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# Community Suicide Awareness and Prevention

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COUN 6785: Social Change in Action:

Prevention, Consultation, and Advocacy

**Social Change Portfolio**

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Contents

Below are the titles for each section of the Social Change Portfolio. To navigate directly to a particular section, hold down <ctrl> and click on the desired section below.

**Please do not modify the content section, nor remove the hyperlinks.**

[Please note that in brackets throughout this template you will see instructions about information to include in each section. Please delete the instructions that are found in brackets, including this message, and replace the bracketed instructions with the relevant content for each section].

# OVERVIEW

Keywords: Suicide, Prevention, Rates in Texas, Rates in Fort-Bend County, Suicide in Katy, Evidence-Based Practices, Culture, Diversity, Advocacy.

## Community Suicide Awareness and Prevention

Goal Statement: To increase awareness of suicide and identify prevention strategies and resources to reduce suicide within my community.

Significant Findings: Suicide is the 11th leading cause of death in Texas and suicide deaths per 100,00 is 12.41 in Fort-Bend county (Fort Bend County Suicide Death Statistics, n.d.). The lifetime medical and work-loss cost of suicide is estimated around $4.264 million and medical cost alone for every attempt is averaged around $8,849 per patient (Texas Department of State Health Services Mobile, n.d.). Key findings show risk factors and protective factors varying across the socio- ecological model of suicide. Research supports Dialectical Behavioral therapy, Cognitive-Behavioral therapy, and Applied Suicide Intervention Skills Training as theories of suicide prevention. In Fort-Bend county, suicide occurs disproportionately among male, white, and below 35 years of age (County Health & Ranking Roadmaps, 2020). Advocacy action to expand the conversation and awareness of suicide can increase protective factors and impact the institutional, community, and public policy levels that surround in one's environment.

Objectives/Strategies/Interventions/Next Steps: The objective is to educate, inform, and expand on suicide prevention towards the target population in the community. Strategies should focus on the implementation of protective factors in resiliency, self-efficacy, familial support, and community collaboration. Cognitive and dialectical behavioral interventions and goals target symptom reduction in suicide ideation, suicidal behaviors, and major depression. The

community-based partner agency in Applied Suicide Intervention Skills Training supported by the National Suicide Prevention Lifeline and the American Foundation for Suicide Prevention is the leading evidence-based program that focuses on presenting suicide intervention skills and workshops regularly for community members. The next steps investigate the different ways suicide can be given a voice and a platform for advocacy that extends beyond the individual.

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# INTRODUCTION

## Community Suicide Awareness and Prevention

Suicide is defined as death by ending one's own life. The World Health Organization (n.d.) further defines suicide as a global phenomenon that accounts for 1.4% of all deaths worldwide; as close to 800,000 people die of suicide globally each year, making it the 18th leading cause of death internationally in 2016. In the United States, suicide is a mental health crisis that keeps rising steadily and is estimated that one suicide attempt occurs every 90 seconds and one suicide completion occurs every 90 minutes (Centers for Disease Control and Prevention [CDC], n.d.). In Fort-Bend county, Katy, TX, suicide has taken a common place among people and vary from all sexes, gender, ages, races, cultural, and ethnic groups. Statistical trends show that suicide is not only a national health problem, but a community health problem that is undergoing in silence. Many suffer in silence for fear of stigma and taboo related to these issues as it takes a tragedy of an admired public figure to talk about these medical conditions (Silence is fatal: Fighting stigma about depression and suicide in our communities, 2014). Among other factors, community silence is linked towards the need for decreasing physical illness, social support, substance use, mental health services, and reducing easy access to lethal means (Fort bend County, TX, n.d.). Approaches to prevention targets community interaction, mindfulness,

preparation on crisis team or gatekeepers, education, presentations, individual, group, and family counseling. The purpose of this paper is to provide a prevention-focused project to raise awareness and foster collaboration.

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# PART 1: SCOPE AND CONSEQUENCES

## Community Suicide Awareness and Prevention

The target mental health problem that I have identified within my community that can be addressed through prevention is suicide. In the United States, suicide is the 10th leading cause of death across age groups, 2nd leading cause of death for young adults, 3rd leading cause of death for youth, and suicide deaths per 1,000 in specified populations nationwide is 14.8 (Centers for Disease Control and Prevention [CDC], n.d.). From 1999 through 2018, the suicide rate increased 35%, from 10.5 per 100,000 to 14.2. (Hedegaard et al., 2020). In Texas, suicide is the 11th cause of death but trends in suicide rates increased 20% for all ages between 2009 and 2018 from 11.8 to 14.2 deaths per 100,000 population (Texas Department of State Health Services Mobile, n.d.). Each day in Texas there are more than 6 suicide deaths and nearly 30 hospitalizations for attempted suicide (Texas Department of State Health Services Mobile, n.d.). In Fort-Bend county, suicide rates increased across all ages between 1999 and 2018 from 7.3 to 12.41 deaths per 100,000 (Fort Bend County Suicide Death Statistics, n.d.).

The consequences of this problem estimated at $4.264 million in lifetime medical and work-loss costs in Texas in 2014 (Texas Department of State Health Services Mobile, n.d.). Estimated medical costs of Texas hospitalizations for suicide attempts average $8,849 per patient, or more than $95.6 million annually (Texas Department of State Health Services Mobile, n.d.). In my community, suicide is an outcome that is traced back from risk factors in how 11.7

percent of people living in Texas reported mental health distress for 14 or more days in the past 30 days (For science. For action. For health, n.d.). Additional risk factors in the general population are linked towards having mental health or substance use disorders, stigma, chronic illness, harmful norms, sociocultural and economic inequalities, adverse life events, and family history of suicide (Centers for Disease Control and Prevention [CDC], n.d.). The goal statement for my social change portfolio is to increase awareness of suicide and identify prevention strategies and resources to reduce suicide within my community.

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## PART 2: SOCIAL-ECOLOGICAL MODEL

### Community Suicide Awareness and Prevention

The socio-ecological model looks at the different levels of influence in individual, peer, school, and community/cultural characteristics as a function of the interaction between the person and the environment (Conyne et al., 2013). Within and across each level, there are identified risk factors that increase the likelihood for undesirable behaviors and identified protective factors that hep to reduce harmful behaviors (Conyne et al., 2013). Behaviors that lead to suicide can happen to anyone at any time and at any place with depression being one of the single best predictors (Capuzzi & Gross, 2019). Besides mental illness, if you are a male; white male; native American; LGBTQ; and elderly person over the age of 65 or have served in the military then you have a high risk of attempting suicide (Harrington & Daughhetee, 2018). In terms of environment, suicide rates were higher in the most rural counties compared with the most urban counties for both males and females in 2018 (Hedegaard et al., 2020).

The level of influence among peers besides having a friend who died by suicide is seen in victimization of peer-directed violence. Peer-directed violence is defined in bullying or multiple forms of direct aggression. Research has shown that individuals who are the targets of

peer-directed violence struggle with lower self-esteem, social isolation, depression, and other psychological difficulties in personality and affective disorders are related to increased suicide risk (Crepeau-Hobson & Leech, 2016). For both males and females, bullying (verbal and electronic) was a powerful predictor of attempting suicide; males who had been bullied were more than six times as likely to report a suicide attempt in the past 12 months than males who had not been bullied and bullied females were more than ten times as likely to report an attempt (Crepeau-Hobson & Leech, 2016).

The level of influence among family members is seen within the family conflict, the family history, and family interactions. Family conflict contributed mostly to younger suicide attempters due to negative self-image from family interactions; for adults, suicide behaviors was linked to relationship problems or seperation (Frey & Cerel, 2015). Family history of suicide is seen to be a major risk factor among family members across sexes and age groups (Frey & Cerel, 2015). Family members who have attempted or completed suicide has shown to increase other family member's risk for suicide and suicidal behaviors, both in adolescents and adults, a connection which exists even after controlling for psychiatric diagnoses and treatment (Frey & Cerel, 2015). Family interactions look at parental expressed emotion and criticism. Parental expressed emotion was linked to ideation, plans, and attempts in adolescents; parental criticism was strongly associated with suicidal behavior (Frey & Cerel, 2015). General family risk factors include poor communication, negative conflict patterns, low levels of warmth and belongingness, transmission of psychiatric disorders, and learned suicidal behaviors or behaviors of impulsivity and aggression (Frey & Cerel, 2015).

Levels of influence among the community and/or cultural characteristics target the communities of color or minorities. The CDC (n.d.) reports the highest number of suicides per

100,000 was 30 to 34 years for Black Americans, 20 to 24 years for Asian-Pacific Islanders, 50 to 54 years for Latino Americans, 20 to 24 years for Native Americans, and 45 to 49 years for White Americans. Perceived racism has been found to be associated with suicide ideation among Asian American adults, gay and bisexual Latino American men, and Native American adolescents (Wong et al., 2014). Racism in the form of racial economic inequality is linked to suicide rates. Research found that in cities with a lower proportion of individuals employed in manufacturing jobs, Black American men experienced greater economic disadvantages (e.g., higher joblessness and poverty rates), which predicted higher Black American male suicide rates (Wong et al., 2014). In socioeconomic status, Latino American communities demonstrated higher suicide rates when they were economically less affluent while in Black American men, a higher socioeconomic status has been shown to be associated with an increased suicide rate (Wong et al., 2014). Demographic differences are seen to carry a stronger link to suicide among communities of color. Studies have consistently shown that U.S. born Latino Americans and Asian Americans have higher suicide ideation, attempt, and death rates than their immigrant counterparts (Wong et al., 2014).

Research on protective factors across the spectrum of suicide is limited. Research studies on the level of influence on the individual level shows statistical significance in how there is greater effectiveness to increase protective factors in a suicidal individual's life than reducing the number of risk factors (Capuzzi & Gross, 2019). Protective factors on the level of influence among peers look at promoting a positive climate, self-efficacy, emotional well-being, external support, problem-solving skills, religious and spiritual beliefs (Capuzzi & Gross, 2019). Protective factors on the level of influence among family members look towards growth among the family unit in family therapy, talking openly about suicidal ideation to friends and family,

parenthood, living in large family households, and social, relational, or familial support (Frey & Cerel, 2015). Protective factors need further research as findings are not generalizable across cultures. Considered protective factors on the level of influence in community and/or culture are seen in community collaboration, counseling interventions that incorporate environment centered or cultural practices, and increase in awareness of access to treatment resources (Wong et al., 2014).

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## PART 3: THEORIES OF PREVENTION

### Community Suicide Awareness and Prevention

Theories of suicide prevention and programs looks at the current evidence-based practices that reduces symptomology and targets the associated risk factors while enhancing the individual's protective factors. There are currently few evidence-based theories and programs that provide prevention tools and treatments for individuals who are at risk for suicide. The Center for Disease Control (n.d.), the National Institute of Mental Health (n.d.), and the American Foundation for Suicide Prevention (n.d.) have recognized Marsha M. Linehan's Dialectical behavioral therapy (DBT) and Cognitive behavioral therapy (CBT) as theories of suicide prevention. Existing evidence-based program for suicide prevention has been identified in gatekeeper training called Applied Suicide Intervention Skills Training (ASIST).

Dialectical behavioral therapy or DBT is a theoretical methodology that combines cognitive-behavioral techniques for emotion regulation and reality testing with concepts of mindful awareness, distress tolerance, and acceptance predominantly derived from Buddhist meditative practice (Capuzzi & Stauffer, 2016). Marsha M. Linehan is an American psychologist who developed DBT in the early 1980s due to her research work with highly suicidal clients meeting criteria for borderline personality disorders (BPD) in behavioral health settings

(Linehan, 1993a). DBT is appropriate for the problem and population that I have identified because the goals help to address behaviors that can lead to the client's death, then behaviors that could lead to premature termination of mental health services, and behaviors that demolish the quality of life and the need for alternative skills (Capuzzi & Stauffer, 2016).

DBT is the most well-researched and efficacious therapeutic intervention from the first randomized control trial of women with BPD and suicidal behavior; showing a reduction of frequency and severity of suicidal behaviors, suicidal ideation, anger expression, hopelessness, and depression (Capuzzi & Stauffer, 2016). Further research support for the theory shows a recent systematic review of thirteen studies affirming that mindfulness-based techniques and interventions have a significant impact on suicidal behavior and ideation by improving executive functioning, life orientation, over general memory, ruminative response, meta-awareness, death anxiety, and attention; attributes that can help address suicidality (Raj et al., 2020). In 10 randomized controlled trials using DBT, four trials recruited highly suicidal BPD clients; DBT participants were significantly less likely to attempt suicide or self-injure, had less medically severe suicidal behavior episodes, had lower treatment dropout, tended to use psychiatric facilities less, and improved more on scores of global and social adjustments (Neacsiu et al., 2012). Empirical outcomes using DBT in theory and treatment adaptations in 18 adolescent research studies support improvements in suicide ideation, suicide behavior, non-suicidal self-injury (NSSI), thoughts of NSSI, BPD symptoms, depressive symptoms, hopelessness, dissociative symptoms, anger, overall psychiatric symptoms, general functioning, and psychosocial adjustment (MacPherson et al., 2013).

Cognitive behavioral therapy or CBT is a theoretical approach that consists of cognitive and behavioral interventions that are direct, structured, goal-oriented, time-limited, and

collaborative to enhance reductions in psychological disturbances, leading to behavioral change (Capuzzi & Stauffer, 2016). The primary principle underlying cognitive behavioral theory is that affect, and behavior are determined by the way in which individuals cognitively structure the world (Capuzzi & Stauffer, 2016, p. 239). According to the cognitive model, suicide crisis is most closely precipitated by states of high hopelessness and a culmination of one's perceived failure at solving problems or coping (Bhar & Brown, 2012). CBT is appropriate for the problem and population that I have identified because of its diverse application towards a variety of individuals with serious mental health issues. CBT is known for its diagnosis and treatment of depression, which can help in predicting early signs of depression and depression among individuals who are at risk of suicide.

Research support for the theory shows consistent results in anti-depressant medication combined with CBT was no better than the use of CBT alone; CBT combined with drug treatment was better than drug treatment alone, concluding that CBT is effective as anti-depressant medication (Capuzzi & Stauffer, 2016). In a suicide prevention systemic review and meta-analysis study, ten randomized trials concluded CBT reduces not only repeated self-harm but also repeated suicide attempts (Gøtzsche & Gøtzsche, 2017). Brown et al. (2018) showed its first study to demonstrate significant reductions in suicide ideation over the course of CBT in a naturalistic sample of civilians with principal PTSD and unspecified anxiety diagnoses, with no evidence of for exacerbation of suicide risk. A recent supporting research shows a promising study using brief cognitive behavioral therapy for suicide prevention in an inpatient setting showed high patient satisfaction and reported lower suicidality and depression at posttreatment (Diefenbach et al., 2020). A recent study aimed to investigate the effect of group CBT on suicidal thoughts of patients with major depressive disorder found that cognitive

behavioral group therapy accompanied by drug therapy may be more effective to prevent suicidal thoughts and be considered as a complementary treatment beside the usual health care for major depression (Ardashir et al., 2018).

Applied Suicide Intervention Skills Training (ASIST) is a public health approach in suicide prevention through a gatekeeper training program. The gate keeper training program is a 2-day, 16-hour workshop that includes interactive role-play, exercises to promote connection and understanding of the suicidal individual, and specific techniques, such as eliciting reasons for living and dying and constructing a safety plan (Foster et al., 2017). The goal aims to reduce risk factors for suicidal behaviors and assist high risk individuals to the resources they need to secure their safety and recovery within their community (Foster et al., 2017). The program is evidence-based due to research support and recognition from the Suicide Prevention Resource Center and the American Foundation for Suicide Prevention.

In a longitudinal pre-post design for gatekeeper training program for youth suggested that participation in ASIST may increase rates of youth identified as at risk, increase the frequency and likelihood with which gatekeepers respond to risk in a recommended fashion, and increase actual numbers of youth referred to an appropriate care setting (Foster et al., 2017). In a national randomized control trial conducted on the National Suicide Prevention Lifeline, callers who spoke with ASIST-trained counselors appeared less depressed, suicidal, and overwhelmed, and there was greater improvement in callers' feeling hopeful than among callers who spoke with a counselor in the wait-listed condition; ASIST-trained counselors were more successful at establishing a connection with callers (Madelyn et al., 2013). In a pre-post quasi-experimental design with treatment and control groups conducted at a university campus supports the claim that ASIST fosters knowledge about suicide and develops more helpful intervention attitudes;

results also corroborate that ASIST enhances feelings of comfort, competence, and confidence at working with a person-at-risk; results agree with others that show ASIST increases SI-skills (Shannonhouse et al., 2017). In today's time, ASIST is arguably the most time intensive (two full days) and clinically oriented of the evidence-based gatekeeper training programs (Foster et al., 2017).

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## PART 4: DIVERSITY AND ETHICAL CONSIDERATIONS

### Community Suicide Awareness and Prevention

Diversity considerations have Euro-American and Native American males complete suicide more often than any other ethnic group (Capuzzi & Gross, 2019). In the year of 2020, Fort-bend county reported 371 deaths per 100,000 by suicide (County Health & Ranking Roadmaps, 2020). Of the 371 reported deaths, the community measures rated individuals who are male, white, and below 35 years of age have higher risk of suicide (County Health & Ranking Roadmaps, 2020). In the same young adult group, Fort-bend county had an increase of suicide rates for men by 26% in having intentional self-harm; 46% of them who died by suicide had a diagnosed mental health condition, and 90% had shown symptoms of a mental illness (n.d., 2021). In Texas, 16.3% of Texas adults (3.3 million) are experiencing a mental illness, compared to 18.6% nationally (n.d., 2021). Evidence exists for an association between mental disorders such as major depressive disorders (MDD), bipolar disorder (BPD), substance dependence (SD), and anxiety disorders and subsequent suicidality and deaths by suicide (Adhikari et al., 2020). In my chosen specific population that is affected by the target problem in my community is identified in young adult white males who struggle with mental health disorders in major depression and bipolar disorder. Recent studies indicate that 60% of those who died by suicide

had a diagnosis of major depression disorder (MDD); 17.3% of those with MDD had a lifetime risk of suicidal ideation, but lifetime risk of a suicidal attempt 4.8% (Wiebenga et al., 2020). In the general population, people with bipolar disorder (BD) are 20% to 60% at risk for suicide; 25% and 60% of individuals with BD attempt suicide at least once in their lives and between 4% and 19% complete suicide (Inder et al., 2016).

The mechanisms to increase the cultural relevance of a prevention program with my identified population is by developing a social network of peer support specialists. European-Americans tend to lean towards an individualistic oriented culture. Peer-delivered services can enhance the cultural traits by drawing upon their lived experiences to share empathy, insights, and skills on how to healthily manage suicidal thoughts and what to expect through the recovery process; serve as role models, inculcate hope, engage by connecting or reducing isolation; help members access the needed resources and support in their community (Thomas & Salzer, 2018). The main purpose of the peer-delivered services is to develop a supportive network of family and friends to help those at risk in facing their struggles and enlist their help in building their resource of caring people (Corey et al., 2015). Another mechanism to increase cultural relevance is through the National Institute of Mental Health's five action steps for helping someone in emotional pain. The five steps for helping someone in emotional pain is a prevention strategy that is person centered through a nonjudgmental approach by being authentic and genuine in being there for the person who is at risk for suicide. The five action steps consist of asking individuals if they are at risk for suicide; keep them safe by reducing access to lethal items or places; be there by listening carefully and learning what the person is thinking and feeling; help them connect with a trusted individual like a family member, friend, spiritual

advisor, or mental health professional; stay connected after a crisis or after being discharged from care (NIMH, n.d.).

The core ethical considerations in prevention programming for my target problem in my community is the duty to protect suicidal members or suicidal mental health consumers. As part of the informed consent process or limits of confidentiality, one must inform consumers that they have an ethical and legal obligation to break confidentiality when they have a good reason to suspect suicidal behavior or risk of self-harm (Corey et al., 2015). If a client or consumer dies of suicide, the risk of malpractice action is greatly reduced if the therapist or professional can demonstrate that a reasonable assessment and intervention process took place; professional consultation was sought; clinical referrals were made when appropriate; and thorough and current documentation was done (Corey et al., 2015). Another core ethical consideration in the prevention programming is stated in the standard A.11.a in the ACA code of ethics (2014) which suggests to recognize the limits of competence to be of professional assistance and know when and how to refer to other services clinically and culturally. Stakeholder collaboration in the prevention programming involves the consumer's family members, friends, community mental health counselors, police department, and the faculty of the community behavioral health center.

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## PART 5: ADVOCACY

### Community Suicide Awareness and Prevention

According to the last domain of the MSJCC guidelines (i.e., IV Counseling and Advocacy Interventions), privileged and marginalized counselors intervene with, and on behalf, of clients at the intrapersonal, interpersonal, institutional, community, public policy, and international/global levels (Multicultural and Social Justice Counseling Competencies, 2015). Each level carries barriers that have a direct or indirect relationship to the target problem. On the

institutional level, barriers look at the school system. The school's systemic structure often struggles to address in promoting the growth for resiliency. Adolescent's level of adjustment to adverse experiences depends on risk and protective factors that contribute to their exploration of their identity role (Nakhid-Chatoor, 2020). Erik Erikson's developmental stages believed that identity vs. role confusion is a result of the adolescents' concern "with what they appear to be in the eyes of others as compared to what they feel they are" (Jones et al., 2014). Confusion can lead to low levels of resiliency where failure at school is experienced, interpersonal conflict with a romantic partner or parent is common, humiliation and frustration experienced by some adolescents struggling with conflicts connected with their sexual orientation (Capuzzi & Gross, 2019). Promoting resilience practices can guide school counselors and teachers in their efforts to foster success for all students' personal, social, academic, and career development and citizen engagement (Capuzzi & Gross, 2019).

In my community, suicide is mentioned or talked in conversation when someone has died of suicide. There is a barrier to social support called stigma. Stigma is a set of negative beliefs that a group of people holds about someone; perceived stigma refers to one's beliefs about stigmatizing attitudes of others; self-stigma occurs when one internalizes public stigma, believing these negative things about oneself (Evans & Abrahamson, 2020). Suicide stigma takes form of social disapproval, isolation, or shunning; while adjectives used to describe people who die by suicide include arrogant, attention-seeking, pathetic, selfish, and weak (Frey et al., 2016). In a recent study, Evans, and Abrahamson (2020) found how suicide stigma was positively correlated with global psychological distress, depression, self-harm, and suicidality. The British Journal of Psychiatry also found how 83% of participants felt conscious of the stigma associated with mental illness and had difficulty seeking help; only 54% of participants had discussed their

suicidal thoughts with their family, peers, and/or spouses (University of Seattle, n.d.). Addressing stigma in my community looks at spreading awareness and education about the myths of suicide. Advocating by participating in discussions and events between individuals with and without mental problems (University of Seattle, n.d.).

On the public policy level, barriers look at the amount of people who do not have healthcare coverage. In Fort-Bend county, 14% of the population who are under the age of 65 are uninsured (County Health & Ranking Roadmaps, 2020). Without healthcare insurance one has reduced access to mental health services. Lack of access to mental health care is one of the contributing factors to the increase in suicide rates or those who are at risk of suicide because of its relation to the underuse of mental health services (Centers for Disease Control and Prevention, n.d.). Research suggests that services provided are maximized when behavioral health care systems are set up to deliver such care effectively and efficiently and can also normalize help-seeking behavior and increase the use of such services (Centers for Disease Control and Prevention, n.d.). Advocating on the public policy level requires supporting state legislation and programs involving mental health and suicide. Advocating can also help to increase funding that addresses suicide for research, education, prevention, and treatment (American Foundation for Suicide Prevention, n.d.).

The one advocacy action to take to address the target problem at each of the levels in institutional, community, and public policy is to talk about suicide. Talking about suicide is an advocacy action because it further emphasizes the importance of expanding the conversation to include protective factors that extend towards resiliency, acceptance, and support (American Foundation for Suicide Prevention, n.d.). Talking about suicide builds resiliency at the institutional level. Pathways of resiliency range from confronting structural inequities, to

instilling a sense of hope and recognizing students' self-righting capabilities, to developing a common language such as covitality for students, parents, and educators to use when talking about suicide or youth at risk in their development (Capuzzi & Gross, 2019). Talking about suicide can lessen the stigma at the community level. Talking by being conscious of your language, share positive messages about mental health, share your own mental health journey, and educate others about suicide can normalize the conversation and impact other people's language on the topic (Centers for Disease Control and Prevention, n.d.). Talking about suicide creates public policies at the local, state, and federal level. On July 16, 2020, the FCC adopted rules to establish "988" as the new number for the National Suicide Prevention Lifeline, connecting Americans with suicide prevention and mental health crisis counselors (Suicide Prevention Hotline, 2020). Talking about suicide is advocacy for suicide and will hopefully be the norm in our society.

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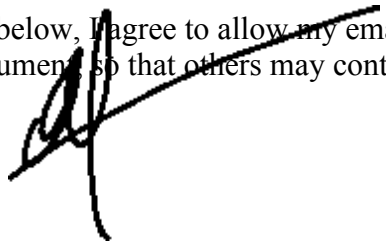
SIGNATURE: 

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