br>• Unexplained drops in academic performance.<br>• Fatigue, anger, irritability, sadness, loss of interest, or other symptoms of depression.<br>• Talking, writing/drawing or pretend play with themes of death.<br>• Making statements such as "I wish I could disappear" or "I hate my life".<br>• Frequent visits to the school nurse with vague physical complaints, such as stomachaches and headachesv |

## *Non-Suicidal Self Injury*

Sometimes self-injury is a sign of suicide risk. Other times, a child may be doing it to cope with overwhelming feelings, fit in with peers, or due to a disability. Self- injurious behavior can include:

- Scratching self with fingernails or objects.
- Cutting or burning skin (i.e., with an eraser).
- Hitting or choking oneself.
- Picking at skin or nails causing bleeding.
- Pulling own hair.
- Banging one's head against the wall.

All students who self-injure should be assessed for suicide risk. Even if they are not suicidal, if they rely on self-injury to cope with their emotions, they should speak with a mental health professional. It's important to remain calm and nonjudgmental when talking to students about self-injury; consequences can inadvertently reinforce the behavior. If a group of children has all been identified as self-injuring, assess each child individually. Warning signs may include:

- Unexplained cuts, bruises, or burns.
- Wearing long sleeves or bracelets to cover marks.
- Avoiding activities that require less clothing, such as swimming.
- Possessing razors or other sharp objects.
- Writing or talking about self-injury, posting on social media.

## *Taking Action for Safety*

Suicide risk may come to educators' attention in a variety of ways, including direct statements, notes, pictures, or as reported by a classmate or parent. Even seemingly casual statements or jokes should be assessed thoroughly and can provide a teachable moment about using safe language. Schools should regularly review protocols so that both employees and students know how to report safety concerns.

**School professionals should never promise to keep safety concerns a secret.**

If a child is experiencing suicidal ideation, most state law requires schools to notify parents. If a child is at imminent risk of harming themselves or others, schools have the responsibility to connect them to emergency psychiatric or medical care.

Educators should use developmentally appropriate language to assess the child's understanding of death and suicide, conceptualize what is causing them distress, and express hope for a safe resolution. Some examples include:

- "_____ was worried about you and came to me for help. They said that you were talking about killing yourself. You're not in trouble and I'm not mad. I really care about you. Can you tell me what happened?"
- "Are you having thoughts of hurting yourself or killing yourself now?"
  - "What are you thinking about doing to kill yourself?"
  - "What is making you so upset that you want to hurt yourself?"
  - "How long have you been feeling this way?" [clarify time points using concrete, child-friendly language, like "before winter break" or "before 2nd grade"]
- "Have you ever tried to hurt/kill yourself before? When was that?" [clarify time points using concrete, child-friendly language]
- "I want to make sure you're safe. Have you talked to your (parent/guardian) about this? Let's talk to them together."

## *Protective Supports*

Just as there are factors that increase a student's risk of suicide, there are also protective factors that mitigate that risk. Schools have a unique opportunity to impact students' mental and emotional well-being, including by adequately supporting educators and families. Some protective factors for children include:

- A sense of belonging; being able to talk to trusted adults about their problems.
- Experiencing success academically and/or in extracurricular activities.
- The ability to identify feelings, utilize coping skills, and solve social problems.
- Safe, stable living environments and strong familial support.
- A positive sense of identity, including healthy racial socialization, LGBTQ+ affirming.
- For Native youth, a connection to tribal culture and spirituality.

## *Safety Planning*

Any student having suicidal thoughts and behaviors should have a safety plan. Safety plans help students and their support system recognize warning signs of a crisis, make the environment as safe as possible, promote safe coping skills, identify trusted adults who can help, and link to appropriate community resources.

A thorough safety plan should include securing the student's environment relative to their risk. Some examples may include:

- Changing their classroom from upstairs to downstairs.

- Having an adult escort them for bathroom breaks.
- Restricting their access to sharp objects, such as scissors and pencil sharpeners.
- Asking the caregiver to look through their backpack for dangerous objects.
- Providing structured activities for recess, such as board games or “lunch bunch” with a trusted adult.

**The safety plan** should be reviewed and agreed to by the child, caregiver, and school site. If ongoing mental health conditions are impacting a child’s access to education, consider a referral to determine the child’s eligibility for a Section 504 plan or an Individualized Education Plan.

## *Communicating with Parents & Caregivers*

Learning that one’s child has experienced STBs can be shocking for caregivers. Fear or concern may be expressed in a variety of ways, including disbelief, anger or denial. Responses may also vary by cultural norms related to geography, race, ethnicity, and/or religion. It is important for schools to communicate promptly and thoughtfully about any warning signs, utilizing language interpreters and cultural brokers, as appropriate.

Emphasize that neither they nor their child are in trouble and reiterate your desire to support the family. Help break the silence about suicide and combat the stigma related to seeking help. Families may be wary of referrals for mental health services, as many marginalized groups, such as Black, Indigenous and People of Color communities, individuals with disabilities, LGBTQ+ people, immigrants, and others have experienced abuse, neglect and discrimination in healthcare systems.

Host parent workshops about suicide awareness and prevention and build partnerships with community groups that can offer enrichment and wellness programming to your school community. Maintain a list of culturally responsive mental health providers in your local region and refer children, as necessary. Parents may worry that their child will be diagnosed, labeled, or medicated without their consent. They may also fear that their child will be removed from the home. It’s important to remind parents that you’re there to help find support for the child/family, while also being transparent about the limits of confidentiality.

Help parents and caregivers access the resources and support they need to spend quality time with their child, supervise them appropriately, respond to their needs, and ask for help when needed. Appropriate referrals may include the child’s primary care physician, a mental health professional, mentoring programs, extracurricular activities, or youth groups.

## *Multi-Tiered Systems of Support at School*

Elementary schools can play a crucial role in building students' capacities for emotion regulation, coping skills, and social problem-solving. These competencies guard against suicide risk over the lifespan. Schools can support families to develop strong family relationships, recognize early indicators of crisis, and seek mental health care. Elementary schools are uniquely positioned to foster resilience through multi-tiered universal, targeted, and intensive approaches to suicide prevention.

**Universal interventions** include school-wide positive behavior supports and social-emotional learning programs and all-staff training on suicide awareness and crisis response.

**Targeted interventions** include small group counseling and/or social-emotional learning programs, multidisciplinary team meetings, and restorative approaches to discipline.

**Intensive interventions** include individual counseling, safety planning, and individualized behavior support plans.

## *Special Considerations for Students with Disabilities*

Individuals with disabilities are at a higher risk of STBs than their non-disabled peers (Moses, 2018). If the student already has an Individualized Education Program (IEP), engage their special education team. The STB may be considered to be related to the child's disability and accommodations, modifications, or related supports and services may need to be added to the child's IEP. If the child does not already have an IEP, a referral may be appropriate for determining eligibility for a Section 504 plan or an IEP.

## *Addressing Challenging Behaviors*

Children often show their mental and emotional distress through their behavior. Children at risk of suicide are more likely to struggle with impulsivity and emotion regulation. If a child with known suicide risk exhibits challenging, disruptive, or unkind behavior, take care in determining the appropriate response. Evaluate the child's behavior using comprehensive functional behavior assessment techniques, and provide a behavior support plan. All children benefit from clear expectations and consistent limits.  Utilize restorative practices to repair harm and restore relationships.

## Conclusion

Educators do tremendous good in the lives of children. In addition to amplifying the strengths and assets of the children in their schools, they work diligently to prevent them from harm. As rates of STBs increase among young children and preteens, elementary school educators can seek best-practice guidance to prevent and respond effectively to STBs. By becoming knowledgeable and confident in their ability to respond, and by contributing to school-wide efforts to build prevention and intervention systems, educators can limit the impact of STBs on the lives of the children in their communities.

## For additional, in-depth guidance, please refer to the complete resource:

Marion, F., O'Malley, M., Palacio, J., & Gomez, J. (2023). *"Self-Harm and Suicide Awareness and Prevention in Childhood and Early Adolescence: A Resource for Elementary School Educators & School-Based Professionals."* Pacific Southwest Mental Health Technology Transfer Center (MHTTC).

## References

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