Information Dissemination in Schools

Issue Brief 1

Youth Suicide Prevention School-Based Guide ©

Suicide was the third leading cause of death in 2009 among middle school youth (10–14 years old) and high school youth (15–19 years old) in the United States (29). In 2009, researchers found that one in seven teenagers in the United States seriously considered suicide, which translates into a significant number of teenagers in our schools (28).

School-based prevention programs for suicide are ideal because the school provides an environment with the highest likelihood of exposure to a prevention program for adolescents (5). Despite a surge in attention, facilitated partly by the Surgeon General's Call to Action to Prevent Suicide (1999), school-based suicide prevention programs by in large have lacked commitment after implementation.

When schools cease to attend to suicide prevention programs, the facts surrounding suicide fail to be communicated to faculty, staff, and students. If this happens, a true understanding about adolescent suicide becomes clouded by myths and presumptuous ideas, which surround the topic of suicide and act as a barrier for suicide prevention programs.

School-based suicide prevention efforts should be facilitated by knowledgeable staff and should make knowledge available to all staff within the school setting (1, 2, 3, 7). Research has shown that teachers are inadequately trained on issues surrounding adolescent suicide and that most schools do not have a training program in place (6, 10).

One study found that teachers who are most likely to have some training or have addressed suicide in their curriculum (health teachers) did not feel confident that they could identify a student at-risk for suicide; only about one in ten (9%) felt confident about identifying a student at-risk (11). This lack of training and apparent lack of confidence is troubling when considering that results from a study found that over 25% of teachers who were surveyed about adolescent suicide reported that they had been approached by teens who were at-risk for suicide (12).

Training faculty and staff is universally advocated and supported by research as an essential and effective component to a suicide prevention program (18-24). Research suggests that training faculty and staff to develop the knowledge, attitudes, and skills to identify students who may be at-risk for suicide and make referrals when necessary can produce positive effects on an educator's knowledge, attitude, and referral practices (2, 24-27).

When schools cease to attend to suicide prevention programs, the facts surrounding suicide fail to be communicated to faculty, staff, and students. If this happens, a true understanding about adolescent suicide becomes clouded by myths and presumptuous ideas, which surround the topic of suicide and act as a barrier for suicide prevention programs.

Prepared By:

Justin Doan
Stephen Roggenbaum
Katherine J. Lazear

CFS Community SOLUTIONS
All Children & Youth—Every Community

USF UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES
Department of Child & Family Studies

Suggested Citation: Doan, J., Roggenbaum, S., & Lazear, K.J. (2012). *Youth suicide prevention school-based guide—Issue brief 1: Information dissemination in schools.* Tampa, FL: University of South Florida, College of Behavioral & Community Sciences, Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies (FMHI Series Publication #218-1-Rev 2012).

This publication is also available on-line as an Adobe Acrobat PDF file: http://theguide.fmhi.usf.edu

Information Dissemination in Schools continued

Training has also been found to increase educators' confidence that they have the ability to recognize a student potentially at risk for suicidal by more than four times that of teachers who don't receive training (13).

It is essential that administrators disseminate current information about adolescent suicide, such as risk factors, referral practices, and what to do when faced with a student potentially at-risk for suicide, to all staff generally in a convenient location for helping troubled teens.

Similar information should be presented to parents, which studies have shown is an essential component of suicide prevention programs (13, 14). It is also important that information provided to parents include a brief discussion about how to limit access to the tools used for suicide, such as gun restriction strategies (3, 14, 15, 16). Research has found that a brief one hour and thirty minute presentation should be sufficient for educating parents about adolescent suicide (14). This presentation should be part of a more comprehensive presentation that may address other issues such as gun restriction strategies or adolescent substance abuse (14). It is essential that parents have access to individuals within the school or information provided to them by the school about adolescent suicide.

Providing educators with the facts does not have to be an exhausting, time-consuming process. Research (2, 5) has shown that one brief, two-hour program produced substantial gains in teachers' awareness of adolescent suicide.

Research (9) also found that the New Jersey Adolescent Suicide Prevention Project, which offered a two-hour educator training program, resulted in an increased awareness in teachers' ability to identify at-risk students, as well as increasing the number of referrals teachers made to mental health professionals. A Colorado school-based suicide prevention program that focused on professional training about adolescent suicide resulted in a larger number of referrals and an overall increase in school staff's knowledge about adolescent suicide (1).

Educating faculty and staff in a brief one-session approach is efficient and more importantly does not lead to any harmful results.

One concern by overwhelmed teachers is that such an information sharing session would be just one more responsibility that they must address and take the burden of action for…however, the Centers for Disease Control (1) found that teachers respond to and receive suicide prevention programs and inservices in a positive and welcoming manner.

Training has been found to increase educators' confidence that they have the ability to recognize a student potentially at risk for suicidal by more than four times that of teachers who don't receive training (13).

Research suggests that teachers believe that they have a large role in identifying students at risk for suicide; that if they did identify students at risk, it would reduce their likelihood of dying by suicide; and that one of the most important things that a teacher could ever do is to prevent a suicide (5, 8). Given the potential impact teachers can have on adolescent suicide and given their apparent response to these programs, it seems prudent that a school should confront suicide and challenge the myths surrounding adolescent suicide.

Only through dedicated administrators, who are willing to disseminate this information about suicide, will teachers be able to effectively combat adolescent suicide. Research has shown that principals have also expressed that in-service training programs are an acceptable method for educating staff about adolescent suicide (14, 17). As mentioned previously, evidence has shown that a brief two-hour in-service is an adequate method for increasing teachers' knowledge…however, small group discussion sessions that allow educators to share their attitudes and concerns about adolescent suicide have also been shown to be effective ways of establishing a sense of cohesion between staff as well as increasing a teacher's confidence in addressing suicide (2).

How a school chooses to disseminate information to educators should be determined by each school in a way that conforms to the attitude of the school as well as the wishes and concerns of the staff. Only in this way will educators and administrators implement and maintain such potentially life-saving, information sharing sessions.

Barriers that have consistently stymied suicide prevention programs from being effectively implemented and maintained include the large and pervasive number of myths that surround adolescent suicide. It is of utmost importance that school staff and administrators be given the truth about adolescent suicide and that the myths surrounding suicide be dispelled.

The chart on page five and six is meant to inform staff in a succinct way about some of the myths that surround adolescent suicide. These myths have created fear in parents, school staff, and the general public and have led many to feel apprehensive about suicide prevention programs in schools... however, research has demonstrated that these myths are

Information Dissemination in Schools continued

just that, myths — grounded not in reality, but in distorted perceptions of reality.

This chart seeks to falsify myths by substituting evidence-based statements designed through research findings for sensationalized conjecture designed through fear and misunderstanding. In doing so, this chart hopefully will enhance confidence and willingness to address suicide prevention in an appropriate manner.

This chart should be provided to staff and parents as part of an in-service or parent-teacher meeting, at which adolescent suicide prevention is discussed. Not included in this issue brief, but found as a standalone document as part of the *Guide* is a concise, true and false test on myths (Checklist 1t), which should be presented to staff as well as parents as a way of increasing their awareness and knowledge about adolescent suicide. By simply giving this true and false test to staff and parents and allowing for some time to discuss questions and concerns, schools can effectively increase awareness about adolescent suicide and may help prevent an incident of suicide in their school. Although numerous studies have mentioned myths surrounding adolescent suicide as barriers for implementing and maintaining suicide prevention programs, there are two that make myths a focus of the research (4, 7). Please refer to The Guide's Annotated Bibliography for an annotated description of both of these studies (www.theguide.fmhi.usf.edu).

References

Information Dissemination in Schools

1. Centers for Disease Control (1992). *Youth suicide prevention programs: A resource guide.* Atlanta, GA: Centers for Disease Control.
2. Garland, A.F., & Zigler, E. (1993). Adolescent suicide prevention: Current research and social policy implications. *American Psychologist, 48*(2), 169–182.
3. Gould, M., Greenberg, T., Velting, D., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(4), 386–405.
4. King, K.A. (1999). Fifteen prevalent myths about adolescent suicide. *Journal of School Health, 69*(4), 159–161.
5. King, K.A., Price, J.H., Telljohann, S.K., & Wahl, J. (1999). High school health teachers' knowledge of adolescent suicide. *American Journal of Health Studies, 15*(3), 156–163.
6. Malley, P.B., Kush, F., & Bogo, R.J. (1994). School based adolescent suicide prevention and intervention programs: A survey. *School Counselor, 42,* 130–136.
7. Mazza, J.J. (1997). School-base suicide prevention programs: Are they effective? *The School Psychology Review, 26*(3), 382–96.
8. Roeser, R.W., & Midgley, C. (1997). Teachers' view of issues involving students' mental health. *Elementary School Journal, 98,* 115–133.
9. Shaffer, D., Garland, A., & Whittle, R. (1988). An evaluation of three youth suicide prevention programs in New Jersey. *New Jersey Adolescent Suicide Prevention Project: Final Project Report.* Trenton, NJ: New Jersey Department of Human Services: Governor's Advisory Council on Youth Suicide Prevention.
10. McEvoy, M.L., & McEvoy, A.W. (1994). *Preventing youth suicide: A handbook for educators and human service professionals.* Holmes Beach, FL: Learning Publications Inc.
11. King, K.A., Price, J.H., Telljohann, S.K., & Wahl, J. (1999). High school health teachers' perceived self-efficacy in identifying students at-risk for suicide. *Journal of School Health, 69*(5), 202–207.
12. Leane, W., & Shute, R. (1998). Youth suicide: The knowledge and attitudes of Australian teachers and clergy. *Suicide and Life-Threatening Behavior, 28*,165–173.

References continued

Information Dissemination in Schools

13. King, K.A. (2001). Developing a comprehensive school suicide prevention program. *The Journal of School Health, 71*(4), 132–137.
14. Kalafat, J. (2003). School approaches to youth suicide prevention. *American Behavioral Scientist, 46*(9), 1211–1223.
15. Berman, A.L., & Jobes, D.A. (1991). *Adolescent suicide: Assessment and intervention.* Washington, DC: American Psychological Association.
16. Miller, D.N., & Dupaul, G.J. (1996). School-based prevention of adolescent suicide: Issues, obstacles, and recommendations for practice. *Journal of Emotional and Behavioral Disorders, 4*(4), 221–230.
17. Miller, D.N., Eckert, T.L., Dupaul, G.J., & White, G.P. (1999). Adolescent suicide prevention: Acceptability of school-based programs among secondary school principals. *Suicide and Life-Threatening Behavior, 29,* 72–85.
18. Hayden, D.C., & Lauer, P. (2000). Prevalence of suicide programs in schools and roadblocks to implementation. *Suicide and Life-Threatening Behavior, 30*(3), 239–251.
19. Parental Division of the American Association of Suicidology. (1999). *Guidelines for school-based suicide prevention programs.* Retrieved March 18, 2003, from www.suicidology.org/associations/ 1045/files/School%20 guidelines.pdf
20. O'Carroll, P.W., Potter, L.B., & Mercy, J.A. (1994). *Programs for the prevention of suicide among adolescents and young adults.* MMWR 43 9 (RR-6); 1-7. Atlanta: US Department of Health and Human Services, Public Health Service, CDC.
21. Kalafat, J., & Brown, C.H. (2001). *Suicide prevention and intervention: Summary of a workshop.* The National Academy of Sciences, Retrieved April 22, 2003 from www.nap.edu/openbook/ 0309076242/html/4.html
22. Davidson, L., & Marshall, M. (2003). *School-Based suicide prevention: A guide for the students, families, and communities they serve.* American Association of Suicidology: The Task Force for Child Survival and Development.
23. Zenere, F.J., & Lazarus, P. J. (1997). The decline of youth suicidal behavior in an urban, multicultural public school system following the introduction of a suicide prevention and intervention program. *Suicide and Life-Threatening Behavior, 27*(4), 387–403.
24. Berman, A.L., & Jobes, D.A. (1995). Suicide prevention in adolescents (ages 12-18). *Suicide and Life-Threatening Behavior, 25,* 143–154.
25. King, D.A., & Smith, J. (2000). Project SOAR: A training program to increase school counselors' knowledge and confidence regarding suicide prevention and intervention. *Journal of School Health, 70,* 402–407.
26. Mackesy-Amiti, M.E., Fendrich, M., Libby, S., Goldenberg, D., & Grossman, J. (1996). Assessment of knowledge gains in proactive training for postvention. *Suicide and Life-Threatening Behavior, 26,* 161–174.
27. Tierney, R.J. (1994). Suicide intervention training evaluations: A preliminary report. *Crisis 15,* 69–76.
28. Centers for Disease Control and Prevention. (June 4, 2010). Youth risk behavior surveillance-United States 2009. *Morbidity and Mortality Weekly Report: Surveillance Summaries, 59*(SS-5).
29. Centers for Disease Control and Prevention: Web-based Injury and Statistics Query and Reporting System. (2012). *Leading causes of death reports.* Retrieved from http://webappa.cdc.gov/sasweb/ncipc/leadcaus10_us.html

Myths and Current Facts About Adolescent Suicide

Myths	Evidence-Based Facts
Youth suicide is an increasing problem in the United States.	For youth age 10 to 24, the suicide rate declined from 9.48/100,000 in 1990 to 6.78/100,000 in 2003. This was a decrease of 28.5% in the rate of youth suicide over 14 years (22). The youth suicide rate for 10-24 year olds rose 8% from 2003 to 2004, then showed a general decline through 2007 (6.3%). The rate has increased again from 2007 to 2009 by 7.2%, the most current year data is available as of this publication (2). The 2009 suicide rate for 15–19 year olds stands at 7.75 per 100,000 and the 2009 suicide rate for 10–14 year olds is 1.30 per 100,000 (2).
Most teenagers will not reveal that they are suicidal or have emotional problems for which they would like emotional help.	Most teens will reveal that they are suicidal. Although studies have shown that they are more willing to discuss suicidal thoughts with a peer than a school staff member (3), this disposition that most teens have towards expressing suicidal ideations could be used for screening adolescents through questionnaires and/or interviews (4).
African-American teens do not die by suicide.	African-Americans do die by suicide. The Center for Disease Control and Prevention reports a 114% increase in suicides among black males aged 10–19 from 1980 to 1995, a rate higher than that of any other group. Among black males aged 10–14 during the same period, the suicide increase was 233%, compared with 120% for white males in the same age group (5). For black males aged 15–19, the suicide rate rose 146%, compared with 22% for white males (5). More recently, the rate of youth suicide among Black youth 10 – 24 years of age declined from nearly 5.5/100,000 in 1999 to 4.4/100,000 in 2007 (2).
Adolescents who talk about suicide do not attempt or die by suicide.	One of the most ominous warning signs of adolescent suicide is talking repeatedly about one's own death (3). Adolescents who make threats of suicide should be taken seriously and provided the help that they need (6).
Educating teens about suicide leads to increased suicide attempts, since it provides them with ideas and methods about killing themselves.	When issues concerning suicide are taught in a sensitive educational context they do not lead to, or cause, further suicidal behaviors (7). Since three-fourths (77%) of teenage students state that if they were contemplating suicide they would first turn to a friend for help, peer assistance programs have been implemented throughout the nation (1). These educational programs help students to identify peers at risk and help them receive the help they need. Such programs have been associated with increased student knowledge about suicide warning signs and how to contact a hotline or crisis center, as well as increased likelihood to refer other students at risk to school counselors and mental health professionals (8, 9, 14). Directly asking an adolescent if he or she is thinking about suicide displays care and concern and may aid in clearly determining whether or not an adolescent is considering suicide. Research shows that when issues concerning suicide are taught in a sensitive and educational manner, students demonstrate significant gains in knowledge about the warning signs of suicide and develop more positive attitudes toward help-seeking behaviors with troubled teens (8, 11). Additionally, recent research indicated that asking about suicidal behavioral does not plant the idea of suicide. Researchers found that students who were asked about suicidal ideation or behavior in a screening survey were no more likely to report thinking about suicide than students not exposed to these questions. The research results seem to indicate that asking about suicidal ideation or behavior may have been helpful for at-risk students (i.e., those with depression symptoms or previous suicide attempts) (25).
Talking about suicide in the classroom will promote suicidal ideas and suicidal behavior.	Talking about suicide in the classroom provides adolescents with an avenue to talk about their feelings, thereby enabling them to be more comfortable with expressing suicidal thoughts and increasing their chances of seeking help from a friend or school staff member (3).
Parents are often aware of their child's suicidal behavior.	Studies have shown that as much as 86% of parents were unaware of their child's suicidal behavior (3). When compared to control subjects, adolescents who died by suicide were found to have had significantly less frequent and less satisfying communication with their parents (1).

Myths and Current Facts About Adolescent Suicide

continued

Myths	Evidence-Based Facts
Most adolescents who attempt suicide fully intend to die.	Most suicidal adolescents do not want suicide to happen (10). Rather, they are torn between wanting to end their psychological pain through death and wanting to continue living, though only in a more hopeful environment. Such ambivalence is communicated to others through verbal statements and behavior changes in 80% of suicidal youths (1).
There is not a significant difference between male and female adolescents regarding suicidal behavior.	Adolescent females are significantly more likely than adolescent males to have thought about suicide and to have attempted suicide (1, 3, 4, 7). More specifically, adolescent females are 1.5 to 2 times more likely than adolescent males to report experiencing suicidal ideation and 3 to 4 times more likely to attempt suicide (1). Adolescent males are 4 to 5.5 times more likely than adolescent females to die by suicide (12). While adolescent females die by suicide in one out of 25 suicide attempts, adolescent males kill themselves in one out of every three attempts (1).
The most common method for adolescent death by suicide is drug overdose.	Guns are the most frequently used method for deaths by suicide among adolescents (3, 12, 13). In 1994, guns accounted for 67% of all adolescent deaths by suicide while strangulation (via hanging), the second most frequently used method for adolescent suicides, accounted for 18% of all adolescent deaths by suicide (1). A shift has taken place in the methods used to attempt suicide. In 1990, firearms were the most common method for both girls and boys. In 2004, hanging/suffocation was the most common method of suicide among adolescent girls, accounting for over two-thirds of suicides among 10- to-14-year-old girls (71.4%) and nearly half among 15-to-19 year-old girls (49%). From 2003 to 2004, there was a 119 percent increase in hanging/suffocation suicides among 10-to -14-year-old girls. For boys and young men, firearms are still the most common method (22). Having a gun in the house increases an adolescent's risk of suicide (15, 23, 24). Regardless of whether a gun is locked up or not, its presence in the home is associated with a higher risk for adolescent suicide. This is true even after controlling for most psychiatric variables. Homes with guns are 4.8 times more likely to experience a suicide of a resident than homes without guns (1). In lieu of these findings, it should not be surprising that restricting access to handguns has been found to significantly decrease suicide rates among 15–24 year olds (1, 15).
Because female adolescents die by suicide at a lower rate than male adolescents, their attempts should not be taken seriously.	One of the most powerful predictors of death by suicide is a prior suicide attempt (1, 3, 4, 12, 15, 16-21). Adolescents who have attempted suicide are 8 times more likely than adolescents who have not attempted suicide to attempt suicide again (1). One-third to one-half of adolescents who kill themselves have a history of a previous suicide attempt. Therefore, all suicide attempts should be treated seriously, regardless of sex of the attempter.
Suicidal behavior is inherited.	There is no specific suicide gene that has ever been identified in determining or contributing to the expression of suicide (1, 12, 20, 21).
Adolescent suicide occurs only among poor adolescents.	Adolescent suicide occurs in all socioeconomic groups (15, 16, 21). Socioeconomic variables have not been found to be reliable predictors of adolescent suicidal behavior (1, 3, 15, 16, 21). Instead of assessing adolescents' socioeconomic backgrounds, school professionals should assess their social and emotional characteristics (i.e., affect, mood, social involvement, etc.) to determine if they are at increased risk.
The only one who can help a suicidal adolescent is a counselor or a mental health professional.	Most adolescents who are contemplating suicide are not presently seeing a mental health professional (7). Rather, most are likely to approach a peer, family member, or school professional for help. Displaying concern and care as well as ensuring that the adolescent is referred to a mental health professional are ways paraprofessionals can help.

References

Myths and Current Facts About Adolescent Suicide

1. King, K.A. (1999). Fifteen prevalent myths about adolescent suicide. *Journal of School Health, 69*(4), 159–161.
2. Centers for Disease Control and Prevention: Web-based Injury and Statistics Query and Reporting System. (2012). *Leading causes of death reports.* Retrieved from http://webappa.cdc.gov/sasweb/ncipc/leadcaus10_us.html
3. Zenere, F.J., & Lazarus, P. J. (1997). The decline of youth suicidal behavior in an urban, multicultural public school system following the introduction of a suicide prevention and intervention program. *Suicide and Life-Threatening Behavior, 27*(4), 387–403.
4. Gould, M.S., & Kramer, R.A. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior, 31*, 6–31.
5. National Center for Health Statistics. *Vital statistics mortality data, underlying cause of death, 1980-1995* {Machine-readable public-use data tapes}. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, 1983–1993.
6. Kirk, W.G. (1993). *Adolescent suicide: A school-based approach to assessment and intervention.* Champain, IL: Research Press.
7. Tierney, R., Ramsay, R., Tanney, B., & Lang, W. (1991). Comprehensive school suicide prevention programs. In Leenaars, A.A., & Wenkstern, S. (Eds.) *Suicide Prevention in Schools.* New York: Hemishere Publishing Corporation.
8. Kalafat, J., & Elias, M. (1994). An evaluation of a school-based suicide awareness intervention. *Suicide and Life-Threatening Behavior, 24*(3), 224–233.
9. Smith, J. (1991). Suicide intervention in schools: General considerations. In Leenaars, A.A., Wenkstern, S. (Eds.) *Suicide Prevention in Schools.* New York: Hemishere Publishing Corporation.
10. King, K.A., Price, J.H., Telljohann, S.K., & Wahl, J. (1999). High school health teachers' knowledge of adolescent suicide. *American Journal of Health Studies, 15*(3), 156–163.
11. Gould, M., Greenberg, T., Velting, D., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(4), 386–405.
12. O'Carroll, P.W., Potter, L.B., & Mercy, J.A. (1994). Programs for the prevention of suicide among adolescents and young adults. *MMWR CDC Surveillance Summary 43* (RR-6). 1–7.
13. Shaffer, D., Garland, A., Vieland, V., Underwood, M., & Busner, C. (1991). The impact of curriculum-based suicide prevention programs for teenagers. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*(4), 588–596.
14. Garland, A.F., & Zigler, E. (1993). Adolescent suicide prevention: Current research and social policy implications. *American Psychologist, 48*(2), 169–182.
15. Borowsky, I.W., Ireland, M., & Resnick, M.D. (2001) Adolescent suicide attempts: Risks and protectors. *Pediatrics, 107*(3), 485–493.
16. Moscicki, E. (1999). Epidemiology of Suicide. In D.G. Jacobs (ed), *The Harvard Medical School Guide to Suicide Assessment and Intervention.* San Francisco: Jossey-Bass Publishing: 40–51.
17. Shaffer D., Gould, M., & Fisher, P. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry, 53,* 339–348.
18. Shaffer, D., Pfeffer, C.R., & Work Group on Quality Issues. (2001). Practice Parameter for the Assessment and Treatment of Children and Adolescents With Suicidal Behavior. *Journal of American Academy of Child and Adolescent Psychiatry, 40*(1) supp, 24–51.
19. Zametkin, A.J. Alter, M.R., & Yemini, T. (2001). Suicide in teenagers: Assessment, management, and prevention. *Journal of American Medical Association, 286*(24). 3120–3125.
20. Lester, D. (2000). *Suicide prevention: Resources for the millennium.* Ann Arbor, MI: Sheridan Books.
21. Brent, D.A. (1995). Risk factors for adolescent suicide and suicidal behavior: Mental and substance abuse disorders, family environmental factors and life stress. *Suicide and Life-Threatening Behavior, 25,* 52–63.
22. Centers for Disease Control and Prevention. (2007). Suicide trends among youths and young adults aged 10-24 years: United States 1990-2004. *Morbidity and Mortality Weekly Report, 56*(35), 905-908.

References continued

Myths and Current Facts About Adolescent Suicide

23. Dahlberg, L.L., Ikeda, R.M., & Kresnow, M. (2004). Guns in the home and risk of a violent death in the home: Findings from a national study. *American Journal of Epidemiology, 160*(10), 929-936. doi:10.1093/aje/kwh309

24. Brent, D.A., & Bridge, J.A. (2003). Firearms availability and suicide: Evidence, interventions, and future directions. *American Behavioral Scientist, 46,* 1192–1210. doi:10.1177/0002764202250662

25. Gould, M.S., Marrocco, F.A., Kleinman, M., Thomas, J.G., Mostkoff, K., Cote, J., & Davies, M. (2005). Evaluating iatrogenic risk of youth suicide screening programs: A randomized controlled trial. *JAMA, 293,* 1635–43.

Youth Suicide Prevention School-Based Guide ©

Prepared by

Justin Doan
Stephen Roggenbaum
Katherine J. Lazear

Developed by

The Department of Child & Family Studies, Louis de la Parte Florida Mental Health Institute in the College of Behavioral and Community Sciences at the University of South Florida. Originally funded by the Institute for Child Health Policy at Nova Southeastern University through a Florida Drug Free Communities Program Award.

Design & Page Layout by

Dawn Khalil

Contact: Stephen Roggenbaum
roggenba@usf.edu
813-974-6149 (voice)

USF UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES