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ABSTRACT
        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. Successful
interventions must also involve schools and communities in approaches that
counter the conditions that produce so much frustration, apathy, alienation,
and hopelessness. This quick training aid presents a brief set of resources
to guide those providing an in-service training session on youth suicide
prevention. The packet contains a brief introduction to the topic with key
talking points, fact sheets, tools and handouts, and a directory of
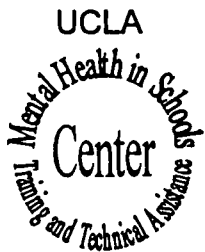additional resources. (GCP)

A Center Quick Training Aid . . .

Suicide Prevention

This document is a hard copy version of a resource that can be downloaded at no cost from the Center's website http://smhp.psych.ucla.edu The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspice of the School Mental Health Project, Dept. of Psychology, UCLA. Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095-1563 (310) 825-3634 Fax: (310) 206-8716; E-mail: smhp@ucla.edu

U.S. Department of Health and Human Services

HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

CMHS
Center for Mental Health Services
SAMHSA
Substance Abuse & Mental Health
Services Administration

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UCLA

Mental Health in Schools
Center
Training and Technical Assistance

The *Center for Mental Health in Schools* operates under the auspices of the School Mental Health Project at UCLA.* It is one of two *national centers* concerned with mental health in schools that are funded in part by the U.S. Department of Health and Human Services, Office of Adolescent Health, Maternal and Child Health Bureau, Health Resources and Services Administration -- with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (Project #U93 MC 00175).

The UCLA Center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. In particular, it focuses on comprehensive, multifaceted models and practices to deal with the many external and internal barriers that interfere with development, learning, and teaching. Specific attention is given policies and strategies that can counter marginalization and fragmentation of essential interventions and enhance collaboration between school and community programs. In this respect, a major emphasis is on enhancing the interface between efforts to address barriers to learning and prevailing approaches to school and community reforms.

U.S. Department of Health and Human Services

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Quick Training Aids

Suicide Prevention

Periodically, windows of opportunities arise for providing inservice at schools about mental health and psychosocial concerns. When such opportunities appear, it may be helpful to access one or more of our Center's *Quick Training Aids.*
Each of these offers a brief set of resources to guide those providing an inservice session. (They also are a form of quick self-tutorial and group discussion.)

Most encompass

* key talking points for a short training session

* a brief overview of the topic

* facts sheets

* tools

* a sampling of other related information and resources

In compiling resource material, the Center tries to identify those that represent "best practice" standards. If you know of better material, please <u>let us know</u> so that we can make improvements.

This set of training aids was designed for free online access and interactive learning. It can be used online and/or downloaded at http://smhp.psych.ucla.edu – go to Quick Find and scroll down in the list of "Center Responses" to *Suicide Prevention.* Besides this Quick Training Aid, you also will find a wealth of other resources on this topic.

Guide for Suggested Talking Points

I. Brief Overview

A. Present main points from:
   Youth Suicide/Depression/Violence 📖 Excerpted from *Addressing*
   Barriers to Learning Newsletter.
   1. Highlight the suicide rates and trends for youth in the section titled "About Suicide and Depression." This forms the crux of the argument that youth suicide prevention is important.
   2. Highlight the underlying problems that might lead to suicide, depression, or violence in the section titled "Linked Problems." Many are reluctant to specifically address suicide in classrooms or with individual children. Along with specific strategies outlined in the "Suicide Prevention" box (pg. 7), interventions can focus on enhancing protective factors (see pg. 8 for an illustrative list).
   3. Distribute "Enhancing Protective Factors and Building Assets" (pg. 8) as a handout for reference and/or discussion. What protective factors are already being enhanced by current school programs? What additional asset-building components would be feasible to incorporate in curricula or school programming?

II. Facts

A. U.S. Suicide Rates by Age, Gender, and Racial Group
   (http://www.nimh.nih.gov/research/suichart.htm) - NIMH Chart.
   1. This chart can be incorporated into a slide and/or handout for presentation.
   2. Possible points for discussion include gender and race differences in suicide rates. Also, the sharp increase in suicides among both Black and White males during adolescence. Cross-reference the CDC Fact Sheet (below).

B. Suicide in the United States
   (http://www.cdc.gov/ncipc/dvp/youth/suicide.htm) - CDC Fact Sheet.
   1. The first bullet point comparing suicide and homicide often catches the attention of the audience and might warrant repeating.
   2. The remaining bullet points in the first section provide information about the scope of the problem, particularly in youth, and may stimulate discussion. Adding a short, local story about youth suicide might help to personalize the numbers.
   3. Also highlight the section titled "Suicide Among the Young." Depending on your audience, some bullet points might be more relevant to discuss than others.
   4. Additional references available from the CDC pertinent to suicide prevention are listed in the bibliography at the end of the Fact Sheet.

C. Injury Mortality Reports
   (http://webapp.cdc.gov/sasweb/ncipc/mortrate.html) - CDC customizable summary statistics. Click here for an example customized report (Note: Double-click the yellow boxes in the Acrobat PDF for SMHP tips). 📖
   1. At some point you might be asked for more specific information, like how local trends compare to the national data. This

resource can help you prepare for such questions by providing you with customized summary statistics from the CDC Injury Mortality database.

2. If you know that your audience is likely to ask particular questions, you might want to run the statistics at the website and print out an informative handout ahead of time.

III. Tools/Handouts - Why and How?

A. Why and How Should Schools Get Involved - 🖾 Excerpted from Center packet entitled: *School Interventions to Prevent Youth Suicide*, pgs. 23-28.

1. Highlight the box on the first page for a concise explanation for why school-based intervention is necessary.
2. The section titled "On Prevention", provides four succinct recommendations for prevention efforts. Highlight how the current training encompasses these recommendations.
3. Research-based answers to concerns about more general and more targeted intervention strategies are also included for your reference. These concerns might arise in discussion or in planning, but are not critical to hand out to everyone.

B. Life-Cycle Commonalities and Age-Group-Specific Aspects of the Suicide Trajectory for Childhood and Adolescence - 🖾 Included in Center packet on Suicide Prevention, pg. 20.

1. This should be a handout. It is a comprehensive, well-organized table of potential risk factors in childhood and adolescence.
2. Highlight the commonalities, these will be helpful in identifying youth at risk even if the age-specific information is not recalled.

C. A Few Examples of Assessing Risk - 🖾 Excerpted from a Center packet entitled: *School Interventions to Prevent Youth Suicide*, pgs. 34-37.

1. This section contains possible screening tools for suicide risk assessment. Depending on your audience, one or more of these tools might be appropriate to handout and discuss.
2. Highlight the section on "DSM-IV Criteria..." This information might be most helpful in terms of early intervention before a suicidal crisis. A possible point for discussion is "How is depression screening being conducted?"

IV. Training Programs

A. Training programs for community members, teachers, school staff, and students - 🖾 Excerpts from CDC (1992). *Youth Suicide Prevention Programs: A Resource Guide*. (Available online)

1. This annotated list is mainly for your reference as organizer of the training. The organizations listed might be able to provide additional literature for the training or follow-up training for implementation of specific intervention strategies.

V. Additional Resources

B. QuickFind on Suicide Prevention 🖾 (printer-friendly format)
To view the web-based quick find on *suicide prevention*, click here.

VI. Originals for Overhead

A. <u>Statistics on Suicide in the United States and Suicide Among the Young</u> – Excerpted from the National Center for Injury Prevention and Control Suicide Prevention Fact Sheet.

B. <u>Why Should Schools Get Involved?</u>

C. <u>Suicidal Assessment Checklist</u> – Excerpted from our Center packet entitled *School Interventions to Prevent Youth Suicide.*

D. <u>Follow-through Steps After Assessing Suicidal Risk Checklist</u> – Excerpted from our Center packet entitled *School Interventions to Prevent Youth Suicide.*

Addressing Barriers to Learning

New ways to think . . .

Better ways to link

to Learning

Volume 4, Number 3
Summer, 1999

...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.

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.

9

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.

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.

*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.

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, 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 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

II. Fact Sheets

U. S. Suicide Rates

Suicide in the United States

Injury Mortality Reports

U.S. SUICIDE RATES BY AGE, GENDER, AND RACIAL GROUP

1998

Legend: ▨ Black Female ▨ White Female ■ Black Male ☐ White Male

Y-axis: SUICIDE RATE PER 100,000 (0, 10, 20, 30, 40, 50, 60, 70, 80)

X-axis (AGE GROUPS): 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85+
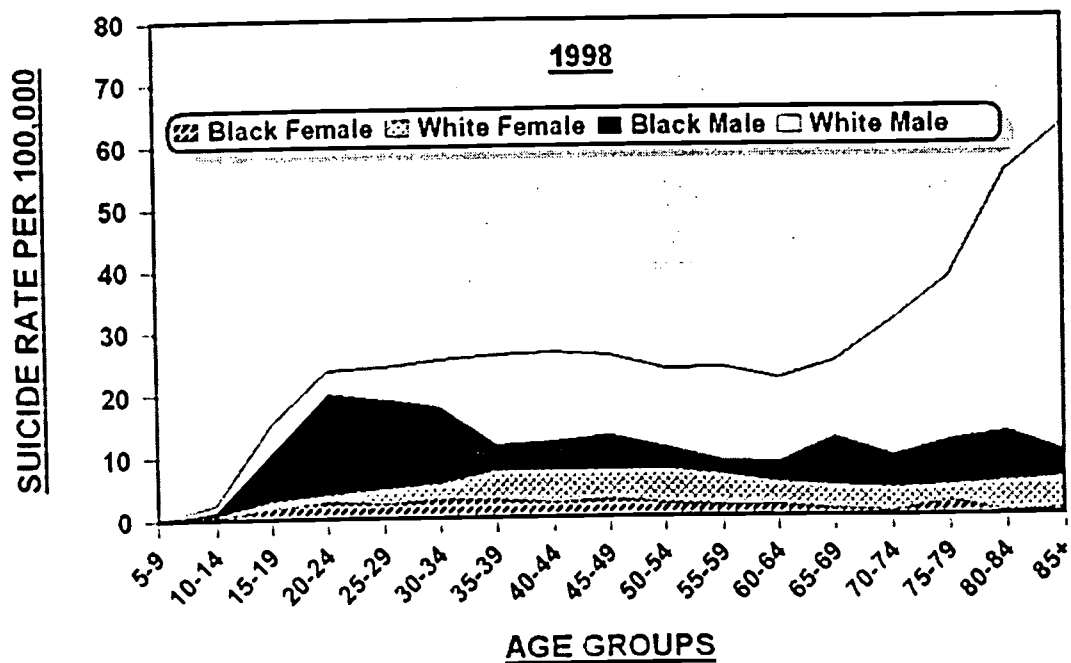
Source: National Institute of Mental Health
Data: Centers for Disease Control And Prevention. National Center For Health Statistics

Available on-line at http://www.nimh.nih.gov/research/suichart.htm

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Suicide in the United States

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The Problem

Suicide took the lives of 30,535 Americans in 1997 (11.4 per 100,000 population).[1]

- More people die from suicide than from homicide. In 1997, there were 1.5 times as many suicides as homicides.[1]

- Overall, suicide is the eighth leading cause of death for all Americans,an d is the third leading cause of death for young people aged 15-24.[1]

- Males are four times more likely to die from suicide than are females.[1] However,f emales are more likely to attempt suicide than are males.[2]

- 1997,w hite males accounted for 72% of all suicides.T ogether,w hite males and white females accounted for over 90% of all suicides.[1] However, during the period from 1979-1992, suicide rates for Native Americans (a category that includes American Indians and Alaska Natives) were about 1.5 times the national rates. There was a disproportionate number of suicides among young male Native Americans during this period,a s males 15-24 accounted for 64% of all suicides by Native Americans.[3]

- Suicide rates are generally higher than the national average in the western states and lower in the eastern and midwestern states.[4]

- Nearly 3 of every 5 suicides in 1997 (58%) were committed with a firearm.[1]

Suicide Among the Elderly

- Suicide rates increase with age and are highest among Americans aged 65 years and older.T he ten year period, 1980-1990, was the first decade since the 1940s that the suicide rate for older residents rose instead of declined.[5]

- Men accounted for 83% of suicides among persons aged 65 years and older in 1997.[1]

- From 1980-1997, the largest relative increases in suicide rates occurred among those 80-84 years of age. The rate for men in this age group increased 8% (from 43.5 per 100,000 to 47.0).[1,6]

- Firearms were the most common method of suicide by both males and females, 65 years and older, 1997, accounting for 77.1% of male and 32.7% of female suicides in that age group.[1]

ERIC
Full Text Provided by ERIC

- Suicide rates among the elderly are highest for those who are divorced or widowed.I n 1992,t he rate for divorced or widowed men in this age group was 2.7 times that for married men,1. 4 times that for never-married men, and over 17 times that for married women.T he rate for divorced or widowed women was 1.8 times that for married women and 1.4 times that for never-married women.[6]

- Risk factors for suicide among older persons differ from those among the young.Ol der persons have a higher prevalence of depression,a greater use of highly lethal methods and social isolation.T hey also make fewer attempts per completed suicide,h ave a higher-male-to-female ratio than other groups,h ave often visited a health-care provider before their suicide, and have more physical illnesses.[7]

Suicide Among the Young

- Persons under age 25 accounted for 15% of all suicides in 1997.[1] From 1952-1995,th e incidence of suicide among adolescents and young adults nearly tripled.F rom 1980-1997,th e rate of suicide among persons aged 15-19 years increased by 11% and among persons aged 10-14 years by 109%. From 1980-1996,th e rate increased 105% for African-American males aged 15-19.[1,8]

- For young people 15-24 years old,s uicide is the third leading cause of death,beh ind unintentional injury and homicide.I n 1997,m ore teenagers and young adults died from suicide than from cancer, heart disease,A IDS, birth defects,s troke,pn eumonia and influenza,an d chronic lung disease *combined*.[1]

- Among persons aged 15-19 years,f irearm-related suicides accounted for 62% of the increase in the overall rate of suicide from 1980-1997.[1]

- The risk for suicide among young people is greatest among young white males; however,f rom 1980 through 1995,s uicide rates increased most rapidly among young black males.[9] Although suicide among young children is a rare event,th e dramatic increase in the rate among persons aged 10-14 years underscores the urgent need for intensifying efforts to prevent suicide among persons in this age group.

CDC's Program in Suicide Prevention

The National Center for Injury Prevention and Control (NCIPC) is working to raise awareness of suicide as a serious public health problem,an d is focusing on science-based prevention strategies to reduce injuries and deaths due to suicide. Current activities include the following:

- The Surgeon General's Call To Action introduces a blueprint for addressing suicide - Awareness,In tervention,an d Methodology (AIM),an approach derived from the collaborative deliberations of the 1st National Suicide Prevention Conference participants.A s a framework for suicide prevention,A IM includes 15 key recommendations that were refined from consensus and evidence-based findings presented at the Reno conference.
- A case-control study that is examining possible risk factors for suicide, including alcohol use,ex posure to previous suicides,an d residential mobility that might lessen opportunities for developing social networks.

- Convening national conferences to exchange information about research and prevention strategies (including the Suicide Prevention Advocacy Network conference held in Reno in October 1998 and the American Indian/Alaska Native Community Suicide Prevention and Network conference held in San Diego in November 1998).
- Support for extramural research that will examine risk factors for suicide in the general population.
- Developed the Suicide Prevention Research Center at the Trauma Institute, University of Nevada School of Medicine.
- Continued support for a Native American suicide prevention center.
- Evaluation of the effectiveness of current suicide prevention programs, including two interventions,on e with youth in New York and one with older persons in South Carolina.

Suicide Prevention Materials Published by CDC

- Centers for Disease Control and Prevention.S urveillance for Injuries and Violence Among Older Adults.MMW R 1999; 48 (No.S S-8); 27-34.
- Centers for Disease Control and Prevention. Suicide Prevention Among Active Duty Air Force Personnel-United States, 1990-1999. MMWR 1999; 48 (No.46) ; 1053-1057.
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- Kachur SP,P otter LB,Ja mes SP,P owell KE. Suicide in the United States, 1980-1992.A tlanta: Centers for Disease Control and Prevention,Nation al Center for Injury Prevention and Control,19 95.Violen ce Surveillance Summary,No.1.
- Centers for Disease Control and Prevention. Suicide among children, adolescents, and young adults--United States, 1980-1992. MMWR 1995; 44:289-291.
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- Centers for Disease Control and Prevention. Programs for the prevention of suicide among adolescents and young adults; and suicide contagion and the reporting of suicide: recommendations from a national workshop.MMWR 1994; 43 (No.RR-6).
- Potter LB,P owell KP,Kach ur SP.S uicide prevention from a public health perspective.S uicide and Life-Threatening Behavior.199 5; 25(1):82-91.

Resources

- Centers for Disease Control and Prevention (CDC),Nation al Center for Injury Prevention and Control (NCIPC) www.cdc.gov/ncipc/ncipchm.htm

- National Suicide Prevention Strategy www.sg.gov/library/calltoaction/strategymain.htm

- Suicide Prevention Advocacy Network (SPAN)
  www.spanusa.org/home.htm

- American Association of Suicidology
  www.suicidology.org or call 1-202-237-2280

- National Institute of Mental Health (NIMH)
  www.nimh.nih.gov

- Substance Abuse and Mental Health Administration (SAMHSA)
  www.samhsa.gov

References

1. CDC unpublished mortality data from the National Center for Health Statistics (NCHS) Mortality Data Tapes.
2. Suicide & Life Threatening Behavior 28(1):1-23,199 8.
3. CDC,Viol ence Surveillance Summary Series,No .2 .19 96.
4. MMWR 46(34):789-792,1997.
5. Am J Public Health 81:1198-1200,1991.
6. MMWR 45(1):3-6,1996.
7. Aging & Mental Health 1(2):107-111,1997.
8. MMWR 44(15):289-291,1995.
9. MMWR 47(10):193-196,1998.

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Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

> **Sample input for CDC customizable Summary Statistics**
> **(See section II.C. in the Guide for Suggested Talking Points)**

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Injury Mortality Reports

Choose your report options, then click the "Submit Request" button below.

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WISQARS
- Leading Causes of Death

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[Search]

Report Options

Mechanism/Cause
[All Injury ▼]

Census Region/State
[United States ▼]

Race
[All Races ▼]

Sex
[Both Sexes ▼]

Manner/Intent
[Suicide ▼]

Year(s) of Report
[1997 ▼] to [1998 ▼]

Hispanic Origin
[All ▼]

Output Options
[Standard Output ▼]

[Submit Request] or [Reset]

Advanced Options

Output Group(s)
1. [Race ▼]   3. [None ▼]
2. [Sex ▼]   4. [None ▼]

Age-Adjusting
Select Standardized Year for Age-Adjusting:
Yes, Use [1940 ▼] as the Standard Year.

No Age-Adjusting Requested

Age Selection

All Ages (includes unknown age)

Age Groups [0-4 ▼] to [Unknown ▼]

Custom Age Range [0] to [18] (0=<1, 85=85+ 199=Unknown)

[Submit Request] or [Reset]

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1997 - 1998, United States
Suicide Deaths and Rates per 100,000
All Races,
Both Sexes, Ages 0 to 18
E950-E959

NOTE: Output is based on the report options specified on the previous page: "National Center for Injury Prevention and Control - Example Input."

Race	Sex	Number of Deaths	Population***	Crude Rate
White	Males	2,187	59,727,002	3.66
	Females	524	56,609,017	0.93
		2,711	116,336,019	2.33
Black	Males	285	11,557,473	2.47
	Females	69	11,195,505	0.62
		354	22,752,978	1.56
Am Indian/AK Native	Males	66	861,351	7.66
	Females	15*	839,320	1.78*
		81	1,700,671	4.76
Asian/Pac Islander	Males	57	3,188,994	1.79
	Females	20*	3,051,486	0.65*
		77	6,240,480	1.23
Total		3,223	147,030,148	2.19

Download Results in a Spreadsheet (CSV) File   Help with Download

* Rates based on 20 or fewer deaths may be unstable. Use with caution.

*** Population estimates are aggregated for multi-year reports to produce rates.

Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC
Data Source: NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates.

Suicide Prevention:
Why and How Should Schools Get Involved

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

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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.

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III. Tools/Handouts

Why and How Should Schools Get Involved

Life Cycle Commonalities

A Few Examples of Assessing Risk

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

Some Concerns About Suicide Prevention Programs

While there are many studies that review the positive aspects
of suicide intervention programs, there is also literature
which addresses ineffective or possibly harmful strategies.
To provide a balance the following information is presented.

Hazell P, King R. Arguments for and against teaching suicide prevention in schools. *Aust N Z J Psychiatry* 1996; 30: 633-642.

•A major concern relates to the responsibility adolescents are made to feel for their peers in such programs. The programs may be asking vulnerable young people to take a huge responsibility for some adolescents who are very disturbed. Those who feel they are responsible to take care of their peers may worsen situations that call for professional help. Hazell P, King R. Arguments for and against teaching suicide prevention in schools. *Aust N Z J Psychiatry* 1996; 30: 633-642.

•Most programs use a video or vignette to introduce the students to the suicide topic. These educational videos tend to dramatize suicide and trivialize the precipitants to the suicide. Thus, these videos are thought to encourage imitation. Gould MS, Wallenstein S, Davidson L. Suicide clusters: a critical review. *Suicide and Life-Threatening Behavior* 1989; 19: 17-29

•The suicide prevention programs also tend to minimize the contribution of mental illness to the problem of suicide. This is also thought to encourage imitation. Garland A. Shaffer D, Whittle B. A national survey of school-based, adolescent suicide prevention programs. *Journal of the American Academy of Child and Adolescent Psychiatry* 1989; 28: 932-934.

•Two previous studies showed that students who were exposed to a suicide prevention program were less likely to recommend mental health evaluation to a suicidal friend. Kalafat J, Elias M. Suicide prevention in an educational context: broad and narrow foci. *Suicide and Life-threatening Behavior* 1995; 25: 123-133.

•Males showed an increase in hopelessness and maladaptive behaviors after exposure to prevention programs. Even after taking part in the program, the majority of males and females said that they would rather talk with a friend about their suicide urges. Overholser JC. Hemstreet AH, Spirito A, Vyse S. Suicide awareness programs in the schools: effects o gender and personal experience. *Journal of the American Academy of Child and Adolescent Psychiatry* 1989: 28: 925-930.

•Some individuals exposed to programs will show a deterioration in attitudes. Overholser JC Hemstreet AH, Spirito A, Vyse S. Suicide awareness programs in the schools: effects of gender and personal experience. *Journal of the American Academy of Child and Adolescent Psychiatry* 1989: 28: 925-930.

Ploeg J, Ciliska D, Dobbins M. A Systematic Overview of Adolescent Suicide Prevention Programs. *Canadian Journal of Public Health.* 1996; 319-324.

•One study found that the program resulted in more students, especially males, suggesting that suicide was a possible solution to their problems. Shaffer D, Garland A, Vieland V, et al. The impact of curriculum-based suicide prevention programs for teenagers. *Journal of the American Academy of Child Adolescent Psychiatry.* 1991; 30: 588-96.

•Another study showed that suicide attempters exposed to the program were more likely to indicate that talking about suicide makes some teens more likely to try and kill themselves. Shaffer D, Vieland V, Garland A, et al. Adolescent suicide attempters; Responses to suicide prevention programs. *Journal of the American Academy of Child Adolescent Psychiatry.* 1991; 30: 588-96.

Rosenman, Stephen J. Preventing suicide: what will work and what will not. *MJA* 1998; 169: 100-102.

•Activities focusing on the identification and intervention of people with "high risk" of suicide are possibly a waste. These activities are ineffective and some may even exacerbate certain situations. Rosenman, Stephen J. Preventing suicide: what will work and what will not. *MJA* 1998; 169: 100-102.

•High-risk individuals need effective advice and treatment that is both available and acceptable to them. If one looks at population suicide rates, agencies such as telephone suicide crisis services seem ineffective. Gunnell D, Frankel S. Prevention of suicide: aspirations and evidence. *BMJ* 1994; 308: 1227-1233.

•Intervention after suicide attempts has had little effect and it is also irregular in its availability. In addition, intervention programs are frequently ignored by those it is intended to benefit. Deykin, Chung-Chen H, Joshi N. Adolescent suicidal and self-destructive behaviors: results of an intervention study. *Journal of Adolescent Health Care* 1986; 7: 88-95.

For more from this Technical Aid Sampler see
http://smhp.psych.ucla.edu/techpak.htm#suicide

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Suicide Prevention:

Life-Cycle Commonalities and Age-Group-Specific Aspects of the Suicide Trajectory for Childhood and Adolescence
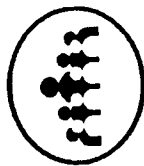
This **Quick Training Aid** was excerpted from a Technical Aid Sampler entitled: *School Interventions to Prevent Youth Suicide*, pp. 20. Center for Mental Health in Schools (2000). **Originally cited from** from: Stillion, J.M., McDowell, E. E., and May J. H. Suicide across the life span: Premature exits. p244. Hemisphere, New York. 1989

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

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.

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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   Y   N
a way to get to a happier afterlife?

(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.

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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.

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

DSM-IV 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.

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Suicide Prevention:
Training programs for community members, teachers, school staff, and students

Training programs for community members

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 1-day sessions. Refresher training incorporates workshop activities, a helper's handbook, and various self-directed learning activities using audiovisuals.

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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.

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.

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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.

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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 1-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.

A Center Response:

The following reflects our most recent response for technical assistance related to SUICIDE PREVENTION. This list represents a sample of information to get you started and is not meant to be an exhaustive list.

(Note: Clicking on the following links causes a new window to be opened. To return to this window, close the newly opened one).

If you go online and access the Quick Find, you can simply click over to the various sites to access documents, agencies, etc. For your convenience here, the website addresses for various Quick Find entries are listed in a table at the end of this document in order of appearance, cross-referenced by the name of the resource.

Center Developed Resources and Tools

- **NEW!** Quick Training Aid
  A brief set of resources to guide those providing an inservice session on **suicide prevention.** Also useful as a quick self-tutorial. (note: opens up in a new window)

- Technical Assistance Sampler on: School Interventions to Prevent Youth Suicide
- A Resource Aid Packet on Responding to Crisis at a School
- Screening/Assessing Students: Indicators and Tools
- An Introductory Packet on Assessing to Address Barriers to Learning
- Hotline Numbers

Relevant Publications on the Internet

- AACAP Fact Sheet: Teen Suicide
- American Academy of Pediatrics Some Things You Should Know About Preventing Teen Suicide
- APA Public Information on Teen Suicide
- Common Misconceptions about Suicide
- Community Learning Network: Teen Suicide Theme Page
- Detecting Suicide Risk in a Pediatric Emergency Department: Development of a Brief Screening Tool
- Explaining Suicide to Children
- Frequently Asked Questions about Suicide (NIMH)

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- Goals and Objectives of the National Suicide Prevention Strategy
- Health Teacher: Suicide Prevention
- Healthtouch: Suicide Facts
- Is Suicide Contagious? A Study of the Relation between Exposure to the Suicidal Behavior of Others and Nearly Lethal Suicide Attempts (PDF Document, 71K)
- Issues to Consider in Intervention Research with Persons at High Risk for Suicidality
- National Strategy for Suicide Prevention (U.S.)
- The Office of Youth Affairs
- Pitfalls: What to Avoid
- Reporting on Suicide: Recommendations for the Media (PDF Document, 173K)
- Students' FAQs about Suicide
- Suicide statistics in the US and San Francisco (1991). From San Francisco Suicide Prevention.
- Symptoms of Depression and Danger Signs for Suicide
- Temporal Variations in School-Associated Violent Deaths (PDF Document, 131K)
- Things to Watch Out for When Assessing Suicide Risk
- What to Do if Someone You Know Becomes Suicidal
- Youth Suicide National Center
- Youth Suicide Prevention Information
- Youth Suicide Prevention Program
- Youth Suicide Prevention Programs: A Resource Guide
- Preventing suicide: what will work and what will not
- Saving Kids from Suicide

Selected Materials from our Clearinghouse

- Youth Suicide Prevention Program, Los Angeles Unified School District
- Evaluation of Suicide Risk Among Adolescents
- A Measure of Adolescent Potential for Suicide (MAPS): Development and Preliminary Findings
- Study on Suicide: Training Manual
- Brief Cognitive-Behavioral Family Therapy for Suicidal Adolescents
- Adolescent Suicide Prevention: A Bibliography of Selected Resources
- Asian-American / Pacific Islander Resource Guide: Suicide, the Hidden Problem
- Crossroads: Coping with Crisis: Personal Wellness Handbook for The Youth Suicide Prevention Program
- Helpline: A Basic Text for Helpline Volunteers
- In His Brother's Footsteps: A Suicide Prevention Handbook for Teens (English and Spanish)
- Interviewing the Suicidal/Depressed Child
- Prevention and Containment of Suicide Clusters
- Responding to Students At-Risk for Suicide
- Study on Suicide: Training Manual
- Youth Suicide Parent Information
- Youth Suicide: Crisis Intervention and Management

Relevant Publications That Can Be Obtained at Your Local Library

- Best Practices in School Psychology III: Best Practices in Suicide Intervention
  National Association of School Psychologists; 4340 East Highway, Suite 402, Bethesda, MD 20814; Phone: (301) 657-0270; Fax: (301) 657-0275.
- Developing a comprehensive school suicide prevention program. (2001). K.A. King. *Journal of School Health*, *71*, 132-137.
- Adolescent Mental Health: Prevention and Treatment Programs. By, A. E. Kazdin (1993). In: *American*

Psychologist, Vol. 48(2): p.127-141.
- Adolescent Suicide Attempters: Response to Suicide Prevention Programs. By, D. Shaffer, V. Vieland, A. Garland, M. Rojas, M. Underwood & C. Busner (1990). In: *Journal of the American Medical Association,* Vol. 264(24): p. 3151-3155.
- Arguments for and against teaching suicide prevention in schools. By, P. Hazell & R. King (1996). In: *Australian and New Zealand Journal of Psychiatry,* 30: 633-642.
- The Impact of Curriculum-based Suicide Prevention Programs for Teenagers. By, D. Shaffer, A. Garland, V. Vieland, M. Underwood & C. Busner (1991). , 23(2), 120-129. *Journal of American Academy of Child and Adolescent Psychiatry* 30, 4: 588-596.
- The Impact of a Suicide Prevention Program for Adolescents on Suicidal Tendencies, Hopelessness, Ego Identity, and Coping. By, I. Orbach & H. Bar-Joseph (1993). *Suicide and Life-Threatening Behavior,* 23(2), 120-129.
- A National Survey of School-Based, Adolescent Suicide Prevention Programs. By, A. Garland, D. Shaffer & B. Whittle (1989). *Journal of American Academy of Child and Adolescent Psychiatry* 28, 6: 931-934.
- Suicide Awareness Programs in the Schools: Effects of Gender and Personal Experience. By, J.C. Overholser, A. H. Hemstreet, A. Spirito, & S. Vyse (1989). *Journal of American Academy of Child and Adolescent Psychiatry,* 28, 6: 925-930.
- Suicide Prevention in an Educational Context: Broad and Narrow Foci. By, J. Kalafat, M. J. Elias (1995). *Suicide and Life-Threatening Behavior,* 25(1): 123-133.
- A Systematic Overview of Adolescent Suicide Prevention Programs. By,J. Ploeg, D. Ciliska, M. Dobbins, S. Hayward, H. Thomas & J. Underwood (1996). *Canadian Journal of Public Health* September-October: 319-324.

Related Agencies and Websites

- American Academy of Child and Adolescent Psychiatry
- American Association of Suicidology (AAS)
- American Foundation for Suicide Prevention (AFSP)
- Suicide Information and Education Center (SIEC)
- Center for Suicide Research and Prevention
- *Hotline Numbers*
- Keep Yourself Alive
- SA\VE: Suicide Awareness \ Voices of Education
- San Francisco Suicide Prevention Website
- SPAN: Suicide Prevention Advocacy Network
    - B-SPAN: The Brown University Chapter of SPAN
- The Befrienders
- The National Committee on Youth Suicide Prevention
- The Office of Youth Affairs

We hope these resources met your needs. If not, feel free to contact us for further assistance. For additional resources related to this topic, use our search page to find people, organizations, websites and documents. You may also go to our technical assistance page for more specific technical assistance requests.

If you haven't done so, you may want to contact our sister center, the Center for School Mental Health Assistance at the University of Maryland at Baltimore.

If our website has been helpful, we are pleased and encourage you to use our site or contact our Center in the future. At the same time, you can do your own technical assistance with "The fine Art of Fishing" which we have developed as an aid for do-it-yourself technical assistance.

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If you go online and access the Quick Find, you can click over to the various sites to access documents, agencies, etc. For your convenience here, the following pages list the website addresses for the various Quick Find entries.

Shortcut Text	Internet Address
Quick Training Aid	http://smhp.psych.ucla.edu/qf/suicide_qt/
Technical Assistance Sampler on: School Interventions to Prevent Youth Suicide	http://smhp.psych.ucla.edu/techpak.htm#suicide
A Resource Aid Packet on Responding to Crisis at a School	http://smhp.psych.ucla.edu/resource.htm#crisis
Screening/Assessing Students: Indicators and Tools	http://smhp.psych.ucla.edu/resource.htm#screening
An Introductory Packet on Assessing to Address Barriers to Learning	http://smhp.psych.ucla.edu/intropak.htm#assessing
Hotline Numbers	http://smhp.psych.ucla.edu/hotline.htm
AACAP Fact Sheet: Teen Suicide	http://www.aacap.org/publications/factsfam/suicide.htm
American Academy of Pediatrics Some Things You Should Know About Preventing Teen Suicide	http://www.aap.org/advocacy/childhealthmonth/prevteensuicide.htm
APA Public Information on Teen Suicide	http://www.psych.org/public_info/TEENAG~1.HTM
Common Misconceptions about Suicide	http://www.save.org/misconc.html
Community Learning Network: Teen Suicide Theme Page	http://www.cln.org themes/suicide.html
Detecting Suicide Risk in a Pediatric Emergency Department: Development of a Brief Screening Tool	http://www.findarticles.com/cf_0/m0950/5_107/74924843/print.jhtml
Explaining Suicide to Children	http://www.save.org/EXPLSUIC.HTM
Frequently Asked Questions about Suicide (NIMH)	http://www.nimh.nih.gov/research/suicidefaq.cfm
Goals and Objectives of the National Suicide Prevention Strategy	http://www.surgeongeneral.gov/library/calltoaction/strategyintro.htm
Health Teacher: Suicide Prevention	http://www.healthteacher.com/lessonguides/injuries/middle/inj5ms/index.asp
Healthtouch: Suicide Facts	http://www.healthtouch.com/bin/EContent_HT/showAllLfts.asp?lftname=NIMH023&cid=HT
Is Suicide Contagious? A Study of the Relation between Exposure to the Suicidal Behavior of Others and Nearly Lethal Suicide Attempts (PDF Document, 71K)	http://aje.oupjournals.org/cgi/reprint/154/2/120.pdf
Issues to Consider in Intervention Research with Persons at High Risk for Suicidality	http://www.nimh.nih.gov/research/highrisksuicide.cfm
National Strategy for Suicide Prevention (U.S.)	http://www.mentalhealth.org/suicideprevention/
The Office of Youth Affairs	http://www.youthaffairs.wa.gov.au/programs/suicide/help.html
Pitfalls: What to Avoid	http://www.sfsuicide.org/html/pitfalls.html
Reporting on Suicide: Recommendations for the Media (PDF Document, 173K)	http://www.appcpenn.org/reports/2001/guidelines809.pdf
Students' FAQs about Suicide	http://www.save.org/question.html

Shortcut Text	Internet Address
Suicide statistics in the US and San Francisco (1991).	http://http://www.sfsuicide.org/html/stats.html
Symptoms of Depression and Danger Signs for Suicide	http://www.save.org/symptoms.html
Temporal Variations in School-Associated Violent Deaths (PDF Document, 131K)	http://www.cdc.gov/mmwr/PDF/wk/mm5031.pdf
Things to Watch Out for When Assessing Suicide Risk	http://www.sfsuicide.org/html/plaid.html
What to Do if Someone You Know Becomes Suicidal	http://www.save.org/whattodo1.html
Youth Suicide National Center	http://www.jaring.my/befrienders/youth1.htm
Youth Suicide Prevention Information	http://www.sanpedro.com/spyc/suicide.htm
Youth Suicide Prevention Program	http://depts.washington.edu/ysp
Youth Suicide Prevention Programs: A Resource Guide	http://www.cdc.gov/ncipc/pub-res/youthsui.htm
Preventing suicide: what will work and what will not	http://www.mja.com.au/public/issues/jul20/rosenman/rosenman.html
Saving Kids from Suicide	http://www.nea.org/neatoday/0004/health.html
Youth Suicide Prevention Program, Los Angeles Unified School District	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC7
Evaluation of Suicide Risk Among Adolescents	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC17
A Measure of Adolescent Potential for Suicide (MAPS): Development and Preliminary Findings	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC40
Study on Suicide: Training Manual	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC19
Brief Cognitive-Behavioral Family Therapy for Suicidal Adolescents	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC35
Adolescent Suicide Prevention: A Bibliography of Selected Resources	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC9
Asian-American / Pacific Islander Resource Guide: Suicide, the Hidden Problem	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC5
Crossroads: Coping with Crisis; Personal Wellness Handbook for The Youth Suicide Prevention Program	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC16
Helpline	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=2303DOC2
In His Brother's Footsteps: A Suicide Prevention Handbook for Teens (English and Spanish)	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC22
Interviewing the Suicidal/Depressed Child	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC15
Prevention and Containment of Suicide Clusters	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC3
Responding to Students At-Risk for Suicide	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC23

Shortcut Text	Internet Address
Youth Suicide Parent Information	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC6
Youth Suicide: Crisis Intervention and Management	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC26
American Academy of Child and Adolescent Psychiatry	http://www.aacap.org/
American Association of Suicidology (AAS)	http://www.suicidology.org/
American Foundation for Suicide Prevention (AFSP)	http://www.afsp.org/
Suicide Information and Education Center (SIEC)	http://www.siec.ca/
Center for Suicide Research and Prevention	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=02169
Hotline Numbers	http://www.spanusa.org/phnumb.htm
Keep Yourself Alive	http://auseinet.flinders.edu.au/projects/keepalive.html
SA\VE: Suicide Awareness \ Voices of Education	http://www.save.org/
San Francisco Suicide Prevention Website	http://www.sfsuicide.org/index2.html
SPAN: Suicide Prevention Advocacy Network	http://www.spanusa.org/
B-SPAN: The Brown University Chapter of SPAN	http://www.brown.edu/Students/B-SPAN/
The Befrienders	http://www.jaring.my/befrienders/index2.htm
The National Committee on Youth Suicide Prevention	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=02535
The Office of Youth Affairs	http://www.youthaffairs.wa.gov.au/programs/suicide/index.html
search	http://smhp.psych.ucla.edu/search.htm
technical assistance page	http://smhp.psych.ucla.edu/techreq.htm
Center for School Mental Health Assistance	http://csmha.umaryland.edu/
"The fine Art of Fishing"	http://smhp.psych.ucla.edu/selfhelp.htm

Originals
for
Overheads

The following can be copied to overhead transparencies
to assist in presenting this material.

Suicide in the United States - The Problem

- More people die from suicide than from homicide.

- Overall, suicide is the eighth leading cause of death for all Americans, and is the third leading cause of death for young people aged 15-24.

- Males are four times more likely to die from suicide than are females. However, females are more likely to attempt suicide than are males.

- White males and white females accounted for over 90% of all suicides.

- Suicide rates are generally higher than the national average in the western states and lower in the eastern and midwestern states.

- Nearly 3 of every 5 suicides (58%) were committed with a firearm.

Source: *National Center for Injury Prevention & Control*

Suicide Among the Young

- Persons under age 25 accounted for 15% of all suicides.

- For young people 15-24 years old, suicide is the third leading cause of death, behind unintentional injury and homicide.

- Among persons aged 15-19 years, firearm-related suicides accounted for 62% of the increase in the overall rate of suicide from 1980-1997.

- The risk for suicide among young people is greatest among young white males; however, from 1980 through 1995, suicide rates increased most rapidly among young black males.

- Although suicide among young children is a rare event, the dramatic increase in the rate among persons aged 10-14 years underscores the urgent need for intensifying efforts to prevent suicide among persons in this age group.

Source: *National Center for Injury Prevention & Control*

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.

- 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.
  (Guetzloe, 1991)

- 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)

SUICIDAL ASSESSMENT -- CHECKLIST
(Suggested points to cover with student/parent)

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

✓ *Does the individual have frequent suicidal thoughts?*

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

✓ *Does the student have a detailed, feasible plan?*

✓ *Has s/he made special arrangements as giving away prized possessions?*

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

(2) REACTIONS TO PRECIPITATING EVENTS

✓ *Is the student experiencing severe psychological distress?*

✓ Have there been major changes in recent behavior along with *negative feelings and thoughts?*

(3) PSYCHOSOCIAL SUPPORT

✓ *Is there a lack of a significant other to help the student survive?*

✓ *Does the student feel alienated?*

(4) HISTORY OF RISK-TAKING BEHAVIOR

✓ *Does the student take life-threatening risks or display poor impulse control?*

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FOLLOW-THROUGH STEPS AFTER ASSESSING SUICIDAL RISK -- CHECKLIST

❑ Avoid saying anything demeaning or devaluing, while conveying empathy, warmth, and respect.

❑ Explain the importance of and your responsibility for breaking confidentiality in the case of suicidal risk.

❑ Be certain the student is in a supportive and understanding environment.

❑ Try to contact parents by phone.

❑ If a student is considered to be in danger, only release her/him to the parent or someone who is equipped to provide help.

❑ Follow-up with student and parents to determine what steps have been taken to minimize risk.

❑ Document all steps taken and outcomes. Plan for aftermath intervention and support.

❑ Report child endangerment if necessary.

We hope you found this to be a useful resource.
There's more where this came from!

This packet has been specially prepared by our Clearinghouse. Other Introductory Packets and materials are available. Resources in the Clearinghouse are organized around the following categories.

Systemic Concerns

- Policy issues related to mental health in schools
- Mechanisms and procedures for program/service coordination
  - Collaborative Teams
  - School-community service linkages
  - Cross disciplinary training and interprofessional education
- Comprehensive, integrated programmatic approaches (as contrasted with fragmented, categorical, specialist oriented services)

- Issues related to working in rural, urban, and suburban areas
- Restructuring school support service
  - Systemic change strategies
  - Involving stakeholders in decisions
  - Staffing patterns
  - Financing
  - Evaluation, Quality Assurance
  - Legal Issues
- Professional standards

Programs and Process Concerns

- Clustering activities into a cohesive, programmatic approach
  - Support for transitions
  - Mental health education to enhance healthy development & prevent problems
  - Parent/home involvement
  - Enhancing classrooms to reduce referrals (including prereferral interventions)
  - Use of volunteers/trainees
  - Outreach to community
  - Crisis response
  - Crisis and violence prevention (including safe schools)

- Staff capacity building & support
  - Cultural competence
  - Minimizing burnout
- Interventions for student and family assistance
  - Screening/Assessment
  - Enhancing triage & ref. processes
  - Least Intervention Needed
  - Short-term student counseling
  - Family counseling and support
  - Case monitoring/management
  - Confidentiality
  - Record keeping and reporting
  - School-based Clinics

Psychosocial Problems

- Drug/alcoh. abuse
- Depression/suicide
- Grief
- Dropout prevention
- Gangs
- School adjustment (including newcomer acculturation)

- Pregnancy prevention/support
- Eating problems (anorexia, bulim.)
- Physical/Sexual Abuse
- Neglect
- Gender and sexuality

- Self-esteem
- Relationship problems
- Anxiety
- Disabilities
- Reactions to chronic illness
- Learning, attention & behavior problems