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ABSTRACT

This guide lists information and resources concerning school interventions to prevent youth suicide. Part 1 includes articles related to youth suicide, depression, and violence, along with a listing of basic facts, statistics, and myths about suicide. A general model of youth suicide is included followed by information on prevention. Part 2 contains information on identifying and addressing risk, risk and protective factors, a suicide assessment checklist, and criteria for diagnosis. Part 3 addresses specific responses to suicidal crises. It also contains descriptions of 15 training programs for community members, teachers, and school staff. The goal of these programs is to train individuals to identify youth at risk of suicidal behaviors and refer them to the appropriate sources of help. This section closes with an overview of various counseling approaches. The guide concludes with an annotated bibliography and list of Web sites from the University of California Los Angeles (UCLA) Center for Mental Health in Schools Training and Technical Assistance Center. (Contains approximately 110 print and Web resources.) (GCP)

Mental Health in Schools Center
Training and Technical Assistance

Technical Assistance Sampler on:

School Interventions to Prevent Youth Suicide

The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA.

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outline: Suicide Prevention

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THE SURGEON GENERAL'S CALL TO ACTION TO PREVENT SUICIDE, 1999

On July 28, 1999, Tipper Gore and Surgeon General David Satcher hosted a press conference at which the Surgeon General unveiled a blueprint to prevent suicide in the United States. The document, entitled "The Surgeon General's Call To Action To Prevent Suicide," outlines more than a dozen steps that can be taken by individuals, communities, organizations and policymakers.

The following letter from the Surgeon General introduces the document (U.S. Public Health Service, The Surgeon General's Call To Action To Prevent Suicide. Washington, DC: 1999.) and can be downloaded from the following website:
http://www.surgeongeneral.gov/osg/calltoaction

A Letter From The Surgeon General
U.S. Department of Health and Human Services

Suicide is a serious public health problem. In 1996, the year for which the most recent statistics are available, suicide was the ninth leading cause of mortality in the United States, responsible for nearly 31,000 deaths. This number is more than 50% higher than the number of homicides in the United States in the same year (around 20,000 homicides in 1996).[1] Many fail to realize that far more Americans die from suicide than from homicide. Each year in the United States, approximately 500,000 people require emergency room treatment as a result of attempted suicide.[2] Suicidal behavior typically occurs in the presence of mental or substance abuse disorders - illnesses that impose their own direct suffering.[3-5] Suicide is an enormous trauma for millions of Americans who experience the loss of someone close to them.[6] The nation must address suicide as a significant public health problem and put into place national strategies to prevent the loss of life and the suffering suicide causes.

In 1996, the World Health Organization (WHO), recognizing the growing problem of suicide worldwide, urged member nations to address suicide. Its document, Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies[7], motivated the creation of an innovative public/private partnership to seek a national strategy for the United States. This public/private partnership included agencies in the U.S. Department of Health and Human Services, encompassing the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS), the National Institute of Mental Health (NIMH), the Office of the Surgeon General, and the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Suicide Prevention Advocacy Network (SPAN), a public grassroots advocacy organization made up of suicide survivors (persons close to someone who completed suicide), attempters of suicide, community activists, and health and mental health clinicians.

An outgrowth of this collaborative effort was a jointly sponsored national conference on suicide prevention convened in Reno, Nevada, in October 1998. Conference participants included researchers, health and mental health clinicians, policy makers, suicide survivors, and community activists and leaders. They engaged in careful analysis of what is known and unknown about suicide and its potential responsiveness to a public health model emphasizing suicide prevention.

This Surgeon General's Call To Action introduces a blueprint for addressing suicide – Awareness, Intervention, and Methodology, or AIM – an approach derived from the collaborative deliberations of the conference participants. As a framework for suicide prevention, AIM includes 15 key recommendations that were refined from consensus and evidence-based findings presented at the Reno conference. Recognizing that mental and substance abuse disorders confer the greatest risk for suicidal behavior, these recommendations suggest an important approach to preventing suicide and injuries from suicidal behavior by addressing the problems of undetected and undertreated mental and substance abuse disorders in conjunction with other public health approaches.

These recommendations and their supporting conceptual framework are essential steps toward a comprehensive National Strategy for Suicide Prevention. Other necessary elements will include constructive public health policy, measurable overall objectives, ways to monitor and evaluate progress toward these objectives, and provision of resources for groups and agencies identified to carry out the recommendations. The nation needs to move forward with these crucial recommendations and support continued efforts to improve the scientific bases of suicide prevention.

Many people, from public health leaders and mental and substance abuse disorder health experts to community advocates and suicide survivors, worked together in developing and proposing AIM for the American public. AIM and its recommendations chart a course for suicide prevention action now as well as serve as the foundation for a more comprehensive National Strategy for Suicide Prevention in the future. Together, they represent a critical component of a broader initiative to improve the mental health of the nation. I endorse the ongoing work necessary to complete a National Strategy because I believe that such a coordinated and evidence-based approach is the best way to use our resources to prevent suicide in America.

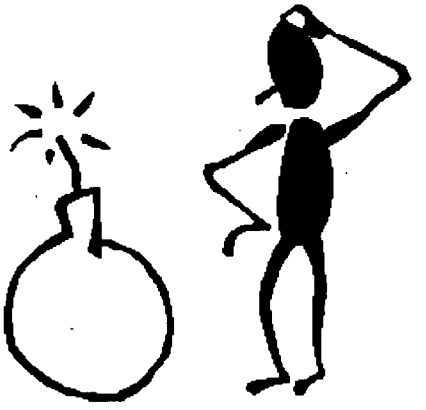
But even the most well-considered plan accomplishes nothing if it is not implemented. To translate AIM into action, each of us, whether we play a role at the federal, state, or local level, must turn these recommendations into programs best suited for our own communities. We must act now. We cannot change the past, but together we can shape a different future.

David Satcher, M.D., Ph.D.
Assistant Secretary for Health and
Surgeon General

*Note: All references from the Surgeon General's Report are included in the reference section of this sampler.

ON SUICIDE AND ITS PREVENTION

- About Youth Suicide/Depression/Violence
- Basic Facts and Stats
- Common Myths
- A general model of youth Suicide
- about Prevention



SCHOOL MENTAL HEALTH PROJECT UCLA

Addressing Barriers to Learning

New ways to think . . .
Better ways to link

Mental Health in Schools Center Training and Technical Assistance

Volume 4, Number 3
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...consider the American penchant for ignoring the structural causes of problems. We prefer the simplicity and satisfaction of holding individuals responsible for whatever happens: crime, poverty, school failure, what have you. Thus, even when one high school crisis is followed by another, we concentrate on the particular people involved -- their values, their character, their personal failings -- rather than asking whether something about the system in which these students find themselves might also need to be addressed.
Alfie Kohn, 1999

Youth Suicide/ Depression/Violence

"I am sad all the time."
"I do everything wrong."
"Nothing is fun at all."
items from the
"Children's Depression Inventory"

Too many young people are not very happy. This is quite understandable among those living in economically impoverished neighborhoods where daily living and school conditions frequently are horrendous. But even youngsters with economic advantages too often report feeling alienated and lacking a sense of purpose.

Youngsters who are unhappy usually act on such feelings. Some do so in "internalizing" ways; some "act out;" and some respond in both ways at different times. The variations can make matters a bit confusing. Is the youngster just sad? Is s/he depressed? Is this a case of ADHD? Individuals may display the same behavior and yet the causes may be different and vice versa. And, matters are further muddled by the reality that the causes vary.

ABOUT YOUTH SUICIDE/ DEPRESSION/VIOLENCE

Excerpted from the UCLA Center for Mental Health in Schools Newsletter.

The causes of negative feelings, thoughts, and behaviors range from environmental/system deficits to relatively minor group/individual vulnerabilities on to major biological disabilities (that affect only a small proportion of individuals). It is the full range of causes that account for the large number of children and adolescents who are reported as having psychosocial, mental health, or developmental problems. In the USA, estimates are approaching 20 percent (11 million).

Recent highly publicized events and related policy initiatives have focused renewed attention on youth suicide, depression, and violence. Unfortunately, such events and the initiatives that follow often narrow discussion of causes and how best to deal with problems.

Shootings on campus are indeed important reminders that schools must help address violence in the society. Such events, however, can draw attention away from the full nature and scope of violence done to and by young people. Similarly, renewed concern about youth suicide and depression are a welcome call to action. However, the actions must not simply reflect biological and psychopathological perspec- tives of cause and correction. The interventions must also involve schools and communities in approaches that counter the conditions that produce so much frustration, apathy, alienation, and hopelessness. This includes increasing the opportunities that can enhance the quality of youngsters' lives and their expectations for a positive future.

About Violence

Violence toward and by young people is a fact of life. And, it is not just about guns and killing. For schools, violent acts are multifaceted and usually constitute major barriers to student learning. As Curcio and First (1993) note:

Violence in schools is a complex issue. Students assault teachers, strangers harm

children, students hurt each other, and any one of the parties may come to school already damaged and violated [e.g., physically, sexually, emotionally, or negligently at home or on their way to or from school]. *The kind of violence an individual encounters varies also, ranging from mere bullying to rape or murder.*

Clearly, the nature and scope of the problem goes well beyond the widely-reported incidents that capture media attention. We don't really have good data on how many youngsters are affected by all the forms of violence or how many are debilitated by such experiences. But few who have good reason to know would deny that the numbers are large. Far too many youngsters are caught up in cycles where they are the recipient, perpetrator, and sometimes both with respect to physical and sexual harassment ranging from excessive teasing and bullying to mayhem and major criminal acts. Surveys show that in some schools over 50% of the students have had personal property taken (including money stolen or extorted). Before recent campaigns for safe schools, one survey of 6th and 8th graders in a poor urban school found over 32% reporting they had carried a weapon to school -- often because they felt unsafe.

About Suicide and Depression

In the Surgeon General's *Call to Action to Prevent Suicide 1999*, the rate of suicide among those 10-14 years of age is reported as having increased by 100% from 1980-1996, with a 14% increase for those 15-19. (In this latter age group, suicide is reported as the fourth leading cause of death.) Among African-American males in the 15-19 year age group, the rate of increase was 105%. And, of course, these figures don't include all those deaths classified as homicides or accidents that were in fact suicides.

Why would so many young people end their lives? The search for answers inevitably takes us into the realm of psychopathology and especially the arena of depression. But we must not only go in that direction. As we become sensitive to symptoms of depression, it is essential to differentiate common-place periods of unhappiness from the syndrome that indicates clinical depression. We must also remember that not all who commit suicide are clinically depressed and that most persons who are unhappy or even depressed do not commit suicide. As the National Mental Health Association cautions: "Clinical depression goes beyond sadness or having a bad day. It is a form of mental illness that affects the way one feels, thinks, and acts." And, it does so in profound and pervasive ways that can lead to school failure, substance abuse, and sometimes suicide.

Numbers for depression vary. The National Institute of Mental Health's figure is 1.5 million children and adolescents. The American Academy of Child and Adolescent Psychiatry estimates 3.0 million. Variability in estimates contributes to appropriate concerns about the scope of misdiagnoses and misprescriptions. Such concerns increase with reports that, in 1998, children 2-18 years of age received 1.9 million prescriptions for six of the new antidepressants (an increase of 96% over a 4 year period) and about a third of these were written by nonpsychiatrists -- generally pediatricians and family physicians. This last fact raises the likelihood that prescriptions often are provided without the type of psychological assessment generally viewed as necessary in making a differential diagnosis of clinical depression. Instead, there is overreliance on observation of such symptoms as: *persistent sadness and hopelessness, withdrawal from friends and previously enjoyed activities, increased irritability or agitation, missed school or poor school performance, changes in eating and sleeping habits, indecision, lack of concentration or forgetfulness, poor self-esteem, guilt, frequent somatic complaints, lack of enthusiasm, low energy, low motivation, substance abuse, recurring thoughts of death or suicide.*

Clearly, any of the above indicators is a reason for concern. However, even well trained professionals using the best available assessment procedures find it challenging to determine in any specific case (a) the severity of each symptom (e.g., when a bout of sadness should be labeled as profoundly persistent, when negative expectations about one's future should be designated as "hopelessness"), (b) which and how many symptoms are transient responses to situational stress, and (c) which and how many must be assessed as severe enough to warrant a diagnosis of depression.

Linked Problems

Wisely, the Surgeon General's report on suicide stresses the linkage among various problems experienced by young people. This point has been made frequently over the years, and just as often, its implications are ignored.

One link is life dissatisfaction. For any youngster and among any group of youngsters, such a state can result from multiple factors. Moreover, the impact on behavior and the degree to which it is debilitating will vary considerably. And, when large numbers are affected at a school or in a neighborhood, the problem can profoundly exacerbate itself. In such cases, the need is not just to help specific individuals but to develop approaches that can break the vicious cycle. To do so, requires an appreciation of the overlapping nature of the many "risk" factors researchers find are associated with youngsters' behavior, emotional, and learning problems.

Risk Factors

Based on a review of over 30 years of research, Hawkins and Catalano (1992) identify the following 19 common risk factors that reliably predict youth delinquency, violence, substance abuse, teen pregnancy, and school dropout:

A. Community Factors
1. Availability of Drugs
2. Availability of Firearms
3. Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime
4. Media Portrayals of Violence
5. Transitions and Mobility
6. Low Neighborhood Attachment and Community Disorganization
7. Extreme Economic Deprivation

B. Family Factors
8. Family History of the Problem Behavior
9. Family Management Problems
10. Family Conflict
11. Favorable Parental Attitudes and Involvement in the Problem Behavior

C. School Factors
12. Early and Persistent Antisocial Behavior
13. Academic Failure Beginning in Late Elementary School
14. Lack of Commitment to School

D. Individual / Peer Factors
15. Alienation and Rebelliousness
16. Friends Who Engage in the Problem Behavior
17. Favorable Attitudes Toward the Problem Behavior
18. Early Initiation of the Problem Behavior

E. 19. Constitutional Factors

Hawkins, J.D. & Catalano, R.F. (1992). *Communities That Care; Action for Drug Abuse Prevention.* Jossey-Bass.

General Guidelines for Prevention

Various efforts have been made to outline guidelines for both primary and secondary (indicated) prevention. A general synthesis might include:

•Systemic changes designed to both minimize threats to and enhance feelings of competence, connectedness, and self-determination (e.g., emphasizing a caring and supportive climate in class and school-wide, personalizing instruction). Such changes seem easier to accomplish when smaller groupings of students are created by establishing smaller schools within larger ones and small cooperative groups in classrooms.

•Ensure a program is integrated into a comprehensive, multifaceted continuum of interventions.

•Build school, family, and community capacity for participation.

•Begin in the primary grades and maintain the whole continuum through high school.

•Adopt strategies to match the diversity of the consumers and interveners (e.g., age, socio economic status, ethnicity, gender, disabilities, motivation).

•Develop social, emotional, and cognitive assets and compensatory strategies for coping with deficit areas.

•Enhance efforts to clarify and communicate norms about appropriate and inappropriate behavior (e.g., clarity about rules, appropriate rule enforcement, positive "reinforcement" of appropriate behavior; campaigns against inappropriate behavior).

Suicide Prevention

With specific respect to suicide prevention programs, one synthesis from the U.S. Dept. of Health and Human Services delineates eight different strategies: (1) school gatekeeper training, (2) community gatekeeper training, (3) general suicide education, (4) screening, (5) peer support, (6) crisis centers and hotlines, (7) means restriction, and (8) intervention after a suicide (CDC, 1992). Analyses suggested the eight could be grouped into 2 sets -- those for enhancing identification and referral and those for directly addressing risk factors. And, recognizing the linkage among problems, the document notes:

Certainly potentially effective programs targeted to high-risk youth are not thought of as "youth suicide prevention" programs. Alcohol and drug abuse treatment programs and programs that provide help and services to runaways, pregnant teens, or school dropouts are examples of programs that address risk factors for suicide and yet are rarely considered to be suicide prevention programs.

Enhancing Protective Factors and Building Assets

Those concerned with countering the tendency to overemphasize individual pathology and deficits are stressing resilience and preventive factors and developing approaches designed to foster such factors. The type of factors receiving attention is exemplified by the following list:

Community and School Protective Factors

- Clarity of norms/rules about behavior (e.g., drugs, violence)
- Social organization (linkages among community members/capacity to solve community problems/ attachment to community)
- Laws and consistency of enforcement of laws and rules about behavior (e.g., limiting ATOD, violent behavior)
- Low residential mobility
- Low exposure to violence in media
- Not living in poverty

Family and Peer Protective Factors

- Parental and/or sibling negative attitudes toward drug use
- Family management practices (e.g., frequent monitoring & supervision/consistent discipline practices)
- Attachment/bonding to family
- Attachment to prosocial others

Individual Protective Factors

- Social & emotional competency
- Resilient temperament
- Belief in societal rules
- Religiosity
- Negative attitudes toward delinquency
- Negative attitudes toward drug use
- Positive academic performance
- Attachment & commitment to school
- Negative expectations related to drug effects
- Perceived norms regarding drug use and violence

Note: This list is extrapolated from guidelines for submitting Safe, Disciplined, and Drug-Free Schools Programs for review by an Expert Panel appointed by the U.S. Department of Education (1999). The list contains only factors whose predictive association with actual substance use, violence, or conduct disorders have been established in at least one empirical study. Other factors are likely to be established over time.

The focus on protective factors and assets reflects the long-standing concern about how schools should play a greater role in promoting socio-emotional development and is part of a renewed and growing focus on youth development. After reviewing the best programs focused on preventing and correcting social and emotional problems, a consortium of professionals created the following synthesis of fundamental areas of competence (W.T. Grant Consortium on the School-Based Promotion of Social Competence , 1992):

Emotional

- identifying and labeling feelings
- expressing feelings
- assessing the intensity of feelings
- managing feelings
- delaying gratification
- controlling impulses
- reducing stress
- knowing the difference between feelings and actions

Cognitive

- self-talk -- conducting an "inner dialogue" as a way to cope with a topic or challenge or reinforce one's own behavior
- reading and interpreting social cues -- for example, recognizing social influences on behavior and seeing oneself in the perspective of the larger community
- using steps for problem-solving and decision-making -- for instance, controlling impulses, setting goals, identifying alternative actions, anticipating consequences
- understanding the perspectives of others
- understanding behavioral norms (what is and is not acceptable behavior)
- a positive attitude toward life
- self-awareness -- for example, developing realistic expectations about oneself

Behavioral

- nonverbal -- communicating through eye contact, facial expressiveness, tone of voice, gestures, etc.
- verbal -- making clear requests, responding effectively to criticism, resisting negative influences, listening to others, helping others, participating in positive peer groups

Note: With increasing interest in facilitating social and emotional development has come new opportunities for collaboration. A prominent example is the Collaborative for the Advancement of Social and Emotional Learning (CASEL) established by the Yale Child Study Center in 1994. CASEL's mission is to promote social and emotional learning as an integral part of education in schools around the world. Those interested in this work can contact Roger Weissberg, Executive Director, Dept. of Psychology, University of Illinois at Chicago, 1007 W. Harrison St., Chicago, IL 60607-7137. Ph. (312) 413-1008.

What Makes Youth Development Programs Effective?

From broad youth development perspective, the American Youth Policy Forum (e.g, 1999) has generated a synthesis of "basic principles" for what works. Based on analyses of evaluated programs, they offer the following 9 principles:

- *implementation quality*
- *caring, knowledgeable adults*
- *high standards and expectations*
- *parent/guardian participation*
- *importance of community*
- *holistic approach*
- *youth as resources/community service and service learning*
- *work-based learning*
- *long-term services/support and follow-up*

See *More Things That Do Make a Difference for Youth* (1999). Available from American Youth Policy Forum. Ph: 202/775-9731.

Initiatives focusing on resilience, protective factors, building assets, socio-emotional development, and youth development all are essential counter forces to tendencies to reduce the field of mental health to one that addresses only mental illness.

System Change

When it is evident that factors in the environment are major contributors to problems, such factors must be a primary focal point for intervention. Many aspects of schools and schooling have been so-identified. Therefore, sound approaches to youth suicide, depression, and violence must encompass extensive efforts aimed at systemic change. Of particular concern are changes that can enhance a caring and supportive climate and reduce unnecessary stress throughout a school. Such changes not only can have positive impact on current problems, they can prevent subsequent ones.

Caring has moral, social, and personal facets. From a psychological perspective, a classroom and school-wide atmosphere that encourages mutual support and caring and creates a sense of community is fundamental to preventing learning, behavior, emotional, and health problems. Learning and teaching are experienced most positively when the learner *cares* about learning, the teacher *cares* about teaching, and schools function better when all involved parties *care* about each other. This is a key reason why caring should be a major focus of what is taught and learned.

Caring begins when students first arrive at a school. Schools do their job better when students feel truly welcome and have a range of social supports. A key facet of welcoming is to connect new students with peers and adults who will provide social support and advocacy. Over time, caring is best maintained through personalized instruction, regular student conferences, activity fostering social and emotional development, and opportunities for students to attain positive status. Efforts to create a caring classroom climate benefit from programs for cooperative learning, peer tutoring, mentoring, advocacy, peer counseling and mediation, human relations, and conflict resolution. Clearly, a myriad of strategies can contribute to students feeling positively connected to the classroom and school.

Given the need schools have for home involvement, a caring atmosphere must also be created for family members. Increased home involvement is more likely if families feel welcome and have access to social support at school. Thus, teachers and other school staff need to establish a program that effectively welcomes and connects families with school staff and other families in ways that generate ongoing social support.

And, of course, school staff need to feel truly welcome and socially supported. Rather than leaving this to chance, a caring school develops and institutionalizes a program to welcome and connect new staff with those with whom they will be working.

What is a psychological sense of community?

People can be together without feeling connected or feeling they belong or feeling responsible for a collective vision or mission. At school and in class, a psychological sense of community exists when a critical mass of stakeholders are committed to each other *and* to the setting's goals and values *and* exert effort toward the goals and maintaining relationships with each other.

A perception of community is shaped by daily experiences and probably is best engendered when a person feels welcomed, supported, nurtured, respected, liked, connected in reciprocal relationships with others, and a valued member who is contributing to the collective identity, destiny, and vision. Practically speaking, such feelings seem to arise when a critical mass of participants not only are committed to a collective vision, but also are committed to being and working together in supportive and efficacious ways. That is, a conscientious effort by enough stakeholders associated with a school or class seems necessary for a sense of community to develop and be maintained. Such an effort must ensure effective mechanisms are in place to provide support, promote self-efficacy, and foster positive working relationships.

There is an clear relationship between maintaining a sense of community and countering alienation and violence at school. Conversely, as Alfie Kohn cautions:

> The more that ... schools are transformed into test-prep centers -- fact factories, if you will -- the more alienated we can expect students to become.

Knowing What to Look For & What to Do

Of course, school staff must also be prepared to spot and respond to specific students who manifest worrisome behavior. Recently, the federal government circulated a list of "Early Warning Signs" that can signal a troubled child. Our Center also has put together some resources that help clarify what to look for and what to do. A sampling of aids from various sources is provided at the end of this article. In addition, see *Ideas into Practice* on p. 9.

Concluding Comments

In current practice, schools are aware that violence must be addressed with school-wide intervention strategies. Unfortunately, prevailing approaches are extremely limited, often cosmetic, and mostly ineffective in dealing with the real risk factors.

In addressing suicide, depression, and general life dissatisfaction, practices tend to overemphasize individual and small group interventions. Given the small number of "support" service personnel at a school and in poor communities, this means helping only a small proportion of those in need.

If schools are to do a better job in addressing problems ranging from interpersonal violence to suicide, they must adopt a model that encompasses a full continuum of interventions -- ranging from primary prevention through early-after-onset interventions to treatment of individuals with severe and pervasive problems. School policy makers must quickly move to embrace comprehensive, multi-faceted school-wide and community-wide models for dealing with factors that interfere with learning and teaching. Moreover, they must do so in a way that fully integrates the activity into school reform at every school site.

Then, schools must restructure how they use existing education support personnel and resources to ensure new models are carried out effectively. This restructuring will require *more than* outreach to link with community resources (and certainly *more than* adopting school-linked services), *more than* coordinating school-owned services with each other and with community services, and *more than* creating Family Resource Centers, Full Service Schools, and Community Schools.

Restructuring to develop truly comprehensive approaches requires a basic policy shift that moves schools from the inadequate two component model that dominates school reform to a three component framework that guides the weaving together of school and community resources to address barriers to development and learning. Such an expanded model of school reform is important not only for reducing suicide, depression, and violence among all children and adolescents, it is essential if schools are to achieve their stated goal of ensuring all students succeed.

Cited References and A Few Resource Aids

Curcio, J. & First, P. (1993). *Violence in the Schools: How to proactively prevent and defuse it.* Newbury Park, CA: Corwin Press.

Kohn, A. (Sept. 1999). Constant frustration and occasional violence: The legacy of American high schools. *American School Board Journal.* On the web at: http://www.asbj.com/current/coverstory/html

The Surgeon General's Call to Action to Prevent Suicide 1999. Available from the U.S. Dept. of Health & Human Services, Download-- http://www.mentalhealth.org/links/suicide.htm

Early Warning, Timely Response: A Guide to Safe Schools (1999). Printed version available from ED PUBS toll-free at 1-877-4ED-PUBS (1-877-433-7827) or by e-mail at edpuborders@aspensys.com. Can be downloaded from web. http://www.ed.gov/offices/OSERS/OSEP/earlywrn.html

Youth Suicide Prevention Programs: A Resource Guide (1992). Available from the U.S. Dept. of Health & Human Services, CDC. Can be downloaded from http://aepo-xdv-www.epo.cdc.gov/wonder/prevguid/p0000024/p0000024.htm

The following are resources put together at our Center. All are available as described on p. 3 (*Center News*); most can be downloaded through our website: *http://smhp.psych.ucla.edu/.*

- *>Screening/Assessing Students: Indicators and Tools*
- *>Responding to Crisis at a School*
- *>Violence Prevention and Safe Schools*
- *>Social and Interpersonal Problems Related to School Aged Youth*
- *>Affect and Mood Problems Related to School Aged Youth*
- *>Conduct and Behavior Problems in School Aged Youth*
- *>What Schools Can Do to Welcome and Meet the Needs of All Students and Families*
- *>Protective Factors (Resiliency)*

Some Websites:

Safe and Drug Free Schools Office, U.S. Dept. of Educ.
http://www.ed.gov/offices/OESE/SDFS

National Institute of Mental Health
http://www.nimh.nih.gov

National School Safety Center
http://nssc1.org

Youth Suicide Prevention Program
http://depts.washington.edu/ysp

Suicide Resources on the Internet
http://psychcentral.com/helpme.htm

Basic Facts and Stats

From:

>>>>Surgeon General's Report

>>>>Vital Statistics

>>>>Fact Sheet on Adolescent Suicide

>>>>MORE STATISTICS

The following excerpt is taken from "The Surgeon General's Call to Action to Prevent Suicide, 1999" and can be found at: http://www.surgeongeneral.gov/osg/calltoaction

Suicide as a Public Health Problem

On average, 85 Americans die from suicide each day. Although more females attempt suicide than males, males are at least four times more likely to die from suicide.[1,8] Firearms are the most common means of suicide among men and women, accounting for 59% of all suicide deaths.[1]

Over time, suicide rates for the general population have been fairly stable in the United States.[9] Over the last two decades, the suicide rate has declined from 12.1 per 100,000 in 1976 to 10.8 per 100,000 in 1996.[10] However, the rates for various age, gender and ethnic groups have changed substantially. Between 1952 and 1996, the reported rates of suicide among adolescents and young adults nearly tripled.[1,11] From 1980 to 1996, the rate of suicide among persons aged 15-19 years increased by 14% and among persons aged 10-14 years by 100%. Among persons aged 15-19 years, firearms-related suicides accounted for 96% of the increase in the rate of suicide since 1980. For young people 15-24 years old, suicide is currently the third leading cause of death, exceeded only by unintentional injury and homicide.[12] More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease combined. During the past decade, there have also been dramatic and disturbing increases in reports of suicide among children. Suicide is currently the fourth leading cause of death among children between the ages of 10 and 14 years.[10]

Suicide remains a serious public health problem at the other end of the age spectrum, too. Suicide rates increase with age and are highest among white American males aged 65 years and older. Older adult suicide victims, when compared to younger suicide victims, are more likely to have lived alone, have been widowed, and to have had a physical illness.[13,14] They are also more likely to have visited a health care professional shortly before their suicide and thus represent a missed opportunity for intervention.[15] Other population groups in this country have specific suicide prevention needs as well. Many communities of Native Americans and Alaskan Natives long have had elevated suicide rates.[16,17] Between 1980 and 1996, the rate of suicide among African American males aged 15-19 years increased 105% and almost 100% of the increase in this group is attributable to the use of firearms.[18]

It is generally agreed that not all deaths that are suicides are reported as such. For example, deaths classified as homicide or accidents, where individuals may have intentionally put themselves in harm's way are not included in suicide rates.[19-21]

Compounding the tragedy of loss of life, suicide evokes complicated and uncomfortable reactions in most of us. Too often, we blame the victim and stigmatize the surviving family members and friends. These reactions add to the survivors' burden of hurt, intensify their isolation, and shroud suicide in secrecy. Unfortunately, secrecy and silence diminish the accuracy and amount of information available about persons who have completed suicide— information that might help prevent other suicides.

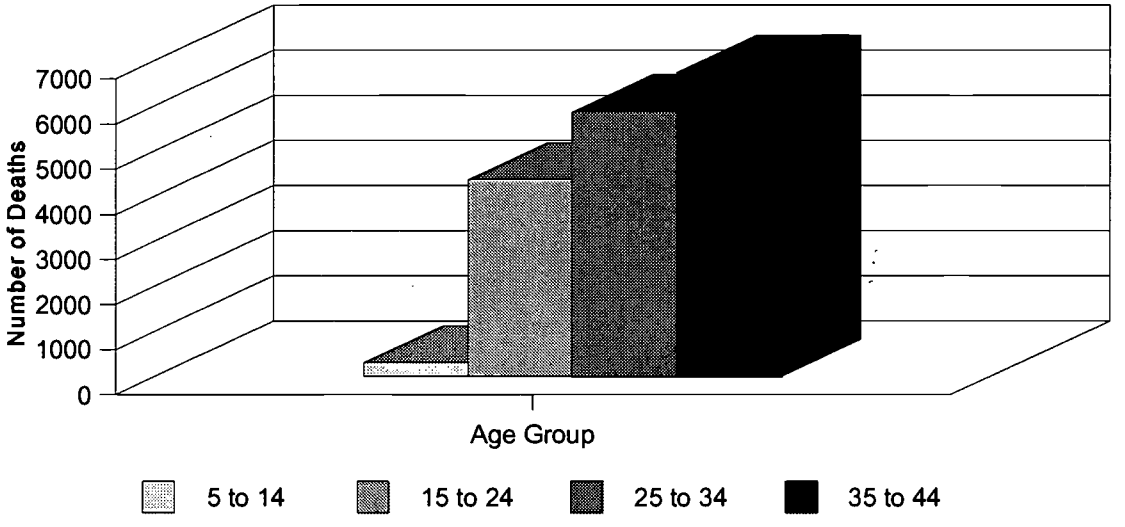
Note: All references from the Surgeon General's Report are included in the reference section of this sampler.

Vital Statistics

Suicide is the third leading cause of death for teenagers 14-24 years old (after unintentional injury and homicide). Suicide rates are increasing for children 14 years and younger.

-National Institute of Mental Health

SUICIDE DEATHS in the US (US National Vital Statistics Report, 1996 data)



MORE STATISTICS

In addition to completed suicides, suicidal ideation (thoughts about hurting or killing oneself) and suicide attempts are quite prevalent in youth. Based on 1997 data from the Center for Disease Control's Youth Risk Behavior Survey, a representative sample of over 16,000 9th through 12th graders) revealed:

20.5% had thought seriously about attempting suicide in the last year
15.7% had made a specific plan to commit suicide in the last year
7.7% reported one or more actual suicide attempts in the last year
2.6% reported a suicide attempt that resulted in injury or poisoning requiring medical attention in the last year

Among persons aged 15-19 years firearm-related suicides accounted for 81% of the increase in the overall rate of suicide from 1980-1992

-National Center for Injury Prevention and Disease Control

Girls are more likely to experience suicidal ideation, create a suicide plan, and make a suicide attempt than boys. However, in all age groups, boys successfully complete suicide more often than girls (the ratio is about 5:1 to 7:1).

-National Institute of Mental Health

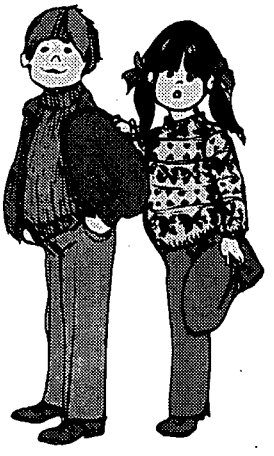
Lesbian and gay youth are 2-6 times more likely to attempt suicide than other youth and account for up to 30% of all completed teen suicides.

-US Department of Health and Human Services

In one study of 229 completed youth suicides,

- **62% had made a remark about suicide prior to the act**
- **45% had consumed or probably consumed alcohol within 12 hours of death (although alcohol was not the immediate cause of death)**
- **76% had experienced a decline in academic performance over the past year**

-Hoberman & Garfinkel (1988)



COMMON MYTHS ABOUT SUICIDE

From: Helping your suicidal child: A chapter for parents. BY: A.A. Leenaars (1993). In *The Cruelest Death*, edited by D. Lester. Charles Press, Philadelphia.

Fable: People who talk about suicide don't commit suicide.

Fact: Of every 10 persons who kill themselves, 8 have given definite advance verbal warning of their suicidal intentions

Fable: Suicide usually happens without warning.

Fact: Many studies have revealed that the suicidal person gives many clues and warnings regarding his suicidal intentions. This is not to say that all suicidal people always give warnings.

Fable: Suicidal people fully intend to die.

Fact: Most suicidal people are undecided about whether they really want to live or die. Sometimes when they attempt suicide they are "gambling with death," and leave it to others to perhaps save them.

Fable: Once a person is suicidal, (s)he is suicidal forever.

Fact: Individuals who wish to kill themselves are suicidal only for a limited period of time. In other words, it is almost always a temporary state.

Fable: Improvement after a suicidal crisis has occurred means the suicidal risk is over.

Fact: Most suicides occur within about 3 months following the beginning of "improvement," when the individual has the energy to put his morbid thoughts and feelings into effect.

Fable: Suicide is more common among the rich--or, conversely, it occurs mostly among the poor.

Fact: Suicide is neither a rich man's disease nor the poor man's curse. Suicide is very "democratic" and is represented proportionately among all levels of society.

And let's add one more:

Myth: Asking an individual about suicidal thoughts, plans, and prior attempts will put ideas into the head of an individual who was not previously suicidal.

Fact: There is no evidence that asking an individual about suicidal ideation will increase the chance that the individual will commit suicide.

A General Model of Youth Suicide

From:
***Children, Youth, and Suicide: Developmental Perspectives* (1994).**
By:
Gil G. Noam & Sophie Borst (Eds.). Jossey-Bass.

One model of youth suicide proposes that suicidal ideation occurs when a number of risk factors (biological, psychological, cognitive, and environmental) interact with one another *and* triggering event(s) to produce suicidal ideation or warning signs that can lead to a trajectory of suicidal behavior.

The following figure and table, taken from Stillion, McDowell, and May (1989)*, illustrate some developmental commonalities as well as childhood vs. adolescent idiosyncracies of suicide trajectory (i.e., risk factors, warning signs, and triggering events).

* Sillion, J. M., McDowell, E. E., & May, J. H. (1989). Suicide Across the Life Span: Premature Exits. Taylor & Francis.

Excerpts from Noam and Borst (1994):

Suicide Trajectory Model

The suicide trajectory model, based on a review of the research and theoretical literature pertaining to suicide in difference age groups (Stillion, McDowell, and May, 1989), is shown in Figure 1.1. This model suggests that there are four major categories of risk factors that contribute to suicidal behavior at every age: biological, psychological, cognitive, and environmental. As the arrows indicate, each of these categories of risk factors may directly influence suicidal ideation and may affect other categories of risk factors. For example, having a biological inclination toward depression can directly affect suicidal ideation and, at the same time, cause an individual to develop low self-esteem and to interpret environmental events selectively in a negative fashion. Likewise, poor environmental conditions, such as an abusive home, can elicit suicidal ideation and also may be a starting point for low self-esteem.

Figure 1.1. (from Stillion, McDowell, & May, 1989, p. 240)

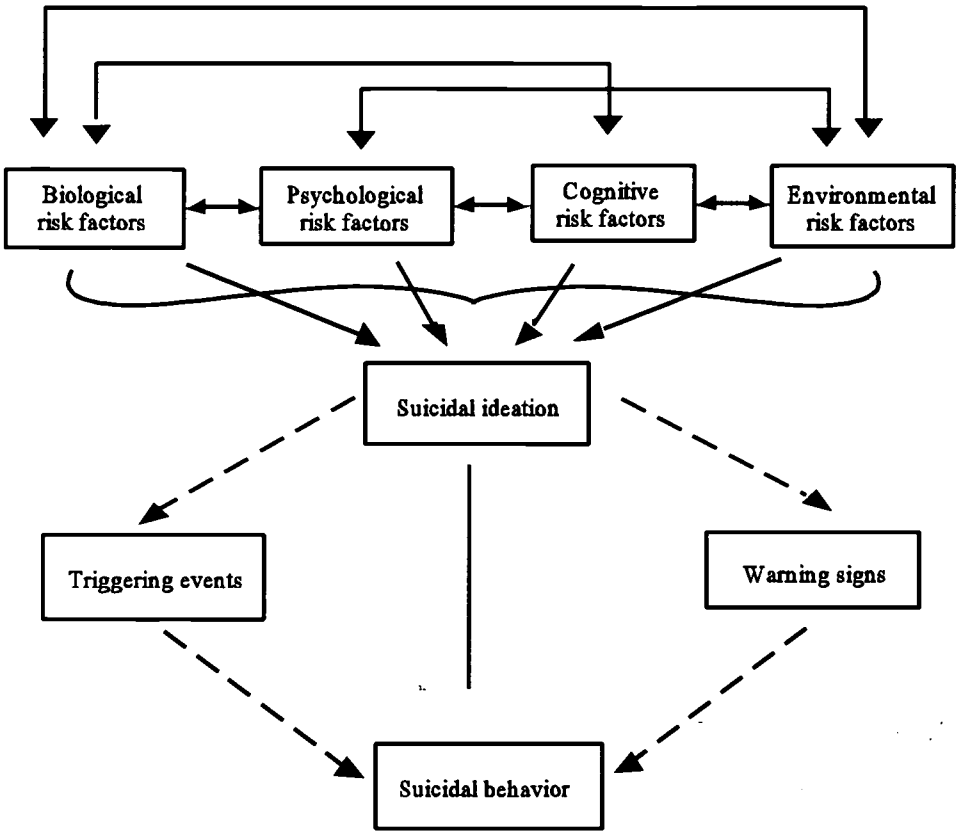


Table 1.2. Life-Cycle Commonalities and Age-Group-Specific Aspects of the Suicide Trajectory for Childhood and Adolescence

Age Group	*Biological Risk Factors*	*Psychological Risk Factors*	*Cognitive Risk Factors*	*Environmental Risk Factors*	*Warning Signs*	*Triggering Events*
Life-cycle commonalities	Depression Genetic factors Maleness	Depression Low self-esteem Helplessness Hopelessness	Rigidity of thought Selective abstraction Overgeneralization Inexact labeling	Negative family experiences Negative life events Presence of firearms	Verbal threats Previous suicide attempts	"Final straw" life event
Childhood (5-14 years old)	Impulsivity	Feelings of inferiority Expendable child syndrome	Immature views of death Concrete operational thinking	Abuse and neglect Inflexible family structure Unclear family member roles Parent conflict	Truancy Poor school performance Anxiety Sleep disturbance Aggression Low frustration tolerance Impulsiveness	Minor life events
Adolescence (15-24 years old)	Puberty Hormonal changes	Identity crisis Fluctuating mood states	Formal operational thinking Idealistic thinking Increased egocentrism Imaginary audience Illusion of invulnerability	Parent conflict Anomic family Drug or alcohol abuse Social isolation Poor peer relationships Population characteristics	Change in habits Self-mutilation Truancy Poor school performance Preparation for death	Failure experiences Problems with peers, parents, siblings, or opposite sex Suicides by peers or famous people

from Stillion, McDowell, and May (1989), p. 244

ABOUT PREVENTION

The following excerpt is taken from "The Surgeon General's Call to Action to Prevent Suicide, 1999" and can be found at: http://www.surgeongeneral.gov/osg/calltoaction

Surgeon General's Blueprint for Preventing Suicide

The Surgeon General's Call to Action introduces an initial blueprint for reducing suicide and the associated toll that mental and substance abuse disorders take in the United States. As both evidence-based and highly prioritized by leading experts, these 15 key recommendations listed below should serve as a framework for immediate action. These recommended first steps are categorized as Awareness, Intervention, and Methodology, or AIM.

Awareness: Appropriately broaden the public's awareness of suicide and its risk factors

Intervention: Enhance services and programs, both population-based and clinical care

Methodology: Advance the science of suicide prevention.

Awareness: Appropriately broaden the public's awareness of suicide and its risk factors

- Promote public awareness that suicide is a public health problem and, as such, many suicides are preventable. Use information technology appropriately to make facts about suicide and its risk factors and prevention approaches available to the public and to health care providers.
- Expand awareness of and enhance resources in communities for suicide prevention programs and mental and substance abuse disorder assessment and treatment.
- Develop and implement strategies to reduce the stigma associated with mental illness, substance abuse, and suicidal behavior and with seeking help for such problems.

Intervention: Enhance services and programs, both population-based and clinical care

- Extend collaboration with and among public and private sectors to complete a National Strategy for Suicide Prevention.
- Improve the ability of primary care providers to recognize and treat depression, substance abuse, and other major mental illnesses associated with suicide risk. Increase the referral to specialty care when appropriate.
- Eliminate barriers in public and private insurance programs for provision of quality mental and substance abuse disorder treatments and create incentives to treat patients with coexisting mental and substance abuse disorders.

- Institute training for all health, mental health, substance abuse and human service professionals (including clergy, teachers, correctional workers, and social workers) concerning suicide risk assessment and recognition, treatment, management, and aftercare interventions.

- Develop and implement effective training programs for family members of those at risk and for natural community helpers on how to recognize, respond to, and refer people showing signs of suicide risk and associated mental and substance abuse disorders. Natural community helpers are people such as educators, coaches, hairdressers, and faith leaders, among others.

- Develop and implement safe and effective programs in educational settings for youth that address adolescent distress, provide crisis intervention and incorporate peer support for seeking help.

- Enhance community care resources by increasing the use of schools and workplaces as access and referral points for mental and physical health services and substance abuse treatment programs and provide support for persons who survive the suicide of someone close to them.

- Promote a public/private collaboration with the media to assure that entertainment and news coverage represent balanced and informed portrayals of suicide and its associated risk factors including mental illness and substance abuse disorders and approaches to prevention and treatment.

Methodology: Advance the science of suicide prevention

- Enhance research to understand risk and protective factors related to suicide, their interaction, and their effects on suicide and suicidal behaviors. Additionally, increase research on effective suicide prevention programs, clinical treatments for suicidal individuals, and culture-specific interventions.

- Develop additional scientific strategies for evaluating suicide prevention interventions and ensure that evaluation components are included in all suicide prevention programs.

- Establish mechanisms for federal, regional, and state interagency public health collaboration toward improving monitoring systems for suicide and suicidal behaviors and develop and promote standard terminology in these systems.

- Encourage the development and evaluation of new prevention technologies, including firearm safety measures, to reduce easy access to lethal means of suicide.

Why should schools get involved?

"Children are...much more likely to come into contact with potential rescuers in the school than they are in other community settings. This is especially true for younger children, who cannot move freely in the community. In many instances, the child's problems, particularly those related to academics or the peer group, are more evident in the school setting than they are in the home...Further, the characteristic problems of a broken home or dysfunctional family, while not necessarily a direct cause of suicidal behavior, reduce the possibility of rescue in that setting." (Guetzloe, 1991, p. 11)

School and community prevention programs designed to address suicide and suicidal behavior as part of a broader focus on mental health, coping skills in response to stress, substance abuse, aggressive behaviors, are most likely to be successful in the long run.

-National Institute of Mental Health

ON PREVENTION

According to Shaffer, Garland, Gould, Fisher, and Trautman (1988), school-based suicide prevention programs tend to have the following goals in common:

1. Heighten awareness of the problem
2. Promote case finding (i.e., teaching teachers and especially other students to identify those who are at risk; increase disclosure of suicidal ideation by decreasing stereotypes that may cause stigma
3. Provide staff and students with information about mental health resources--specifically how they operate and how they can be accessed
4. Improve teenagers' coping abilities by training in stress management or coping strategies

The following excerpt is from Sandoval, Davis, & Wilson, 1987, pp. 105-106:

A distinction is usually drawn between primary prevention which is aimed at the entire population, and secondary prevention which is aimed at those individuals who are at risk.

Primary Prevention

School personnel may work with the entire student body on suicide prevention by routinely including units on this topic in the curriculum at various levels, particularly in secondary schools; or they may institute discussions or modules at a time when there is some currency to the topic. Examples of opportune times are when a child in the school has committed suicide or made an attempt and has come to the notice of the student body at large. Other opportunities for primary prevention may be stimulated by the airing of television programs or movies which become popular and are seen by large numbers of students in a school. Primary prevention is usually accomplished in group settings using pre-planned curriculum material...

Secondary Prevention

Working with students who are at risk of attempting suicide constitutes secondary prevention. The individual most at risk is one who has attempted suicide in the past, but other students experiencing loss or shame are also at risk. Secondary prevention is likely to occur in individual or small group sessions and takes place as needed when risk factors build.

The Pros and Cons of General Education Programs

There is a dearth of research evaluating youth suicide programs. Most of this research has focused on evaluating general education programs. In these programs, students are generally taught about suicide facts (and dispel myths), warning signs and risk factors, and provided information about mental health resources should they or one of their peers become suicidal. A small handful of general education programs focus on coping skills to deal with stressful situation. On average, these programs last 2 hours and have typically been integrated into the curricula of health classes. The research findings regarding the efficacy of these programs have been mixed. First, some researchers have found that students tend to already be fairly knowledgeable about warning signs and youth suicide (e.g., Garland, Shaffer, & Whittle, 1989; Kalafat & Elias, 1994). Nevertheless, many studies have found increases in knowledge about facts and warning signs of suicide after completing general education programs compared to control group students. Moreover, students who participated in these programs tend to know more about mental health referral sources than their control group counterparts. A few studies have found positive changes in self-reported attitudes about coping skills in reaction to stress, hopelessness, and depression.

Despite these potential benefits, research suggests that general education programs may not be as effective as school personnel and mental health professionals would hope. For instance, many studies have found that while general education programs may increase students' general knowledge about suicide and warning signs, they do little to change students' attitudes about

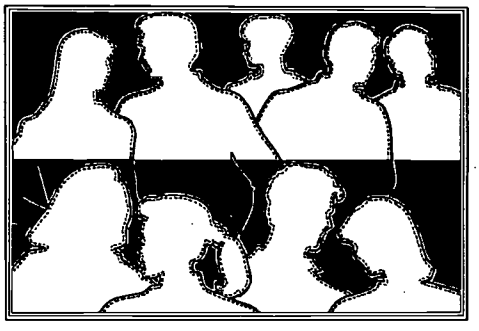
suicide and help-seeking behaviors. This finding has held despite efforts such as using better trained instructors or more sensitive instruments. Furthermore, researchers have primarily examined suicide knowledge and attitudes and have not looked at actual behaviors.

While there is little evidence, in general, for increases in suicidal behavior or ideation in participants of general education programs, at least one large study found disconcerting iatrogenic effects of these programs on students who are at risk for suicide. More specifically, it found that those students who reported a previous suicide attempt tended to not find the program helpful. Moreover, a greater proportion of previous attempters who had completed the program, compared to attempters who had not experienced the program, reported that they would not want to reveal suicidal ideation to others, believed that they could not be helped by a mental health profession, and stated that suicide was a reasonable solution to their problems (Garland, Shaffer, & Whittle, 1988).

Thus, according to the CDC (1992), "Person's considering school-based general suicide education as a prevention strategy should also recognize that not all curricula are necessarily well-conceived. Some curricula are quite sensational, and thus may foster psyched contagion. Other curricula tend to 'normalize' suicide in a manner that some researchers fear will promote suicidal thinking by lessening whatever protective effects may derive from the social 'taboo' associated with suicide. Still other curricula inadvertently provide teens with clear 'how-to' instructions for committing suicide..."

Many suicide researchers believe that broad-based primary prevention programs focusing on health enhancement may be of greater value than programs that address only suicide.

-Center for Disease Control



ON ASSESSING SUICIDE RISK

- Identifying and Addressing Risk
- Risk and protective factors
- Suicide Assessment--Checklist
- Follow-through Steps After Assessing for Suicidal Risk--Checklist
- Criteria for diagnosis

The following excerpts ("Identifying and Addressing Risk" and "The Public Health Approach") are taken from "The Surgeon General's Call to Action to Prevent Suicide, 1999" and can be found at: http://www.surgeongeneral.gov/osg/calltoaction

Identifying and Addressing Risk

Unfortunately, it is difficult to identify particular individuals at greatest risk for suicidal behaviors or completed suicide. Measures to screen the general population for suicide risk lack the precision needed to identify in advance only those people who eventually would die by suicide. Because suicide screening in the general population currently is not feasible, it is especially important for suicide prevention programs to include broader approaches that benefit the whole population as well as efforts focused on smaller, high-risk subgroups that can be identified. Within those subgroups, a different approach to screening — screening programs for specific disorders, like depression, that are associated with suicide— can be used to identify and direct people to highly effective treatments that may lower their risk of suicide.

Often, the suicide prevention efforts in place are directed primarily at improving clinical care for the individual already struggling with suicidal ideas or the individual requiring medical attention for a suicide attempt. Suicide prevention also demands approaches that reduce the likelihood of suicide before vulnerable individuals reach the point of danger. Applying the public health approach to the problem of suicide in the United States will maximize the benefits of efforts and resources for suicide prevention.

The Public Health Approach

Suicide is a public health problem that requires an evidence-based approach to prevention. In concert with the clinical medical approach, which explores the history and health conditions that could lead to suicide in a single individual, the public health approach focuses on identifying and understanding patterns of suicide and suicidal behavior throughout a group or population. The public health approach defines the problem, identifies risk factors and causes of the problem, develops interventions evaluated for effectiveness, and implements such interventions widely in a variety of communities.[48,49]

Although this description suggests a linear progression from the first step to the last, in reality the steps occur simultaneously and depend on each other. For example, systems for gathering information to define the exact nature of the suicide problem may also be useful in evaluating programs. Similarly, information gained from program evaluation and implementation may lead to new and promising interventions. Public health has traditionally used this model to respond to epidemics of infectious disease. During the past few decades, the model has also been used to address other problems that are likewise complicated and challenging to prevent, such as chronic disease and injury.

(continued on the next page)

The Public Health Approach Applied to Suicide Prevention

Defining the Problem

The first step includes collecting information about incidents of suicide and suicidal behavior. It goes beyond simple counting. Information is gathered on characteristics of the persons involved, the circumstances of the incidents, events that may have precipitated the act, the adequacy of support and health services received, and the severity and cost of the injuries. This step covers the who, what, when, where, how, and how many of the identified problem.

Identifying Causes and Protective Factors

The second step focuses on why. It addresses risk factors such as depression, alcohol and other drug use, bereavement, or job loss. This step may be used to define groups of people at higher risk for suicide. Many questions remain, however, about the interactive matrix of risk and protective factors in suicide and suicidal behavior and, more importantly, how this interaction can be modified.

Developing and Testing Interventions

The next step involves developing approaches to address the causes and risk factors that have been identified. Testing the effectiveness of each approach is a critical part of this step to ensure that strategies are safe, ethical, and feasible. Pilot testing, which may reveal differences among particular age, gender, ethnic and cultural groups, can help determine for whom a suicide prevention strategy is best fitted.

Implementing Interventions

The final step is to implement interventions that have demonstrated effectiveness in preventing suicide and suicidal behavior. Implementation requires data collection as a means to continue evaluating effectiveness of an intervention. This is essential because an intervention that has been found effective in a clinical trial or academic study may have different outcomes in other settings. Ongoing evaluation builds the evidence base for refining and extending effective suicide prevention programs. Determination of an intervention's cost-effectiveness is another important component of this step. This ensures that limited resources can be used to achieve the greatest benefit.

As interventions for preventing suicide are developed and implemented, communities must consider several key factors. Interventions have a much greater likelihood of success if they involve a variety of services and providers. This requires community leaders to build effective coalitions across traditionally separate sectors, such as the health care delivery system, the mental health system, faith communities, schools, social services, civic groups, and the public health system. Interventions must be adapted to support and reflect the experience of survivors and specific community values, cultures, and standards. They must also be designed to benefit from multi-ethnic and culturally diverse participation from all segments of the community.

As it evolves, America's National Strategy for Suicide Prevention must recognize and affirm the value, dignity, and importance of each person. Everyone concerned with suicide prevention shares the responsibility to help change and eliminate the societal conditions and attitudes that often contribute to suicide. Individuals, communities, organizations, and leaders at all levels should collaborate in promoting suicide prevention. Final development of a National Strategy for Suicide Prevention and the success of these essential action steps ultimately rest with individuals and communities and institutions and policy makers across the United States.

The following excerpt is taken from "The Surgeon General's Call to Action to Prevent Suicide, 1999" and can be found at: http://www.surgeongeneral.gov/osg/calltoaction

RISK AND PROTECTIVE FACTORS

Risk Factors

Understanding risk factors can help dispel the myths that suicide is a random act or results from stress alone. Some persons are particularly vulnerable to suicide and suicidal self-injury because they have more than one mental disorder present[40], such as depression with alcohol abuse[41]. They may also be very impulsive and/or aggressive[42], and use highly lethal methods to attempt suicide. As noted above, the importance of certain risk factors and their combination vary by age, gender, and ethnicity.

The impact of some risk factors can be reduced by interventions (such as providing effective treatments for depressive illness).[31,43] Those risk factors that cannot be changed (such as a previous suicide attempt) can alert others to the heightened risk of suicide during periods of the recurrence of a mental or substance abuse disorder, or following a significant stressful life event.[31,44]

Risk factors include:

- ✓ Previous suicide attempt
- ✓ Mental disorders — particularly mood disorders such as depression and bipolar disorder
- ✓ Co-occurring mental and alcohol and substance abuse disorders
- ✓ Family history of suicide
- ✓ Hopelessness
- ✓ Impulsive and/or aggressive tendencies
- ✓ Barriers to accessing mental health treatment
- ✓ Relational, social, work, or financial loss
- ✓ Physical illness
- ✓ Easy access to lethal methods, especially guns
- ✓ Unwillingness to seek help because of stigma attached to mental and substance abuse disorders and/or suicidal thoughts
- ✓ Influence of significant people—family members, celebrities, peers who have died by suicide—both through direct personal contact or inappropriate media representations
- ✓ Cultural and religious beliefs—for instance, the belief that suicide is a noble resolution of a personal dilemma
- ✓ Local epidemics of suicide that have a contagious influence
- ✓ Isolation, a feeling of being cut off from other people

Some lists of warning signs for suicide have been created in an effort to identify and increase the referral of persons at risk. However, the warning signs given are not necessarily risk factors for suicide and may include common behaviors among distressed persons, behaviors that are not specific for suicide. If such lists are applied broadly, for instance in the general classroom setting, they may be counterproductive. In effect, indiscriminate suicide awareness efforts and overly inclusive screening lists may promote suicide as a possible solution to ordinary distress or suggest that suicidal thoughts and behaviors are normal responses to stress.[45] Efforts must be made to avoid normalizing, glorifying, or dramatizing suicidal behavior, reporting how-to methods, or describing suicide as an understandable solution to a traumatic or stressful life event. Inappropriate approaches could potentially increase the risk for suicidal behavior in vulnerable individuals, particularly youth.[46,47]

Protective Factors

Protective factors can include an individual's genetic or neurobiological makeup, attitudinal and behavioral characteristics, and environmental attributes.[31] Measures that enhance resilience or protective factors are as essential as risk reduction in preventing suicide. Positive resistance to suicide is not permanent, so programs that support and maintain protection against suicide should be ongoing.

Protective factors include:

Effective and appropriate clinical care for mental, physical, and substance abuse disorders
Easy access to a variety of clinical interventions and support for help seeking
Restricted access to highly lethal methods of suicide
Family and community support
Support from ongoing medical and mental health care relationships
Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
Cultural and religious beliefs that discourage suicide and support self-preservation instincts

The risk factors that lead to suicide (especially mental and substance abuse disorders) and the protective factors that safeguard against it form the conceptual framework for the prevention recommendations developed and presented in this document and in the evolving National Strategy for Suicide Prevention.

A Few Examples of Assessing Risk...

EVALUATION OF SUICIDE RISK AMONG ADOLESCENTS

This is an evaluation form for one-on-one assessment of suicide risk for adolescents. Included are sections on current suicidal ideation and behavior, personal and family history of suicidal behavior, precipitating events, and warning signs. Suicide risk scoring instructions are provided. "Imminent Danger Assessment" and "Plan of Action" forms are included as follow-up materials.

Source: Mary Jane Rotheram-Borus & Jon Bradley
Columbia University, Division of Child Psychiatry
Research Foundation for Mental Hygiene
722 West 168th Street
New York, NY 10032
(212) 960-2548

A MEASURE OF ADOLESCENT POTENTIAL FOR SUICIDE (MAPS)

This journal article describes an assessment instrument designed to address suicide potential of youth ages 14-18, who are at risk for suicidal behaviors. Qualities of the scale are evaluated.

Source: L. L. Eggart, et al. (1994). A measure of adolescent potential for suicide (MAPS): Development and preliminary findings. Suicide and Life Threatening Behavior, 24 (4), 359-381.

SUICIDAL ASSESSMENT – CHECKLIST*

Student's Name:_____ Date:_____ Interviewer: _____

(Suggested points to cover with student/parent)

(1) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH

Does the individual have frequent suicidal thoughts? Y N

Have there been suicide attempts by the student or significant others in his or her life? Y N

Does the student have a detailed, feasible plan? Y N

Has s/he made special arrangements as giving away prized possessions? Y N

Does the student fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife? Y N

(2) REACTIONS TO PRECIPITATING EVENTS

Is the student experiencing severe psychological distress? Y N

Have there been major changes in recent behavior along with negative feelings and thoughts? Y N

(Such changes often are related to recent loss or threat of loss of significant others or of positive status and opportunity. They also may stem from sexual, physical, or substance abuse. Negative feelings and thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes inwardly directed anger.)

(3) PSYCHOSOCIAL SUPPORT

Is there a lack of a significant other to help the student survive? Y N

Does the student feel alienated? Y N

(4) HISTORY OF RISK-TAKING BEHAVIOR

Does the student take life-threatening risks or display poor impulse control? Y N

*Use this checklist as an exploratory guide with students about whom you are concerned. Each yes raises the level of risk, but there is no single score indicating high risk. A history of suicide attempts, of course, is a sufficient reason for action. High risk also is associated with very detailed plans (when, where, how) that specify a lethal and readily available method, a specific time, and a location where it is unlikely the act would be disrupted. Further high risk indicators include the student having made final arrangements and information about a critical, recent loss. Because of the informal nature of this type assessment, it should not be filed as part of a student's regular school records.

FOLLOW-THROUGH STEPS AFTER ASSESSING SUICIDAL RISK -- CHECKLIST

____(1) As part of the process of assessment, efforts will have been made to discuss the problem openly and nonjudgmentally with the student. (Keep in mind how seriously devalued a suicidal student feels. Thus, avoid saying anything demeaning or devaluing, while conveying empathy, warmth, and respect.) If the student has resisted talking about the matter, it is worth a further effort because the more the student shares, the better off one is in trying to engage the student in problem solving.

___(2) Explain to the student the importance of and your responsibility for breaking confidentiality in the case of suicidal risk. Explore whether the student would prefer taking the lead or at least be present during the process of informing parents and other concerned parties.

___(3) If not, be certain the student is in a supportive and understanding environment (not left alone/isolated) while you set about informing others and arranging for help.

___(4) Try to contact parents by phone to

a) inform about concern
b) gather additional information to assess risk
c) provide information about problem and available resources
d) offer help in connecting with appropriate resources

Note: if parents are uncooperative, it may be necessary to report child endangerment after taking the following steps.

____(5) If a student is considered to be in danger, only release her/him to the parent or someone who is equipped to provide help. In high risk cases, if parents are unavailable (or uncooperative) and no one else is available to help, it becomes necessary to contact local public agencies (e.g., children's services, services for emergency hospitalization, local law enforcement). Agencies will want the following information:

*student's name/address/birthdate/social security number
*data indicating student is a danger to self (see Suicide Assessment -- Checklist)
*stage of parent notification
*language spoken by parent/student
*health coverage plan if there is one
*where student is to be found

____(6) Follow-up with student and parents to determine what steps have been taken to minimize risk.

____(7) Document all steps taken and outcomes. Plan for aftermath intervention and support.

____(8) Report child endangerment if necessary.

Suicidal ideation can be a symptom of depression. At the same time, other symptoms of depression can serve as warning signs for suicidal ideation...

CRITERIA FOR DIAGNOSIS OF MAJOR DEPRESSIVE EPISODE

(Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), American Psychiatric Association, 1994)

Five or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

(1) depressed mood most of the day, nearly every day, as indicated by either subjected report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restless or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

Culture and age considerations: In some cultures, depression may be expressed through somatic symptoms. In addition, somatic complaints, irritability, and social withdrawal tend to be especially common in children, whereas psychomotor retardation, hypersomnia, and delusions are less common in children than adolescents.

ON PREVENTION ACTIVITIES

- Responding to Suicidal Crisis
- Training Programs for:
  - Community Members
  - Teachers and School Staff
- Counseling Approaches

RESPONDING TO SUICIDAL CRISIS

(from the UCLA Center for Mental Health in Schools newsletter, winter, 1997)

In developing our Center's Resource Aid Packet on *Responding to Crisis at a School,* we were impressed by the good work being done by so many people around the country. The unfortunate fact that so many students feel despair and consider suicide has resulted in important common practices at school sites.

Changing systems in schools to support students and reduce unnecessary stress is the first line of defense. However, when concerns arise about a specific student, school staff must be ready to respond. The suicide assessment and follow-through checklists on pages 10 and 11 are a compilation of best practices and offer tools to guide intervention.

When a Student Talks of Suicide . . .

You must assess the situation and reduce the crisis state (see accompanying Suicidal Assessment Checklist). The following are some specific suggestions.

What to do:

- Send someone for help; you'll need back-up.
- Remain calm; remember the student is overwhelmed and confused as well as ambivalent.
- Get vital statistics, including student's name, address, home phone number and parent's work number.
- Encourage the student to talk. Listen! Listen! Listen! And when you respond, reflect back what you hear the student saying. Clarify, and help him or her to define the problem, if you can.

Consider that the student is planning suicide. How does the student plan to do it, and how long has s/he been planning and thinking about it? What events motivated the student to take this step?

- Clarify some immediate options (e.g., school and/or community people who can help).
- If feasible, get an agreement to no-suicide ("No matter what happens, I will not kill myself.")
- Involve parents for decision making and follow-through and provide for ongoing support and management of care (including checking regularly with parents and teachers).

What to avoid:

- Don't leave the student alone and don't send the student away
- Don't minimize the student's concerns or make light of the threat
- Don't worry about silences; both you and the student need time to think
- Don't fall into the trap of thinking that all the student needs is reassurance
- Don't lose patience
- Don't promise confidentiality -- promise help and privacy
- Don't argue whether suicide is right or wrong

When a Student Attempts Suicide . . .

A student may make statements about suicide (in writing assignments, drawing, or indirect verbal expression). Another may make an actual attempt using any of a variety of means. In such situations, you must act promptly and decisively.

What to do:

- Be directive. Tell the student, "Don't do that; stand there and talk with me." "Put that down." "Hand me that." "I'm listening."
- Mobilize someone to inform an administrator and call 911; get others to help you; you'll need back-up.
- Clear the scene of those who are not needed.
- An "administrator" should contact parents to advise them of the situation and that someone will call back immediately to direct the parent where to meet the youngster.
- Look at the student directly. Speak in a calm, low voice tone. Buy time. Get the student to talk. Listen. Acknowledge his or her feelings "You are really angry." "You must be feeling really hurt."
- Secure any weapon or pills; record the time any drugs were taken to provide this information to the emergency medical staff or police.
- Get the student's name, address and phone.
- Stay with the pupil; provide comfort.
- As soon as feasible, secure any suicidal note, record when the incident occurred, what the pupil said and did, etc.
- Ask for a debriefing session as part of taking care of yourself after the event.

What to avoid:

- Don't moralize ("You're young, you have everything to live for.")
- Don't leave the student alone (even if the student has to go to the bathroom).
- Don't move the student.

In all cases, show concern and ask questions in a straightforward and calm manner. Show you are willing to discuss suicide and that you aren't appalled or disgusted by it. Open lines of communication. Get care for the student.

Training programs for community members

From: Youth Suicide Prevention Programs: A Resource Guide
U.S Department of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Injury Prevention and Control
Publication date: 09/01/1992
http://wonder.cdc.gov/wonder/prevguid/p0000024/entire.htm

The goal of these programs is to train community members to identify young people at risk of suicidal behaviors and to refer them to appropriate sources of help. Most of these programs provide both training and informational materials for parents, teachers, counselors, health-care professionals, clergy, policemen and the general public.

Adolescent Suicide Awareness Program (ASAP)
Contact:
Adolescent Suicide Awareness Program (ASAP)
Diane Ryerson, MSW, Director,
Counseling and Education Services
South Bergen Mental Health Center
516 Valley Brook Avenue
Lyndhurst, NJ 07071
(201) 935-3322
Targets: Police, clergy, emergency room personnel, staff of pediatricians' and family practice physicians' offices.
Years in operation: 9
Description: ASAP sponsors a basic training curriculum for police recruits, a 1.5-hour awareness program for all municipal and county police, and an intensive program for juvenile officers. A multitiered training program will be established for clergy, involving seminarians, parochial school teachers, funeral directors, and youth ministers. To supplement instructional units, a "Clergy Specific" information package will be developed and widely distributed. Police were trained in identifying, managing, and obtaining professional help for suicidal teenagers. Specific operating procedures were provided Clergy were trained in crisis intervention skills and increased information, especially in regard to identifying warning signs, will equip clergy with a focused, more effective approach to counseling troubled teens and their families.

Adolescent Suicide Awareness Program (ASAP) -- "Don't Say Goodbye" Media Campaign
Targets: Middle school and high school students, parents, educators, general public, dropouts.
Years in operation: 1
Description: Multimedia public mental health education campaign encourages teens and adults to recognize youths at risk and get them professional help by calling a county psychiatric crisis phone number. Phase 1: Set of six posters, wallet cards, brochures, print ads, and bill boards. Phase 2: Six TV and four radio spots.

Youth Suicide Prevention Program

Contact:

Youth Suicide Prevention Program
Evelyn Hatfield, Youth Suicide Prevention Specialist
Prince William County Community Services Board
Prevention Branch (PWCCSB-PB)
8033 Ashton Avenue
Manassas, VA 22110
(703) 792-7730

Targets: Students, parents, professionals, and the general public of Prince William County.

Years in operation: 4

Description: This is a comprehensive community program aimed at promoting positive mental health attitudes. Program staff members train school personnel how to identify and help suicidal youths and help them to develop crisis teams. They will also conduct suicide prevention classes and provide postvention support when asked. Program staffers already work with junior and senior high schools and are starting to move into elementary schools.

There is also a community group on suicide prevention called the "Prince William Youth Suicide Prevention Coalition," whose activities include an annual "Love Life Day" and the providing of grants to schools to establish prevention activities. Another component is a student group ("Friends Are Needed" (FAN) Club) concerned with suicide prevention. School representatives attend training sessions to learn how to initiate suicide prevention programs in their schools. In addition, the coalition produces parent and teen directories of warning signs, actions to take, and sources of help, and is involved in legislative efforts to limit methods of committing suicide.

LivingWorks Education, Inc.

Contact:

Bryan Tanney, M.D.
LivingWorks Education, Inc.
Suite 704 300 Meredith Road, NE
Calgary, Alberta T2E 7A8
Canada
(403) 242-3397; FAX (403) 268-9201

Targets: Community members, employee assistance staff, mental health caregivers, police, corrections agency personnel, school personnel (at all levels of expertise).

Years in operation: 10

Description: The core of this program is the Intervention Workshop, originally modeled after the American Heart Association's 'Heart Saver' Program. Based on an adult education model of continuing professional education, the program is designed for all caregiver groups, including, but not limited to, often under-served community "gatekeepers." Its content is fully described in the Suicide Intervention Skills Workshop of the California Department of Mental Health also included in this chapter. A "Training for Trainers" course certifies trainers to present the workshop and other components of the program. Other activities are integrated with the workshop presentation and include sensitization and awareness education, bereavement intervention training, advanced treatment seminars, and refresher training.

The core program is a 2-day workshop on emergency first aid in suicide intervention. The first day covers issues related to attitudes and knowledge about suicide. The second day focuses on modeling and

practicing intervention skills.

The trainer's program is a 5-day course on instructing the Intervention Workshop. Certified trainers are provided with trainer handbooks, manuals, workshop handouts, audiovisual aids, and ongoing consultation support.

Sensitization materials for community-wide distribution include pamphlets and an audiovisual.

The Awareness Program, intended for a general public audience, can vary from an hour to a day. Different modules cover definition of suicide, magnitude of the problem, warning signs, first aid hints, and policy and program issues. Interested presenters are provided a manual complete with suggested scripts and slides. There is also instructional design information for building additional topic modules.

The bereavement training and the advanced treatment seminars and workshops are l-day sessions. Refresher training incorporates workshop activities, a helper's handbook, and various self-directed learning activities using audiovisuals.

Suicide Intervention Skills Workshop

Contact:

David Neilsen, MSW, Program Coordinator,
California Department of Mental Health
Suicide Prevention Project Division of Community Programs
Room 250 1600 Ninth Street
Sacramento, CA 95814
(916) 323-9296

Targets: Community members, mental health personnel, school personnel, social services personnel, and law enforcement officers.

Years in operation: 5

Description: The "Suicide Intervention Skills Workshop" is identical to the "Intervention Workshop" of LivingWorks Education, Inc., Calgary, Alberta, also described in this chapter. The curriculum features a series of large and small group activities, minilectures, audiovisuals, and role playing exercises designed to help people increase both their abilities and level of confidence when working with suicidal individuals. The workshop includes 14 hours of learning experiences. The first day focuses upon the examination of caregivers' attitudes and specific assessment skills. The second day concentrates upon intervention strategies and skill building through the use of large group simulations and small group role plays that involve all participants.

The workshop presents a forum where participants are encouraged to examine suicide intervention from a number of perspectives involving their attitudes, knowledge, and skills. The workshop presents a specific intervention model with detailed descriptions of key tasks and techniques. The training emphasizes how caregivers are to engage persons at risk while doing accurate assessments for risk. A key feature of the intervention model is the exploration of ambivalence and how this exploration assists in the discussion of resources and the formation of an appropriate action plan to prevent suicide.

An important objective of the workshop is to increase the participants' awareness of community resources and networks, and their value. Participants learn about the range of resources available to at-risk persons in their communities, from the self-help groups to the most intensive levels of hospital care.

Center for Indian Youth Program Development
Contact:
Sally Davis, Director
Center for Indian Youth Program Development
Division of School Health
University of New Mexico School of Medicine
Albuquerque, NM 87131
(505) 277-4462
Targets: Native American youth.
Years in operation: 8
description: The University of New Mexico (UNM) and the Indian Health Service formed a partnership to develop a teen health project in response to input from communities. Program staffers include nurse practitioners, health educators, substance abuse educators, psychologists, youth counselors, and other support personnel. In designing the program, they aimed for accessibility, free comprehensive services, teenage participation in planning and carrying out the program, and community support and participation. The program is not medically oriented; instead, it focuses on promoting physical and mental health. Teacher training uses a substance abuse curriculum that includes a section on suicide. Related activities include Students Against Drunk Driving (SADD), Teen Health Awareness Days, Adventure Clubs, improvisational Teen Life Theater, intergenerational events, and a visit to a hospital emergency room that is part of an effort to train students as peer leaders in alcohol and substance abuse prevention (ASAP).

Center services are available on-site at four rural New Mexico high schools. In addition, the program provides technical assistance to other schools and community groups. Services provided by the Center include: Mental health counseling; Alcohol abuse evaluation, counseling, and education; Suicide prevention; Health education and promotion; Physical examinations; Pregnancy testing; Family planning; Programs to reduce school absenteeism and truancy.

Jail Suicide Prevention Program
Contact:
Lindsay M. Hayes, M.S., Assistant Director
Jail Suicide Prevention Program
National Center on Institutions and Alternatives
40 Lantern Lane
Mansfield, MA 02048
(508) 337-8806
Targets: Staff in jails, detention centers, and police lockups.
Years in operation: 14
Description: The National Center on Institutions and Alternatives determined that, by conducting an intake screening, properly trained correctional personnel can effectively assess inmates' suicidal potential, both at the booking stage and during subsequent phases of the inmates' incarceration. In addition to assessing inmates' suicidal potential, staff members using intake screening can detect any medical or mental health problem, determine alcohol or drug intoxication, and address classification needs. This is a high-risk population. On the basis of the results of the national study of jail suicides, researchers estimated that the suicide rate of inmates in detention facilities is about nine times greater than that of the general population (Hayes and Rowan, 1988). Suicide is the leading cause of death in jails.

Training consists of an 8-hour suicide prevention program for jail and lockup officers that will enable them to identify, manage, and serve high-risk mentally ill and suicidal inmates. Advanced training is provided to jail administrators in the division and to corrections staff. Technical assistance is offered on a national basis.

Bongar, B., and Harmatz, M. Clinical psychology graduate education in the study of suicide: availability, resources, and importance. Suicide and Life Threatening Behavior 1991;21:231-244.
Hayes, L., and Rowan, J. National Study of Jail Suicide: Seven Years Later. Alexandria (VA): National Center on Institutions and Alternatives, 1988.
Johnson, F.G., Ferrence, R., and Whitehead, P.C. Self-injury: identification and intervention. Canadian Psychiatry Association Journal 1973;18:101-105.
Tierney, R.J. Comprehensive evaluation for suicide intervention training [dissertation]. Calgary, Alberta: University of Calgary, 1988.

Suggested Additional Reading

Ramsay, R.F., Cooke, M.A., Lange, W.A. Alberta suicide prevention training programs: a retrospective comparison with Rothman's developmental resource model. Suicide and Life Threatening Behavior 1990;24:335-351.
State of California Department of Mental Health. The California Helpers Handbook for Suicide Intervention. Sacramento, CA, 1987.

Training programs for teachers and school staff/students

From: Youth Suicide Prevention Programs: A Resource Guide
U.S Department of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Injury Prevention and Control
Publication date: 09/01/1992
http://wonder.cdc.gov/wonder/prevguid/p0000024/entire.htm

BRIDGES (Building Skills to Reach Suicidal Youth)
Contact:
Building Skills to Reach Suicidal Youth
Charlsetta Sutton, ACSW, BCD
Karen Dunne-Maxim, R.N., M.S.
UMDNJ--CMHC
671 Hoes Lane
Piscataway, NJ 08855-1392
(908) 463-4109
Targets: School personnel (guidance staff, teachers) , Agency staff who work with youth
Years in operation: 7
Description: School personnel training lasts 16 hours (2 days). BRIDGES trains school personnel to accurately distinguish students at risk for suicidal behavior from those who are depressed. Personnel learn to assess students' risks, to intervene when appropriate, to work with families and peers, to follow referral procedures, and to develop school policy and procedures with regard to suicide prevention and postvention. No formal evaluations have yet been made of this program.

Pennsylvania Network for Student Assistance Services (PNSAS)
Contact:
Roberta Chuzie
Student Assistance Services Station Square
200 Commerce Court Building, 2nd Floor Pittsburgh, PA 15219
(412) 394-5837
Targets: All buildings at the secondary level in all school districts.
Years in operation: 6
Description: The Student Assistance Program (SAP) focuses on early identification, intervention, and referral of at-risk students to community resources for assessment and treatment. A SAP core team within a school building consists of six school personnel trained to identify and refer at-risk students to community resources. Two service-provider representatives (one mental health and one drug and alcohol expert) train with the core team and serve as ad hoc members on the team. SAP team members do not diagnose or offer treatment to students; instead, they refer them to appropriate community assessment and treatment resources. There is a direct link between schools and local mental health and drug and alcohol service providers.

SAP team members attend an initial 5-day residential training course: 2 days of lectures; 2 days of exercises, role-playing, and practicing intervention models to establish team roles and responsibilities; and 1 day of questions, reinforcement, and planning for the creation and implementation of individual SAPs.

STAR -- Services for Teens At Risk

Contact:

Dr. David Brent, Director
Services for Teens At Risk (STAR)
WPIC (Western Psychiatric Institute and Clinic)
Pittsburgh, PA 15213
(412) 624-5211

Targets: School personnel, at-risk youth.

Years in operation: 4 (for both the Outreach and Outpatient Clinic programs).

Description: STAR Center offers three programs designed specifically to help school personnel identify and refer at-risk youths.

Level 1: Administrators, teachers, counselors, and others who are in daily contact with students learn to identify potential risk factors, recognize behavior patterns of adolescents who may possibly become suicidal, and follow referral procedures.

Level 2: During a 2-day workshop, school personnel learn to evaluate a youth's level of risk and to work effectively with families, students, and mental health agencies.

Level 3: Trains in-house personnel to continue Level 1 training in their school.

STAR Center also works to implement programs in communities and schools immediately following a suicide. Teams from STAR Center conduct postvention sessions that are designed to prevent further suicides through individual student screening, small group discussions, and education. In addition, STAR Center offers outpatient clinical treatment for adolescents at Western Psychiatric Institute and Clinic (WPIC).

Suicide Prevention Center Programs

Contact:

Linda Mates, LPCC
Executive Director
Suicide prevention Center, Inc.
PO Box 1393
Dayton, OH 45401
(513) 297-9096

Targets: Students (junior high and high school), teachers & staff.

Years in operation: 10

Description: The Suicide Prevention Center (SPC) provides training as part of a broad range of crisis support Services, including a 24-hour crisis hotline, training of professionals (teachers, service providers, clergy, physicians, police), and a crisis response team for postvention work for individuals or groups. The program provides in-service training on recognition of depression and suicidal behavior; short-term crisis intervention; school and community resources; and factual information about suicide. Specific programs operating as part of Project Lifesaver are:

Staying Alive: A program that targets minorities and uses other community members, such as barbers and hairstylists.

Finding Hope: Training program for parents.

Life Saver III: A 3-year pilot program training undergraduate, graduate, and postgraduate students (teachers, administrators, school counselors, and nurses).

Crisis Intervention

Contact:

Dr. J.L. DeChurch
Executive Director
Division of Student Services
Dade County Public Schools
1444 Biscayne Boulevard, Suite 202
Miami, FL 33132
(305) 995-7315

Targets: All students.

Years in operation: 5

Description: Dade County established a Department of Teenage Pregnancy and Suicide Prevention in 1987, which in turn became the Department of Crisis Intervention, whose purpose is to prepare staff at the district, region, and school levels to identify, assist, and refer students at risk. The department trains "crisis care core teams" in every school to counsel staff and the community in times of crisis. A hotline is available to assist administrators, counselors, and other support staff. Training of crisis core teams in the schools is done by the District Crisis Team, which consists of one counselor and one psychologist. Training consists of a 3-hour program. Crisis teams are present in all schools; this is a county-mandated requirement. School staff includes counselors, teachers, social workers, occupational specialists, college advisors, psychologists, bus drivers, cafeteria workers, students, peer counselors, and parents.

Project SOAR (Suicide: Options, Awareness, Relief)

Contact:

Project SOAR
Judie Smith, MA
Specialist in psychological Social Services
Dallas Independent School District
1401 South Akard
Dallas, TX 75215
(214) 565-6700

Target: Teachers, staff, and counselors.

Years in operation: 3

Description: Project SOAR is a comprehensive program that covers prevention, intervention, and postvention. Prevention consists of suicide awareness lessons for teachers and staff. Intervention consists of training school counselors in all secondary and elementary schools in risk assessment of potential suicides through personal verbal interviews. A crisis team does postvention for students and teachers. There is also a peer support system and a section called Quest on esteem building. A committee of community mental health professionals advises the suicide and crisis management program.

An 18-hour course was designed to train one school counselor from each high school and middle school to become a primary caregiver. Caregivers coordinate suicide prevention efforts in their local building and conduct the initial intervention when a student threatens or attempts suicide. To minimize the disruption of their ongoing job responsibilities, the 180 primary caregivers were selected to receive training over 4 months.

All other elementary and secondary school counselors who are not designated as the primary caregiver receive 6 hours of instruction. All counselors, including the primary caregivers, receive 3 hours of follow-up training each year. The trainers, members of the Dallas Independent School District (DISD)

Psychological/Social Services Crisis Team, are always available for consultation. A school psychologist or home school coordinator will assist with high-risk cases. The course was adapted for use by other student services personnel: school psychologists, home school coordinators, parent ombudsmen, special education crisis staff, nurses, and drug counselors.

The professional staff of the DISD includes 9,600 employees made up of teachers (83%), professional support personnel (8%), campus administrators (5%), and central office administrators. An additional 5,400 employees provide support services, such as maintenance, cafeteria help, and transportation.

The objectives of the course are to examine attitudes toward suicide, gain knowledge about crisis theory and the dynamics of suicide, sharpen skills of empathy and active listening, and learn a counseling model for crisis intervention. The goal for the training is to help the school counselor develop the skills of a crisis counselor. The training program will provide instruction on how to identify students who may be at risk for suicide, assess the level of that risk, provide crisis intervention counseling, complete and file a report with the DISD Psychological/Social Services Department, and refer the at-risk student to a mental health agency or private therapist as needed.

Adolescent Suicide Prevention Program

Contact:

Adolescent Suicide Prevention Program
Myra Herbert, LCSW, Coordinator
Social Work Services
Special Education Department
Fairfax Public Schools
10310 Layton Hall Drive
Fairfax, VA 22030
(703) 246-7745

Targets: School personnel

Years in operation: 8

Description: The aim of this program is to help teachers and school staff become aware of and able to identify suicide-prone youths. The program includes a crisis management plan for schools to use in handling the aftermath of suicides and other crises that affect both the staff and student populations. The plan involves community agencies as well as school personnel.

Related components include sections in the health and family life education curricula that begin in the fourth grade. These sections cover a variety of affective and mental health issues in the early grades and extend to suicide discussion in the higher grades. Students can take an elective course for credit in the Peer Helper Program in which the same issues are discussed in greater detail. Workshops that involve both school and community resources are also offered for the parents.

Suicide awareness and prevention training is given over a 2-day period to faculty in high schools and secondary schools, and in-service sessions are held periodically.

Weld County Suicide Prevention Program

Contact:

Weld County Suicide Prevention Program
Susy Ruof, M.A.
5290 Mesquite Court
Johnstown, CO 80534
(303) 587-2336

Targets: Students, school staff, parents, community members.
Years in operation: 6
Description: This program develops crisis teams for schools (from in-place staff) and a student curriculum for grades 3-12. The training acquaints the crisis team with the signs of suicidal behavior in students and teaches interviewing skills and counseling techniques for dealing with suicidal students and their parents. The training also addresses legal issues changes in confidentiality, documentation, public relations, team structure to reduce individual stress, procedures and policies, interagency agreements, suicide contagion and postvention, working with the media, and safety factors in working with students. The student curriculum varies, depending on the grade, but mainly consists of information about depression and its role in suicidal thoughts, how and where to get help for one's self or a friend, and how to develop coping or problem-solving skills.

The crisis team members undergo extensive training (30 hour) in suicide awareness, counseling techniques, and methods and resources for help and referral. A l-hour training session is provided each year to all school staff to give them a basic understanding and an awareness of the issue and of what they can do. An additional 4-hour training session is given to all administrators on legal issues, policies, and procedures.

References:
Youth Suicide Prevention Programs: A Resource Guide. Sept, 1, 1992. U.S Department of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Injury Prevention and Control. Contact: Mary A. Fenley, National Center For Injury Prevention and Control, Centers for Disease Control, 1600 Clifton Rd NE, MS:(F-36), Atlanta, GA 30333.

PSYCHSOCIAL TREATMENTS FOR
ADOLESCENT DEPRESSION

Peter M. Lewinsohn
Oregon Research Institute
Gregory N. Clarke
Kaiser Permanente Center for Health Research

Table 1. Intervention Types Described in Adolescent Depression Treatment Literature.
(from: Lewinsohn & Clarke, 1998)

Cognitive techniques (COG)
Constructive thinking (rational emotive therapy, cognitive therapy)
Positive self-talk
Being your own coach
Coping skills
Self-change skills (self-monitoring, goal setting, self-reinforcement)
Family context (FAM)
Conflict resolution
Communication skills
Parenting skills
Behavioral (BEH)
Problem-solving skills
Increasing pleasant activities
Social skills (assertiveness, making friendships, role modeling)
Affective education and management (AEM)
Relaxation
Anger Management

A Few Examples of Counseling Approaches...

BRIEF COGNITIVE-BEHAVIORAL FAMILY THERAPY FOR SUICIDAL ADOLESCENTS

This handbook describes the Successful Negotiation/Acting Positively (SNAP) therapy which is a brief (six session), highly structured, family treatment program for adolescent suicide attempters. SNAP therapy strives to develop a positive family environment by focusing attention on problematic situations rather than difficult individuals and teachers family members a systematic method for solving the family problems that can lead to suicidal crises.

Source: J. C Piacentini, M. J., Rotheram-Borus, & C. Cantwell. (1995). Brief Cognitive-Behavioral Family Therapy for Suicidal Adolescents (Innovations in Clinical Practice: A Source Book, v. 14). Professional Resource Press/Professional Resource Exchange, Inc.: Sarasota, FL.

TREATING DEPRESSION IN CHILDREN AND ADOLESCENTS

This publication presents a guide to the evaluation and treatment of depression in children and adolescents. It compares and contrasts assessment instruments and treatment techniques and describes the conditions under which the various methods are likely to be the most useful. Methods discussed include social learning, operant, and drug treatments. A unique feature of the book is a chapter on how to develop a treatment plan.

Source: J. L. Matson. (1989). Treating Depression in Children and Adolescents. Pergamon Press: New York.

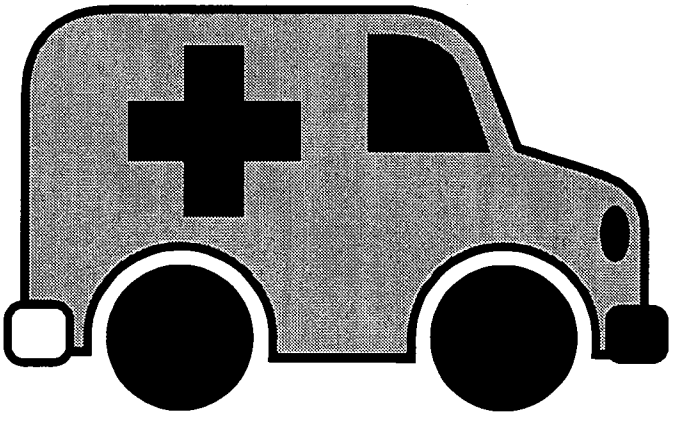
STUDY ON SUICIDE (SOS)

The SOS Training Manual addresses the problem of adolescent suicide in order to save teenage lives, but also to identify young people who might be suicidal later in life, if they are not helped in their formative years. The concepts of SOS are applicable to any group at risk for suicide. This manual provides step-by-step instructions for the planning process and for the SOS training programs.

Source: J. Coombs. (1990). Study on Suicide: Training Manual.
Mental Health Materials Center
P.O. Box 304
Bronxville, NY 10708
(914) 337-6595

ON AFTERMATH ASSISTANCE & PREVENTION OF CONTAGION

- Postvention
- Procedures to Follow in the Aftermath of a Suicide



In a study of 229 completed youth suicides, 29% took active precautions to avoid discovery Hoberman & Garfinkel (1988)

POSTVENTION

When a Student Commits Suicide

Despite efforts to prevent suicide and intervene with high-risk youth, a student might successfully commit suicide, nonetheless. It is important to note that research has found that when news of suicide is prominently displayed in the media or suicide is addressed in a fictional television show or popular movie, there is a predictable increase in suicidal deaths among young people during the following weeks (Shaffer, Garland, Gould, Fisher, & Trautman, 1988). Sometimes, they take the form of "copy cat" suicides. Moreover, suicide clusters tend to occur more frequently than by chance alone. Thus, Shaffer, et al. (1988) advocate the need for "postvention" once a suicide by a student has occurred. Postvention refers to intervention conducted with survivors, school, or community once a suicide has occurred. They suggest that postvention can actually serve preventive functions by: "(a) providing structure for understanding death, thus alleviating some of the guilt and isolation experienced by family survivors, (b) minimizing the scapegoating that can affect parents, teachers, the school, or particular peers, and (c) reducing the likelihood of imitation either within the family or within the community or both." p.684

The reader may also want to refer to our Center's resource aid packet on "Responding to a Crisis at School."

According to 1993 data, the most common method of suicide for individuals under 25 was firearms (two-thirds), followed by hanging and poisoning.

Procedures to Follow in the Aftermath of a Suicide

(from "Procedures to Follow in the Aftermath of a Suicide" from Youth Suicide: Crisis Intervention and Management; Guetzloe, 1991, pp. 18-25)

Carefully planned postvention procedures should be put into place immediately following the suicide of a student or member of the faculty or staff...

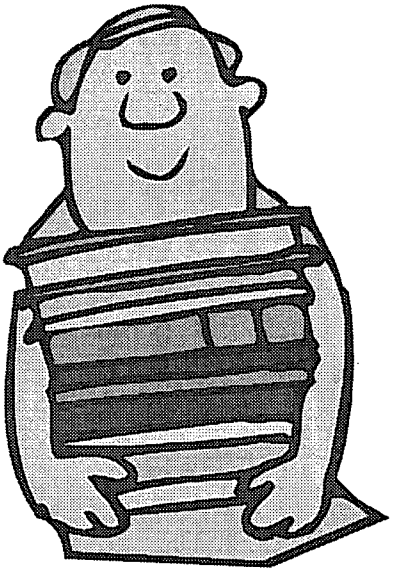
1. Great care must be taken to avoid romanticizing or glorifying a suicide...
2. The act should not be described as courageous or rational...
3. The victim should not be eulogized; there should be no in-school memorial services for a suicide victim...
4. Administrators and faculty should express sorrow that the school has suffered a loss and acknowledge that a normal routine is impossible at such a time, but the school schedule should be disrupted as little as possible...

Components of the School Plan for Postvention...

1. Notifying faculty by means of a "telephone tree" procedure...
2. Notifying members of the school parent organization or parent contact group...
3. Contacting the victim's family...
4. Informing the media...
5. Notifying community agencies...
6. Holding a pre-school faculty meeting...
7. Requesting assistance from other schools or districts...
8. Informing students...
9. Establishing an in-school crisis center...
10. Encouraging students to express their feelings to peers, family, and adults in the school and community...
11. Notifying parents of students who seem to be extremely affected...
12. Having a counselor present during each of the victim's classes or activities...
13. Gathering the personal belongings of the deceased...
14. Provision of "roaming" substitutes for teachers who need respite...
15. Provision of counselors for faculty and staff...
16. Holding evening meetings for parents and the community...
17. Holding evening meetings for students during parent meetings...
18. Providing information about the memorial service or funeral arrangements...
19. Visiting the bereaved family...
20. Working with survivors...
21. Modifying the School Postvention Plan...

Additional Resources

- References from the surgeon general's report
- Books and book chapters
- Journal Articles, Briefs, and Reports
- Websites



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Books and book chapters

Compas, B.E., Connor, J. & Wadsworth, M. (1997). Prevention of depression.*IN: Healthy children 2010: Enhancing children's wellness*. R.P. Weissberg, T.P. Gullotta, et al. (Eds.). Sage Publications, Inc., Thousand Oaks, CA.

This chapter reviews research on depression in children and adolescents. Proposes future directions of for the development of programs to prevent depression during childhood and adolescence; these directions include: (1) reducing suicide among youth by recognizing depression as a risk factor; (2) reducing mental disorder among youth , including addressing depression; and (3) enhancing quality of life for overall health improvement.

Fairchild, T.N. (1997). Suicide intervention. *IN: Crisis intervention strategies for school-based helpers (2nd ed.)*. T.N. Fairchild, et al. (Eds.). Charles C. Thomas Publisher, Springfield, IL. P. 278-322.

This chapter discusses ways in which school-based helpers can be of assistance to suicidal persons.

Goldman, S. & Beardslee, W.R. (1999). Suicide in children and adolescents. IN: *The Harvard Medical School guide to assessment and intervention*. D.G. Jacobs, et al. (Eds.). Jossey-Bass, Inc., Publishers, San Francisco, CA. P.417-442.

This book chapter reviews the epidemiology and risk factors for childhood and adolescent suicidal behaviors. Authors integrate this information into a clinical model that can be used for assessing, understanding, and treating the individual suicidal child and end with some recommendations for future areas of investigation.

Guetzloe, E. (1991). *Youth Suicide: Crisis Intervention and Management*. Communities Against Substance Abuse: San Marcos, TX.

This document provides an overview of youth suicide (including warning signs, risk factors, and precipitating events, as well as other factors related to youth suicide). It talks about the school role as a potential precipitating event for suicidal behavior, using case examples to illustrate. It also provides advise regarding the school's responsibility in suicide prevention and discusses the assessment of suicide risk. Guetzloe also includes a list of steps for crisis intervention in a school setting, and also describes a list of procedures for schools to follow in the aftermath of a suicide.

Kalafat, J. (1997). Prevention of youth suicide. *IN: Healthy children 2010: Enhancing children's wellness*. R.P. Weissberg, T.P. Gullotta, et al. (Eds.). Sage Publications, Inc., Thousand Oaks, CA. P. 175-213.

Provides an overview of current school-based youth suicide prevention efforts.

Mauk, G.W. & Sharpnack, J.D. (1998). A light unto the darkness: The psychoeducational imperative of school-based suicide postvention. IN: *Adolescent psychiatry: Developmental and clinical studies*, vol. 23. A.H. Esman, L.T. Flaherty, et al. (Eds.). The Analytic Press, Inc., Hillsdale, NJ. P. 179-205.

The authors discuss adolescent suicide. They describe a successful program geared to the needs of peer and classmate survivors in such situations.

Noam, G. G., & Borst, S. (Eds). *(1994). Children, Youth, and Suicide: Developmental Perspectives.* Jossey-Bass Publishers: San Francisco, CA.

This book takes a developmental approach to the discussion of youth suicide. It providesconceptual models for the understanding of youth suicide. Further, it presents developmental differences that occur between different age groups with respect to youth suicide.

Park, J.C. & Boyd, A.O. (1998). Depression and suicide: Injecting hope. IN: *Crisis counseling for a quality school community: Applying W. Glasser's choice theory*. L.L. Palmatier, et al. (Eds.). Accelerated Development, Inc., Bristol, PA. P. 207-225.

Presents information to school counselors, nurses, psychologists, administrators, teachers, and other school personnel about intervention strategies in situations where suicide is a real possibility. Additional information here will show professionals in schools what to do about a student at risk for suicide until professional help arrives.

Poland, S. (1989). *Suicide intervention in the schools*. Guilford Press, New York, NY.

Contains many practical examples of how a school system can approach the topic of suicide intervention in the schools. The case examples provided are composites of suicidal students with whom the author has worked with.

Journal Articles, Briefs and Reports

Ackerman, G.L. (1993). A congressional view of youth suicide. *American Psychologist*, v48 (n2), 183-184.

Reviews the results of a national survey of adolescents about their knowledge of, and attitude toward, youth suicide. Also provides information about adolescents' explanations for self-destructive behavior. Given this information, recommendations for effective preventive interventions and policy decisions are offered.

Adams, C.M. (1996). Adolescent suicide: One school's response. *Journal of Secondary Gifted Education*, v7 (n3), 410-417.

Documents the responses of a state-supported residential high school for giftedstudents following the 1994 suicides of three students. The school's measures to develop a screening procedure, design a prevention program, disseminate information about adolescent suicide, and host a conference are outlined, as is a separate crisis management workshop.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual-IV.* *:*.

This publication provides diagnostic criteria for all mental disorders, including depression and otherchildhood/adolescent disorders.

Berman, A.L. & Jobes, D.A. (1995). Suicide prevention in adolescents (age 12-18). *Suicide & Life-Threatening Behavior*, v25 (n1), 143-154.

The epidemiology of adolescent suicide is summarized with particular emphasis on temporal trends by age and gender. "First generation" prevention programs are examined, followed by a description of selective, targeted, "second generation" prevention efforts, which are focused toward targets of individual predisposition, the social milieu, or proximal agents associated with high risk for suicidal behavior.

Blatt, S. J. (1995). The destructiveness of perfectionism: Implications for the treatment of depression. *American Psychologist, v49* (n12), 1003-1020.

Discusses perfectionism in high-achieving individuals and its relation to depression and suicide.

Boehm, K. E & Campbell, N.B. (1995). Suicide: A review of calls to an adolescent peer listening phone service. *Child Psychiatry and Human Development*, v26 (n1), 61-66.

Describes calls about suicide to a teen listening phone service over a period of 5.5 years. Of the 11,152 calls received, 441 of them were about suicide. Those concerned with suicide also discussed other serious issues such as self-esteem, family problems, substance use, and abuse and were less likely to be calling "just to talk."

Boergers, J., & Spirito, A. (1999, Spring). Outpatient care of adolescent suicide attempters. *Clinical Child Psychology Newsletter*, 8-10.

Discusses typical counseling techniques used in treating suicidal adolescents. This article also reviews drop-out rates and barriers to treatment.

Borowsky, I. W., et al. (1999, June). Suicide attempts among American Indian and Alaska Native youth. *Archives of Pediatrics and Adolescent Medicine,*573-580.

This article examines suicide attempts in a large sample (11,600 students) of 7th through 12th graders in reservation communities in 8 different states across the United States. Risk and protective factorsfor suicide attempts are discussed. (note: free copy available from Dr. Borowsky, Division of General Pediatrics and Adolescent Health, University of Minnesota, Box 571 FUMC, 420 Delaware St. SE, Minneapolis, MN 55455 or borow004@gold.tc.umn.edu.)

Center for Disease Control. (1995, April 28). Fatal and nonfatal suicide attempts among adolescents--Oregon, 1988-1993. *Morbidity and Mortality Weekly Report, v44*, (n16), 312-323.

Surveys suicide attempts in Oregon over a 5-year period and summarizes data including the characteristics of fatal and nonfatal suicide attempts, methods used, gender and age differences, and reasons for the attempt.

Center for Disease Control. (1998, March 20). Suicide among Black youth--United States, 1980-1995. *Morbidity and Mortality Weekly Report, v47* (n10), 193-196.

Examines trends in suicide among Black youth over a 15-year period. Reviews trends in demographic changes by age, ethnicity (as compared to white youth), gender, geographic location, and risk factors.

Center for Disease Control (1998, April 10). Suicide prevention evaluation in a Western Athabaskan American Indian tribe--New Mexico, 1988-1997. *Morbidity and Mortality Weekly Report, v47*, (n13), 257-261.

Discusses and prevention and intervention program implemented into a Native American community in New Mexico. Examines suicidal behavior before and after program implementation.

Ciffon, J. (1993). Suicide prevention: A classroom presentation to adolescents. *Social Work*, v38 (n2), 197-203.

Subjected suicide prevention program for high school sophomores to statistical analysis of effectiveness. Results showed that disturbingly high proportion of adolescents had undesirable attitudes about suicide in baseline period. Program appeared to have caused significant shift from undesirable to desirable attitudinal responses in six of eight areas.

Collins, S. & Angen, M. (1997). Adolescents voice their needs: Implications for health promotion and suicide prevention. *Canadian Journal of Counseling*, v31 (n1), 53-66.

Investigated self-perceived need for health-related services, instruction, and environmental changes among 2,370 10th-12th graders in 3 Calgary senior high schools. Results are discussed.

Coy, D.R. (1995). The need for a school suicide prevention policy. *NASSP Bulletin*, v79 (n570), 1-9.

Discusses the need for school suicide prevention policy. Posits that administrators should adopt cautious and comprehensive policies, risk management, and prevention programs and that educators should recognize suicide warning signs.

Davidson, M.W. & Range, L.M. (1999). Are teachers of children and young adolescents responsive to suicide prevention training modules? Yes. *Death Studies*, v23 (n1), 61-71.

Examined whether teachers would be responsive to suicide prevention training, which might include teaching about suicide warning signs and offering specific suggestions such as using no-suicide agreements as a stop gap measure until students (and their families) can be seen by a counselor or other trained professional. Results are discussed.

Downey, A.M. (1991). The impact of drug abuse upon adolescent suicide. *Omega:Journal of Death and Dying*, v22 (n4), 261-275.

Explored the hypothesis that the increased use, misuse, and abuse of drugs is one of the myriad explanations for the escalation in youth suicidal behavior during the past 25 years. Used clinical case histories and research results to exemplify the impact of heightened drug usage as an argument for the upsurge in youth suicide.

Eggert, L.L., et al. (1994). A measure of adolescent potential for suicide (MAPS): Development and preliminary findings. *Suicide & Life-Threatening Behavior*, v24 (n4), 359-381.

Describes an instrument designed to assess the suicide potential of youth (ages 14-18) who are at risk for suicidal behaviors. Two samples were used to examine psychometric properties of the Measure of Adolescent Potential for Suicide (MAPS). Results revealed strong validity and reliability for MAPS.

Eggert, L. L., Thompson, E. A., Herting, J. R., & Nicholas, L. J. (1995). Reducing suicide potential among high-risk youth: Tests of a school-based prevention program. *Suicide and Life-Threatening Behavior, 25,* 276-296.

Provides background information on school-based suicide prevention programs. The study describes a 3-stage identification process of identifying suicidal youth. All suicidal youth received a comprehensive suicide assessment and were then placed in one of three groups: 1) one semester of group intervention, 2) two semesters of group intervention, or 3) no intervention. Data suggest that all three groups showed decreases in suicidal behaviors, depression, hopelessness, stress, and anger. Furthermore, all three groups showed increased self-esteem and network social support. The researchers attribute this to the therapeutic effects of the comprehensive suicide assessment.

Personal control only increased in the two treatment groups and not in the control group.

Eggert, L.L., Thompson, E.A., Herting, J.R. & Nicholas, L.J. (1999). Reducing suicide potential among high-risk youth: Tests of a school-based prevention program. Erratum. *Suicide & Life-Threatening Behavior*, v29 (n1), 96.

Reports an error in the original article by l.L. Eggert et al (Suicide and Life-Threatening Behavior, 1995 [Sum], v25[2], 276-296). The correct information is provided. This original article examined the efficacy of a school-based prevention program for reducing suicide potential among high-risk youth. Refer to the original articles for results of the study.

Garofalo, R., & Wolf, R. C. (1999, May). Sexual orientation and risk of suicide attempts among a representative sample of youth. *Archives of Pediatrics and Adolescent Medicine,* 487-493.

Examines a large sample (more than 3,000) of high school students and compares suicide attempts of those who describe themselves as gay, lesbian, bisexual, or "not sure" to heterosexual students. Such students are more likely attempt suicide than heterosexual students. (note: free copy can be attained from Dr. Garofalo at rgarafalo@jrihealth.org or at the Division of General Pediatrics, Children's Hospital/Harvard Medical School, Boston, MA. (617) 355-6714.

Garland, A., Shaffer, D., & Whittle, B. (1989). A national survey of school-based, adolescent suicide prevention programs. *Journal of the American Academy of Child and Adolescent Psychiatry,* v28 (n6), 931-934.

Found that most of the programs reviewed were 2 hours or less and subscribed to the "stress model" of suicide (which the authors suggest might be problematic). The paper also discusses the potential deleterious effect of curricula-based suicide prevention programs and recommends that the curricula should instead be directed at adults in teachers to help them recognize the warning signs of at-risk students.

Garnefski, N. & Diekstra, R. (1997). Adolescents from one parent, stepparent and intact families: Emotional problems and suicide attempts. *Journal of Adolescence*, v20 (n2), 201-208.

Self-report questionnaire data from a large community sample of adolescents (aged 12-19 years) were analyzed to investigate the differences between adolescents living in intact families, 1-parent families, and stepparent families with regard to emotional problems and suicidality. Results are discussed.

Gutstein, S. Rudd, M.D. (1990). An outpatient treatment alternative for suicidal youth. *Journal of Adolescence*, v13 (n3), 265-277.

Examined the safety and effectiveness of an outpatient treatment program for suicidal children and adolescents that used a clinical team approach and clinical team / family member gatherings to prevent future extreme reactions to stresses and developmental transitions. Evaluation of the program indicated significant long-term improvement.

Hennig, C.W., Crabtree, C.R. & Baum, D. (1998). Mental health CPR: Peer contracting as a response

to potential suicide in adolescents. *Archives of Suicide Research*, v4 (n2), 169-187.

Contracting has been used as a response to individuals at risk of suicide for over 30 years. In the present study, almost 396 high school students were given a survey about their experiences with suicide. Results are discussed.

Herring, R. (1990). Suicide in middle school: Who said kids will not? *Elementary School Guidance and Counseling*, v25 (n2), 129-137.

Examines suicide attempts and completions among middle school students to alert middle school counselors to the reality of child suicide. Discusses common symptomatic areas under the categories of drug abuse, social influences, acting out, pubescence, depression, and nuclear threat. Offers suggestions for the prevention of child suicide and delineates the roles of the school counselor in suicide prevention.

Hoberman, H. M., & Garfinkel, B. D. (1988). Completed suicide in children and adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 27, 689-695.

Examines characteristics of 229 youths under 19 years old who completed suicides over a 10-year period. Psychological autopsies were performed and results discuss demographic characteristics, method of death, circumstances of suicide, psychiatric history, precipitating events, psychosocial characteristics, and school performance during the year prior to their death.

Hovey, J.D. (1998). Acculturative stress, depression, and suicidal ideation amongMexican-American adolescents: Implications for the development of suicide prevention programs in schools. *Psychological Reports*, v83 (n1), 249-250.

Explored the relationship of scores on acculturative stress with those on depression and suicidal ideation among 26 male and 28 female immigrant Mexican-American students from a Southern California high school. Results are discussed.

Kalafat, J. (1994). On initiating school-based suicide response programs. *Special services in the schools*, v8 (n2), 21-31.

Discusses initiation of school-based adolescent suicide response programs by reviewing recommended strategies and issues. Issues include program rationale, responsibilities of schools and teachers, and concerns about the impact of programs. Strategies include using appropriate instructional principles, maintaining systematic / ecological focus, involving all stakeholders, and evaluating program efficacy. Reviews available resources for program implementation.

Kalafat, J. & Elias, M.J. (1992). Adolescents' experience with and response to suicidal peers. *Suicide & Life-Threatening Behavior*, v22 (n3), 315-321.

Investigated high school students' knowledge of suicidal peers. Found 68 percent of females and 42.5 percent of males knew peer who had committed or attempted suicide.

Kalafat, J., & Elias, M. (1994). An evaluation of a school-based suicide awareness intervention. *Suicide and Life-Threatening Behavior, 24,* 224-233.

Assesses the efficacy of suicide intervention classes (three 40-minute lessons on suicide). Data suggest that students started out with fairly reasonable views concerning suicide, there were some improvements in attitudes regarding how to deal with peers. However, most attitudes did not change as a result of being in the program.

Kalafat, J. & Elias, M.J. (1995). Suicide prevention in an educational context: Broad and narrow foci. *Suicide & Life-Threatening Behavior*, v25 (n1), 123-133.

Evaluation strategies for focused educational programs in suicide prevention are explored. Additionally, a broad, systematic approach is called for that increases student participation; such an approach appears to have been effective with a variety of youth deviant behaviors. A combination of these broad and narrow foci may be necessary to address suicidal behavior in the educational context.

Kalafat, J. & Gagliano, C. (1996). The use of simulations to assess the impact of an adolescent suicide response curriculum. *Suicide & Life-Threatening Behavior*, v26 (n4), 359-364.

Employed simulations of encounters with suicidal peers to assess the impact of classroom suicide response lessons. Results provide evidence for the efficacy of such classes.

Kalafat, J. & Ryerson, D.M. (1999). The implementation and institutionalization of a school-based youth suicide prevention program. *Journal of Primary Prevention.* V19 (n3), 157-175.

Describes the implementation and institutionalization of a comprehensive, county-wide, school-based youth suicide prevention program.

Kaplan, S.J., Pelcovitz, D., Salzinger, S., Mandel, F., et al. (1997). Adolescent physical abuse and suicide attempts. *Journal of the American Academy of Child & Adolescent Psychiatry*, v36 (n6), 799-808.

The rate of suicide attempts and the exposure to risk factors for suicide in a sample of 99 confirmed cases of physically abused adolescents was compared with those of a control community sample of 99 nonabused adolescents (aged 12-18 years). Results are discussed.

Kopper, B.A., Osman, A., Osman, J.R. & Hoffman, J. (1998). Clinical utility of the MMPI-A content scales and Harris-Lingoes subscales in the assessment of suicidal risk factors in psychiatric adolescents. *Journal of Clinical Psychology*, v54 (n2), 191-200.

This study of 143 inpatient adolescents (mean age 15.9 years) investigated the clinical utility of the MMPI-A in assessing suicidal risk factors by examining the unique contribution of the content scales and Harris-Lingoes subscales beyond what is provided by the basic clinical scales. Results are discussed.

Kotch, K. (1999). Childhood depression. *The Congressional Quarterly Researcher, v9,* (n26), 593-616.

This issue of the *CQ Researcher* examines the issues in childhood depression, including reviewing the role schools could play in the prevention and treatment of depression. Depression, as it relates to suicide, is also discussed.

Lester, D. (1992). State initiatives in addressing youth suicide: Evidence for their effectiveness. *Social Psychiatry and Psychiatric Epidemiology*, v27 (n2), 75-77.

Examined the efficacy of state government initiatives and school-based suicide prevention programs for preventing teen suicides.

Lewinsohn, P. M., & Clarke, G. N. (1999). Psychosocial treatments for adolescent depression. *Clinical Psychology Review, v19,* (n3), 329-342.

Reviews the research on cognitive-behavioral therapy (CBT) and provides an overview of techniques that are typically effective in treating adolescent depression. It also compares the merits of various treatment characteristics (e.g., number of sessions, group vs. individual therapy, age modifications, etc.).

Malley, P., et al. (1994). School-based adolescent suicide prevention and intervention programs: A survey. *School Counselor*, v24 (n2), 130-136.

Survey of school counselors revealed that schools with a written suicide policy incorporated more of the recommended components of suicide prevention programs than schools lacking written guidelines. Almost half of the schools did not use components that are necessary to ensure a systematic and comprehensive suicide prevention program.

Malley, P. & Kush, F. (1994). Comprehensive and systematic school-based suicide prevention programs: A checklist for counselors. *School Counselor*, v41 (n3), 191-194.

Reviews literature germane to school-based suicide prevention programs and identifies components that are descriptive of comprehensive and systematic school-based suicide programs. Uses literature review to devise checklist to enable school counselors to compare their programs with current views of prevention of teenage suicide. Checklist is appended and readers are instructed in how to assess their school program using the checklist.

Mazza, J.J. (1997). School-based suicide prevention programs: Are they effective? *School Psychology Review*, v26 (n3), 382-396.

Reviews the theoretical orientation, targeted populations, goals, and methods for examining efficacy of school-based programs. Results show that most programs are of short duration, follow a stress-related model, and fail to assess actual suicidal behaviors.

McFarland, W.P. (1998). Gay, lesbian, and bisexual student suicides. *Professional school counseling*, v1 (n3), 26-29.

Provides the statistical profile of suicidal gay, lesbian, and bisexual youth and discusses the suicidal risk factors for this population. As well, it proposes preventive and responsive interventions for school counselors.

Metha, A. McWhirter, E. (1997). Suicide ideation, depression, and stressful life events among gifted adolescents. *Journal for the Education of the Gifted*, v20 (n3), 284-304.

Differences in life-change events, life stress, depression, and suicide ideation were investigated in a mixed-ethnic sample of 34 gifted and 38 nongifted urban junior high school students. Results are discussed.

Metha, A., Weber, B & Webb, L.D. (1998). Youth suicide prevention: A survey and analysis of policies and efforts in the 50 states. *Suicide & Life-Threatening Behavior*, v28 (n2), 150-164.

State-level initiatives directed at youth suicide prevention since 1980 were analyzed. During 1992 and 1996, each governor was surveyed regarding his/her state's efforts in youth suicide prevention. Results are discussed.

Miller, D.N. & DuPaul, G.J. (1996). School-based prevention of adolescent suicide: Issues, obstacles, and recommendations for practice. *Journal of Emotional and Behavioral Disorders*, v4 (n4), 221-230.

Reviews several adolescent suicide prevention procedures and empirical evidence regarding their effectiveness. Results indicate that although research is limited, best practice involves a school-based prevention approach that includes a mixture of primary and secondary prevention components. Seven specific recommendations to schools are offered.

Miller, D.N., Eckert, T.L., DuPal, G.J. & White, G.P. (1999). Adolescent suicide prevention: Acceptability of school-based programs among secondary school principals. *Suicide & Life-Threatening Behavior*, v29 (n1), 72-85.

Examined 185 high school principals' acceptability ratings of 3 school-based programs for the prevention of adolescent suicide. Discusses the results of this study.

Orbach, I. & Bar-Joseph, H. (1993). The impact of a suicide prevention program for adolescents on suicidal tendencies, hopelessness, ego identity, and coping. *Suicide & Life-Threatening Behavior*, v23 (n2), 120-129.

Examined effectiveness of experiential suicide prevention program. Findings showed that experimental groups were superior to controls, with at least some dependent measures pointing out effectiveness of the program.

Patton, G.C., Harris, R., Carlin, J.B., Hibbert, M.E., et al. (1997). Adolescent suicidal behaviours: A population-based study of risk. *Psychological Medicine*, v27 (n3), 715-724.

Studied non-fatal suicide behaviors in 1,699 Australian 15-16-year-old secondary school students at 44 schools in the state of Victoria. Results are discussed.

Peach, L. & Reddick, T.L. (1991). Counselors can make a difference in preventing adolescent suicide. *School Counselor*, v39 (n2), 107-110.

Asserts that school counselors can play vital role in the prevention of adolescent suicide. Lists warning signs of suicide risk and characteristics of at-risk students. Presents set of guidelines for helping potential suicide victims. Sees key to teenage suicide prevention to be communication skills. Identifies components for suicide prevention plans.

Ploeg, J., Ciliska, D., Dobbins, M., Hayward, S., Thomas, H., & Underwood, J. (1996). A systematic overview of adolescent suicide prevention programs. *Canadian Journal of Public Health, v87,* (n5), 319-324.

Discusses common goals of school-based adolescent suicide prevention programs. Reviews the efficacy of curricula-based prevention programs in schools and discusses both the beneficial and harmful effects of this prevention approach.

Popenhagen, M. P., & Qualley, R. M. (1998). Adolescent suicide: Detection, intervention, and prevention. *Professional School Counseling, v1,* (n4), 30-36.

Provides and overview of suicide assessment (including risk factors), intervention practices (including school involvement, advice for teachers), and school-based prevention practices.

Range, L.M. (1993). Suicide prevention: Guidelines for schools. *Educational Psychology Review*, v5 (n2), 135-154.

Discusses adolescent suicide and school-based prevention. Topics include: (1) prevalence of suicide, (2) assessment of suicidal history, thoughts, and intention, (3) intervention strategies for teachers, parents, and administrators, and (4) postvention. It is suggested that an understanding of the suicidal teen's perception of suicide as a solution rather than a problem may help educators in prevention efforts.

Rasmussen, K.M., Negy, C., Carlson, R. & Burns, J.M. (1997). Suicide ideation and acculturation among low socioeconomic status Mexican-American adolescents. *Journal of Early Adolescence*, v17 (n4), 390-407.

Examined whether Mexican-American adolescents' suicide ideation could be predicted from their acculturation levels. Cultural inhibitory variables that possibly decrease Hispanics' suicidal behaviors are discussed.

Remafdi, G., French, S., Story, M., Resnick, M.D., et al. (1998). The relationship between suicide risk and sexual orientation: Results of a population-based study. *American Journal of Public Health*, v88 (n1), 57-60.

Examined the relationship between sexual orientation and suicide risk in a population-based sample of adolescents. Subjects were selected from the 1987 Adolescent Health Survey, a cross-sectional statewide survey of 7th-12th grade public high school students. Results are discussed.

Resnick, M. D., et al. (1997). Protecting adolescents from harm: Findings from the National Longitudinal Study on Adolescent Health. *JAMA, v278,*(n10), 823-832.

Examines a large sample of 7th-12th graders from 80 high schools and their feeder middle schools. The study identifies risk factors for suicidality, emotional distress, violence, substance use, and sexual behavior. Protective factors for these behaviors are also reviewed.

Reynolds, W. M. (1991). A school-based procedure for the identification of adolescents at risk for suicidal behaviors. *Family Community Health, 14 (3),*64-75.

Proposes a 2-stage screening process for identifying adolescents at risk for suicidal behaviors. Stage 1 involves screening, while Stage 2 calls for systematic clinical evaluation using a semi-structured clinical interview.

Robert, R.E., Chen, R. & Roberts, C.R. (1997). Ethnocultural differences in prevalence of adolescent suicidal behaviors. *Suicide & Life-Threatening Behavior*, v27 (n2), 208-217.

Data from an ethnically diverse sample of middle school students (6th-9th graders) were analyzed for ethnic differences in suicidal ideation, thought about suicide in the past 2 weeks, suicide plans, and suicide attempts. Results are discussed.

Roberts, R.E., Roberts, C.R. & Chen, R.Y. (1998). Suicidal thinking among adolescents with a history of attempted suicide. *Journal of the American Academy of Child & Adolescent Psychiatry*, v37 (n12), 1294-1300.

Examined the risk of suicidal plans and ideation, depression, and other factors (low self-esteem, loneliness, fatalism, pessimism) among adolescents with a lifetime history of attempted suicide. A self-administered questionnaire was used in a school-based survey of 5 middle schools. Results are discussed. In sum, the strong association between history of suicide attempts, current ideation, and depression indicates that past suicide attempts occur in the context of other signs of psychosocial dysfunction.

Rotheram-Borus, M. J., & Trautman, P. D. (1988). Hopelessness, depression, and suicidal intent among adolescent suicide attempters. *Journal of the American Academy of Child and Adolescent Psychiatry, v27,* (n6), 700-704.

Examines a group of 44 minority female suicide attempters. Compares depression and hopelessness of this group of suicide attempters to a similar group of psychiatrically disturbed nonattempters.

Results suggest that hopelessness should not be used as the sole indicator of suicide risk.

Sandoval, J. & Brock, S.E. (1996). The school psychologist's role in suicide prevention. *School Psychology Quarterly*, v11 (n2), 169-185.

Discusses the involvement of school psychologists in dealing with youth suicide. Discusses primary, secondary, and tertiary prevention techniques and working with aftermath of a suicide attempt. Argues for differential services and attention for alternative education students, gay and lesbian youth, certain ethnic minority youth, and individuals with psychopathology.

Sandoval, J., Davis, J. M., & Wilson, M. P. (1987). An overview of the school-based prevention of adolescent suicide. *Special Services in the Schools, 3,* 103-120.

Provides an overview of options available to schools for the prevention of adolescent suicide. Primary and secondary prevention programs are discussed, as are potential barriers to prevention activities.

Shaffer, D., Garland, A., Gould, M., Fisher, P., & Trautman, P. (1988). Preventing teenage suicide: A critical review. *Journal of the American Academy of Child and Adolescent Psychiatry, 27,* 575-687.

Provides overview of teen suicide. The paper also discusses preliminary psychological autopsy data from 173 youth under 20 years old. Overviews of primary prevention and the need for postvention are also presented.

Stefanowski-Harding, S. (1990). Child suicide: A review of the literature and implications for school counselors. *School Counselor*, v37 (n5), 328-336.

Reviews the literature on childhood suicide. Looks at current statistics on the occurrence of suicide among children. Examines characteristics and risk factors associated with the suicidal child, causes and signs of childhood suicide, developmental issues, exceptional children, and treatment interventions. Discusses six implications of childhood suicide for school counselors.

Vannatta, R.A. (1997). Adolescent gender differences in suicide-related behaviors. *Journal of Youth & Adolescence*, v26 (n5), 559-568.

Examined gender differences in risk factors that increase the probability of self-reported suicidal behavior among 7^{th}-12^{th} grade students in a northern Midwest school district. Results revealed significant gender differences in that the demonstration of more aggressive behaviors increased the likelihood of males reporting suicidal behavior.

Vieland, V., Whittle, B., Garland, A., Hicks, R., & Shaffer, D. (1991). The impact of curriculum-based suicide prevention programs for teenagers: An 18-month follow-up.

Describes a very short-term, teacher-administered school suicide prevention program. The study evaluates the efficacy of the program in changing views/attitudes, coping behaviors, and suicide

attempts. There was no convincing evidence for any program effect. Future directions are discussed in light of previous research.

Webb, L.D. & Metha, A. (1996). Suicide among American Indian youth: The role of the schools in prevention. *Journal of American Indian Education*, v36 (n1), 22-32.

Compares suicide rates among American Indian youth with those for other racial groups and discusses suicide risk factors for the general youth population and for American Indian youth. Describes school-based programs in terms of suicide prevention, intervention, and "postvention" strategies, with emphasis on adaptation to specific cultures.

Wetzler, S., et al. (1996). Characteristics of suicidality among adolescents. *Suicide & Life-Threatening Behavior*, v26 (n1), 37-45.

Examines the characteristics of suicidality and psychopathology (including depression, aggression, impulsivity, and stressful life events) among four groups of depressed adolescent outpatients. The nonsuicidal group was differentiated from the three suicidal groups on the basis of suicidality and psychopathology. The three suicidal groups were differentiated from one another on the basis of suicidality but not psychopathology.

Williams, K. (1997). Preventing suicide in young people: What is known and what is needed. *Child: Care, Health & Development*, v23 (n2), 173-185.

Reviews suicide and its prevention in young people from the perspective of health research and services. Results are discussed.

Workman, C.G. & Prior, M. (1997). Depression and suicide in young children. Issues in Comprehensive Pediatric Nursing, v20 (n2), 125-132.

Provides descriptions on the profile of depression and suicide in young children. Proposes that prevention strategies need to be accessible to the child both at home and in school.

Yuen, N., et al. (1996). The rate and characteristics of suicide attempters in the native Hawaiian adolescent population. *Suicide & Life-Threatening Behavior*, v26 (n1), 27-36.

Surveyed native Hawaiian high school students for symptoms of psychopathology and suicide attempts in the previous 6 months. Seventy-seven students reported making a suicide attempt. There were no significant differences in prevalence rates for males and females. Depression, anxiety, aggression, substance abuse symptoms, and low family support were significantly correlated with suicide attempts.

Zenere, F.J. III. & Lazarus, P.J. (1997). The decline of youth suicidal behavior in urban, multicultural public school system following the introduction of a suicide prevention and intervention program. *Suicide & Life-Threatening Behavior*, v27 (n4), 387-403.

Evaluated the effectiveness of a suicide prevention and intervention program in a large, urban,

multicultural school district. Program evaluation was conducted by tracking students' suicidal ideations, attempts and completion over a 5-year period. Results show that the rate of suicidal ideations remains relatively stable, despite prevention programming, while the rate of student suicide attempts and completions has been dramatically reduced.

Websites

Internet Web sites can be goldmines of information. They have reports, publications, online resources (e.g., catalogs, technical assistance), model programs, and links to other resources. We cite a few here to illustrate the nature of what is available.

American Foundation for Suicide Prevention **http://www.afsp.org**
This Foundation is dedicated to advancing our knowledge of suicide and our ability to prevent it. This site is very easy to navigate, and is updates regularly. It contains some very interesting articles on the subject of suicide and the issues surrounding it.

Canadian Association for Suicide Prevention **http://www3.sympatico.ca/masecard**
This is a non-profit national association promoting treatment, education, and research on suicidal behavior in Canada. Text is available in English and French.

Suicide Awareness / Voices of Education **http://www.save.org**
Includes a helpful Frequently Asked Questions (FAQ) file, general information on suicide and some common statistics, symptoms of depression, a book list and much more in an easy-to-read format. Frequently updated.

American Association of Suicidology **http://www.suicidology.org**
The American Association of Suicidology (AAS) promotes research, public awareness programs, and education and training for professionals and volunteers. In addition, it serves as a national clearinghouse for information on suicide. The site provides things you should know about suicide, membership information, a listing of AAS publications, and conference information.

American Psychological Association Help Center
http://helping.apa.org/warningsigns/violence.html
This brochure describes the "Warning Sings" project. To help youth proactively address the problem of violence, APA and MTV have teamed up to provide youth with information about identifying the warning signs of violent behavior and how to get help if they recognize these signs in themselves or their peers.

Facts for Families **http://www.aacap.org/web/aacap/factsFam**
These brochures are provided to educate parents and families about psychiatric disorders affecting children and adolescents.

Suicide Information and Education Centre **http://www.siec.ca**
Suicide Information and Education Centre (SIEC) is a library and resource center. They do not do crisis intervention or counseling; instead, this site gives recommendations on where to get help, in both Canada and the U.S. Located on this site is a comprehensive list of suicide prevention resources, crisis support information, and links to other helpful suicide prevention sites. This site was found to be very user friendly, and would be very helpful to someone that is thinking about committing suicide or knows someone that may be suicidal.

National Depressive and Manic-Depressive Association **http://www.ndmda.org**
This site provides an overview of depressive and bipolar disorders and their symptoms. Several educational booklets are available on these subjects. A section titled *Ask the Doctor* posts answers to questions posed by the visitors. Special areas are devoted to related issues including suicide and adolescents. National DMDA membership. Program, and chapter information is also included. This is an informative site for the patient as well as their family members.

National Institute of Mental Health **http://www.nimh.nih.gov/research/suicide**
This site provides the latest statistics on suicide--including gender differences, age differences, risk factors, etc.--from the National Institute of Mental Health's Suicide Research Consortium. Other useful links can be found at this site as well.

National Center for Injury Prevention and Control (NCIPC)
http://www.cdc.gov/ncipc/D.P./sunifacts.htm
This is a program sponsored by the Center for Disease Control (CDC) in suicide prevention. Its objective is to raise awareness of suicide as a serious public health problem. It focuses on science-based prevention strategies to reduce injuries and deaths due to suicide.

http://www.cdc.gov/ncipc/osp/mortdata.htm

This site, also by NCIPC, provides access to national injury and mortality statistics, including deaths occurring as the result of suicide. In addition, suicide statistics can be examined by state. Another link provides comparative data on the leading causes of death for various age groups.

Youth Suicide Prevention Program **http://www.weber.u.washington.edu**
The Youth Suicide Prevention Program is a Washington State based suicide intervention program. Their web sites describes the warning signs of suicide and tips on how to react to them, as well as advice on how to handle suicide in the media. There is also contact information for crisis lines, suicide intervention training programs, and suicide survivor's groups within Washington State.

Youth Risk Behavior Surveillance System
http://www.cdc.gov/nccdphp/dash/yrbs
This site provides access to data from the Youth Risk Behavior Surveillance System (YRBSS) of the Division of Adolescent and School Health (DASH). It is sponsored by the Center for Disease Control's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). Here you can link to the most recent results of the Youth Risk Behavior Survey which contains data from a large, representative sample of 9th-12th graders. Statistics include the percentage of students reporting suicidal ideation, attempts, and serious attempts in the last year. However, no data on completed suicides are provided. The most recent data are from 1997 (select links to "Summaries of 1997 National Data" or "Youth Risk Behavior Trends Fact Sheet").

Make A Noise **http://makeanoise.ysp.org.au**
A community development approach to youth suicide prevention in Australia, focusing on providing young people with information and referrals on youth health issues well before reaching crisis point.

1000 Deaths **http://www.1000deaths.com**
1000 Deaths is devoted to raising awareness of survivor issues and offering comfort and support to those who have lost a loved one to suicide.

Suicide: Read This First **http://www.metanoia.org/suicide**
If you are considering suicide, go here. In the format of a crisis intervention, this site is dedicated to helping people who are considering suicide get through their crisis. It stems from the author's 14 years of work with online (and telephone) crisis counseling and online support groups on depression and suicide. Includes links as well as lots of helpful information.

Suicide Prevention Triangle **http://www.SuicidePreventTiangles.Org**
Everything you want to know about suicide, its various explanations, resources for rescue, and the positive value of visual art images dealing with suicidal themes. This site also includes free self-assessment software and downloadable text in zip format.

Suicide Resources on the Internet **http://psychcentral.com/helpme.htm**
Links to helpful mailing lists and common suicidal resources on line. Many of these resources come from the Suicide Resources FAQ.

Gay Bisexual Male Youth Suicide Studies **http://www.virtualcity.com/youthsuicide**
Demographic work done on the basis of sexual orientation. These results challenge most established beliefs about the male youth suicide problem in the field of suicidology.

Light for Life Foundation **http://www.yellowribbon.org**
Provides information on the Yellow Ribbon Program for preventing youth suicide. Also included are suicide facts and statistics.

San Francisco Suicide Prevention **http://www.sfsuicide.org**
The San Francisco Suicide Prevention is the oldest volunteer crisis online in the U.S. Founded in 1963 with the initial focus of providing telephone intervention to people experiencing suicidal crisis. A good site for basic information on suicide (i.e., warning signs, advice, statistics and more).

A Comprehensive Approach to Suicide Prevention **http://www.lollie.com/suicide/html**
The approach to suicide prevention used is inspirational posters, brochures, lists of actions, and stories.

The Samaritans of Boston **http://vcc.mit.edu/comm/samaritans**
The Samaritans of Boston is a not-for-profit volunteer organization dedicated to reducing the incidence of suicide by befriending individuals in crisis and educating the community about effective prevention strategies. This site includes general information on suicide along with detailed descriptions of such prevention strategies.

Now is Not Forever **http://wwwidealist.com/cgi-bin/hts-v2.99?survival.hts+b**
Originally designed for teens as a part of Dr. J. Kent Griffiths' studies of adolescent suicide, this interactive site is useful for anyone who is contemplating suicide or who has already made a suicide attempt. If you are not in crisis, but worried about someone who is, this site may help you discover

some useful ways to respond.

Keep Yourself Alive **http://Auseinet.flinders.edu.au/projects/kya**
This is a manual that is part of a package designed to: provide a comprehensive introductory guide to the management of suicidal behaviors and completed suicide; raise the awareness of the professionals with regard to the seriousness of suicidal behaviors in Australia; and to improve crisis, therapy and postvention skills for working in this challenging area. This manual is presented in Adobe Acrobat (PDF) form which requires the Adobe Reader. Visitors can download the entire book or individual chapters.

Overcoming Depression and Preventing Suicide **http://ub-counseling.buffalo.edu/Depression**
This site was originally designed to help students at the State University of New York identify depression, so that they may seek help from the University's Counseling Center. The information here may be helpful to anyone with questions about depression / suicide. General information including symptoms is provided.

Internet & International Crisis Resources & Information
http://www.cis.ohio-state.edu/hypertext/faq/usenet/suicide/resources/faq.html
A one page listing of suicide resources. Descriptions are provided for each resource listed.

Depression and Related Affective Disorders Association (DRADA)
http://www.med.jhu.edu/drada
This organization's mission is "to alleviate the suffering arising from depression and manic depression by assisting self-help groups, providing education and information, and lending support to research programs. It works in collaboration with the Department of Psychiatry at Johns Hopkins University School of Medicine. The site provides general information, access to books and videos, support group information, and links to other sites.

Other Related Resources from our Center

Our Clearinghouse has information on a variety of topics relevant to mental health in schools specifically and addressing barriers to learning in general. We have collected resources from across the country. Most of what we have gathered is still in its original form (e.g., guides, resources aids, instruments, articles, fact sheets, reports, etc.). Over time, we are integrating some of the material into specifically developed Introductory, Resource Aid, and Technical Aid Packets. The attached list highlights additional items from our current holdings. For material that is still in its original form, you probably will want to directly contact the source. However, if this is not feasible, feel free to contact us.

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