School-Based Guide ©

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INSTITUTE FOR CHILD HEALTH POLICY

FMHI Louis de la Parte Florida Mental Health Institute

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Overview/Issue Briefs

Youth Suicide Prevention School-Based Guide ©

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http://www.fmhi.usf.edu/institute/pubs/bysubject.html
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Checklists/Programs/Resources

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Developed by...
The Louis de la Parte Florida Mental Health Institute at the University of South Florida, funded by the Institute for Child Health Policy at NOVA Southeastern University through a Florida Drug Free Communities Program Award.

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Youth Suicide Prevention School-Based Guide

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Overview

The Guide: Overview

The Youth Suicide Prevention School-Based Guide is designed to provide accurate, user-friendly information. First, checklists can be completed to help evaluate the adequacy of the schools' suicide prevention programs. Second, information is offered in a series of issue briefs corresponding to a specific checklist. Each brief offers a rationale for the importance of the specific topic together with a brief overview of the key points. The briefs also offer specific strategies that have proven to work in reducing the incidence of suicide, with references that schools may then explore in greater detail. A resource section with helpful links is also included. The Guide will help to provide information to schools to assist them in the development of a framework to work in partnership with community resources and families.

The issue briefs and resource/links section, their content and recommendations will continually evolve as new research is conducted, the best available evidence is evaluated, and prevention programs are utilized and tested.

The Guide

- Identifies and defines the elements of a comprehensive, school-based suicide prevention program.
- Examines the scientific literature to determine which of these elements have been proven to work in reducing the incidence of suicide.
- Contains checklists and self-assessment instruments that may be completed by schools to evaluate the adequacy of their suicide prevention programs.

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Youth Suicide Prevention School-Based Guide: Overview

continued

- Provides a guide to help school administrators and their partners add program elements that would result in more comprehensive programs and/or would replace unproven strategies with proven strategies.
- Has been reviewed by national experts in suicide prevention, behavioral and physical health providers, and community-based school personnel, advocates, families and youth. The Guide, annotated bibliography, and literature review will be available on a University of South Florida's website.

The first issue brief in this series is designed to assist in debunking myths that may serve as barriers to implementation of a school-based suicide prevention program. Countering myths with reality and evidence-based statements may enhance confidence and willingness to address youth suicide prevention.

The remaining briefs each cover individual topics related to suicide prevention that are especially pertinent to school administrators and their community partners.

Under separate cover is **The Guide's** Annotated Bibliography, providing a compiled resource of research publications related to suicide prevention and school-based prevention programs to support the development of the Youth Suicide Prevention School-Based Guide. It is available online at http://www.fmhi.usf.edu/institute/pubs/bysubject.html

Youth Suicide

Youth Suicide — as stark as the words sound, this phenomenon reflects a silent epidemic too frequently ignored except by those who have been devastated by it. Youth suicide is a critical but under-reported and under-treated public health crisis.

Consider these alarming statistics:

- Suicide accounts for 13% of all adolescent deaths and ranks third as an overall cause of death in adolescents. (1)
- Suicide among children 10–14 increased by 100% from 1980–1996. (2)
- An estimated 3,500 adolescents attempt suicide daily; 35 of them die. (3)
- An average of one youth, under the age of 25, dies by suicide every 2 hours. (4)
- More teenagers die by suicide than die from cancer, AIDS, birth defects, stroke, pneumonia, influenza and chronic lung disease combined. (5)
- Between 1980 and 1995, the suicide rate among African American youth, ages 10–14, increased 233%. The suicide rate for comparable whites increased 120%. (6)
- 90% of teenagers who die by suicide have a mental health problem, usually depression, substance abuse, or both. (7)

As chilling as these statistics are, they do not begin to compare to the grief, anguish, confusion, guilt and devastation felt by the family and friends of an adolescent who dies by suicide. After a suicide crisis, friends and family are at an increased risk of developing posttraumatic stress disorders. (9)

Mental health and mental illness are shaped by age, gender, race, and culture as well as other distinctions of diversity found within all of these population groups — for example, physical disability or a person's sexual orientation. The consequences of not understanding these influences can result in unintentional and harmful effects.

With minority youth more likely to express feelings of alienation, cultural and societal conflicts, academic anxieties, and feelings of victimization, it has become clear that careful attention must be paid to the needs of minority youth and their families within the context of their culture.

While disparities in the health status of people of diverse racial, ethnic and cultural backgrounds remains a major problem for all youth, undiagnosed and untreated mental health problems, particularly depression and substance abuse, play a significant role in the prevalence of youth suicidal behavior. (8)

It is likely that suicide is significantly under-reported and that statistics can underestimate the true extent of the problem. Deaths classified as homicides or accidents, for example, where teenagers may have deliberately put themselves in harm's way, are not included in rates.

Youth Suicide Prevention School-Based Guide: Overview

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Unexpected death is always painful, but perhaps none more so than the self-destruction of a young person and a life, with all its potential and promise, cut short by one desperate and all too final act.

Our nation's schools, in partnership with families and communities, are the obvious places to identify youth at risk of suicide. Healthy, supportive and informed schools can do much to prevent youth suicide, to identify students at risk and to direct youth to prompt, effective treatment. Prevention, education, intervention and postvention (i.e., response to suicide attempts and completions) are the keys to reducing the number of young people who take their own lives. Our nation's schools are clearly essential community settings for suicidal prevention programs. In schools, rather than in the home or community, students' problems with academics, peers and other issues are much more likely to be evident, and suicidal signals may occur here with the greatest frequency. At school, students have the greatest exposure to multiple helpers such as teachers, counselors, coaches, staff and classmates who have the potential to intervene. Research has found that schools provide an ideal and strategic setting for preventing adolescent sucide (10).

Schools need to understand not only the issues of suicide, but also the positive role they can play. However, given the multiple demands on school systems, districts, schools and school staff, they need up-to-date, accurate and user-friendly information, guidelines and tools to assist them in their efforts. Suicide is a public health problem that requires an evidence-based approach to prevention. The public health approach defines the problem, identifies risk factors and causes of the problem, develops interventions evaluated for effectiveness, and implements such interventions widely in a variety of communities.(2) Wading through professional journals, examining the evidence, reviewing and evaluating the literature and then drawing conclusions

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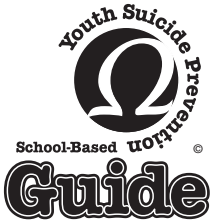
Overview continued

developing action plans and implementing them describes an often overwhelming course of action for educators, administrators and school systems.

The Youth Suicide Prevention School-Based Guide is a comprehensive, evidence-based guide designed to assist schools, in partnership with families and community partners, in improving their suicide prevention programs or creating new ones. **The Guide** will allow school administrators to assess the adequacy of their suicide prevention program and to improve its scope and effectiveness. **The Guide** builds on reviews of the literature and current research, exemplary plans and initiatives throughout North America; evidence associated with suicide prevention programs; and field-based information from educators, clinicians, families, youth, and advocates.



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Information Dissemination in Schools

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Issue Brief

Youth Suicide Prevention School-Based Guide ©

Suicide was the third leading cause of death in 2000 among 10–14 year olds and 15–19 year olds in the United States (3). In 2002, researchers found that one in five teenagers in the United States seriously considers suicide, which translates into slightly over one million teenagers. (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 false 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 (18,19,20,21,22,23,24). Research suggests that

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Information Dissemination in Schools continued

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 (2,24,25,26,27).

Training has also been found to increase educators' confidence that they have the ability to recognize a potentially suicidal student 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-shot 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 in-services in a positive and welcoming manner.

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 committing 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.

Information Dissemination in Schools continued

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 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 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 stand-alone document in the left hand side of the folder 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.

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Myths and Current Facts About Adolescent Suicide

Myths	Evidence-Based Facts
Adolescent suicide is a decreasing problem in the United States.	While the suicide rate for the general population has remained relatively stable since the 1950s, the suicide rate for adolescents has more than tripled (1). Presently, the suicide rate for 15–19 year olds stands at 11 per 100,000 (2). From 1980 to 1992, the suicide rate for 15–19 year olds and 10–14 year olds increased 28% and 120% (1).
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 commit suicide.	African-Americans do commit suicide and the numbers of suicides reported for this group has increased at an alarming rate. 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).
Adolescents who talk about suicide do not attempt or commit 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).

Myths and Current Facts About Adolescent Suicide

continued

Myths	Evidence-Based Facts
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, adolescent suicide victims were found to have had significantly less frequent and less satisfying communication with their parents (1).
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 complete a suicide attempt (12). While adolescent females complete one out of 25 suicide attempts, adolescent males complete one out of every three attempts (1).
The most common method for adolescent suicide completion is drug overdose.	Guns are the most frequently used method for completing suicides among adolescents (3,12,13,). In 1994, guns accounted for 67% of all completed adolescent suicides while strangulation (via hanging), the second most frequently used method for adolescent suicide completions, accounted for 18% of all completed adolescent suicides (1). Having a gun in the house increases an adolescent's risk of suicide (15,22). 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 complete suicide at a lower rate than male adolescents, their attempts should not be taken seriously.	One of the most powerful predictors of completed suicide is a prior suicide attempt (1,3,4,12,15,16-22). 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.

Myths and Current Facts About Adolescent Suicide

continued

Myths	Evidence-Based Facts
Suicidal behavior is inherited.	There is no specific suicide gene that has ever been identified in determining or contributing to the expression of suicide (1,12,20,21,22).
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 family member, peer, 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.

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Notes

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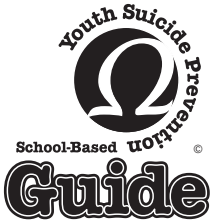

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School Climate

2

Issue Brief

Youth Suicide Prevention School-Based Guide ©

The school's climate refers to both the physical and aesthetic qualities of the school, as well as the emotional and psychological qualities of the school. The emotional and psychological qualities of a school refer to the attitudes, beliefs, and feelings of the faculty, staff, and students (1). The physical environment includes campus walkways and grounds, parking lots, school vehicles, cafeterias, bathrooms, gymnasiums, classrooms, and the equipment that is used in each of these places (2). Both qualities have a direct affect on the health, safety, performance, and the feeling of connectedness the staff and students have for their school.

Connectedness

Research has shown that students who feel connected to their school (e.g., felt teachers treated them fairly, felt close to people at school, felt like a part of their school) are less likely to experience suicidal thoughts and experience emotional distress (2,4,47). The National Longitudinal Study on Adolescent Health surveyed more than 90,000 students (grades 7–12) and found that students' feeling of connectedness was the number one protective factor against suicidal behavior (3). Students who feel connected to the school are also less likely to drink alcohol, carry weapons, or engage in other delinquent behavior (2). Research suggests that schools that wish to foster a feeling of connectedness in students should consider providing students with after school activities or clubs (4,5), allowing students some involvement in decision making relating to issues that will affect them within their school (2,4), and creating small-sized student learning groups where students can discuss bias, prejudice, and the fair and equal treatment of all students in the school (5).

Participation

Research has shown that when students participate in decisions regarding their school and their community they tend to be healthier and more productive (4,9,10,48). Assigning students roles in the school is an essential element for ensuring a healthy school climate (2,4,5,10,11). A comprehensive 15,000-hour study of classroom strategies by the Surgeon General on Youth Violence found that academic achievement increased as the number of meaningful roles that the school assigned to students increased (45). It is important for schools to involve students in

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meaningful school roles and decisions in order to foster a sense of ownership in students. Students can play important roles in the school, acting as office helpers, classroom helpers, hallway monitors, school council members, or play a primary role in any number of student school committees such as a safe school planning committee. In the past, these jobs have been under-advertised to students who don't "excel". These jobs have been offered more as a reward to those who have succeeded in the past instead of as an opportunity for those who may have failed in the past and now feel discouraged or intimidated. Some suggest that these "underachievers" should be actively involved in such opportunities because these individuals may be the most at-risk for suicidal or violent behavior (2). Through their involvement with the school, these students (those potentially at-risk) may feel more connected to the school, which has been found to be an important protective factor for suicidal behaviors and ideations (2,4,39,46,47).

Academic Achievement

Two of the main focal points for schools are academic achievement and supporting students so that they may achieve these high academic standards. Schools should set academic goals for success and advancement (7) and provide encouragement to students when they meet or exceed these goals (2). A school may choose to use the media to put the names or faces of students who achieve their goals in print or on screen as well as displaying students' work in and around school (7). In order for students to achieve their academic potential and in order to decrease their likelihood of suicidal behaviors or other violent behaviors, students must feel safe.

Safety

Lack of physical and/or emotional safety is likely to result in unconstructive educational outcomes such as poor academic performance or truancy. Research has shown that students who feel victimized by other students or staff have an elevated risk of suicidal ideations and behaviors (12,13,20).

Bullying is the repeated infliction or attempted infliction of injury, discomfort, or humiliation of a weaker student by one or more students with more power (14,15). Students at-risk for being bullied include those that "don't fit in" (16,17), those perceived as homosexual, bisexual, or trans-gendered (6,18,19), those who are socially isolated or lack social skills (59), and those that differ from the majority of their classmates in regards to race, religion, or ethnicity (2). It is essential that schools train their staff to identify harassing behavior and how to effectively intervene (2,6,11,21). Research also suggests that schools implement tolerance education into existing curriculum (if they do not do so already) and train school staff to teach tolerance in the classroom (6,7).

Teachers need not be the only source contributing to a school climate that reduces bullying. Adolescents tend to watch and mimic the behaviors they observe in adults, which means that schools which set high expectations on all staff to behave respectfully and kindly to others have the potential to increase these positive characteristics in their students (2,22). However, teachers are the primary source of contact with students and they are primarily responsible for educating and promoting the success of the students. For this reason, schools need supportive teachers who have the ability to develop positive relationships with the students.

Teachers should fashion a classroom where students feel respected, supported, and feel comfortable approaching an adult when confronted with problems (2,4,7,46,48). Research shows that a positive relationship with an adult, not necessarily with a teacher, is one of the most critical factors in preventing student violence, suicide, and bullying (5,10,46,48). A positive relationship with an adult is also important in order for students to feel comfortable enough to share information about a potentially dangerous situation (5). In roughly three out of four school shootings studied by the U.S. Secret Service, the attackers told someone of their plans before the attack (23).

Research has also found that adolescents are most likely to know in advance about a potentially dangerous and violent situation, particularly suicidal behavior or thoughts from peers (35,49-52)**.**

For this reason, it is important for schools to create ways for students to feel comfortable enough about providing information to an adult when confronted with a potentially dangerous situation. Students should be provided a list of adults in school that they may contact if they feel unsafe or if they have knowledge about a potentially dangerous situation. Students are more likely to feel connected to their school if they believe that they are being treated fairly, feel safe, and believe that teachers are supportive (8).

In order for schools to maintain a caring and supportive staff, schools may wish to train teachers on the importance of acting in a caring and nurturing manner to students, remaining attentive to students' needs and wishes, recognizing signs of distress in students, and being able to recognize and intervene in a bullying situation (4,6). Research has found that teachers make effective informants about students' mental health issues (24,25,26) and although they should not diagnose and treat adolescents who may be suicidal, they should certainly be taught how to recognize and refer students who may be at-risk for engaging in suicidal thoughts or behaviors, which research has found to be an essential component of any suicide prevention program (11,37,43,51-58). Research suggests that training be done at the beginning of the school year and that teachers be given periodic opportunities to discuss students who may be displaying worrisome behavior (7). Training done at the beginning of the year will also allow a school to review its safety plan and the policies governing a safe school climate. Training should be done by someone who has experience with social-skills programs and who has the skills needed to conduct in-service training (5). By training staff in such a way, schools become more safe and the potential to reach a student at-risk for suicidal thoughts and actions (as well as other violent acts) becomes greater, thereby decreasing the likelihood of a school tragedy.

Training

Just as teachers should be trained and educated, students should be taught about how to interact with peers and adults, particularly about how to solve interpersonal conflicts in a nonviolent fashion (5). A safe school is one that helps students develop appropriate problem-solving and conflict resolution strategies. Skills training that focuses on problem solving, coping, and conflict resolution strategies have shown positive results on distress coping skills (38,39). These training programs have also been shown to reduce completed and attempted suicides in adolescents (37) and may be one of the most effective ways to prevent adolescent suicide (36). Empirical evaluations of programs that have focused on such skills training strategies have found an increase or enhancement of factors that protect adolescents from suicide while reducing the risk factors for suicide in these adolescents (40,41,42,46,48).

These strategies have also been suggested as a way to reduce depression, hopelessness, and drug abuse in adolescents, all risk factors for suicidal behaviors and/or thoughts (43). These skills can be taught by focusing on social skills and problem-solving skills directly through lessons or indirectly by incorporating these skills into existing classes, such as a health class, drivers education class, physical education class, or a reading class (5). Strengthening social skills has also been found to have a positive effect on cognitive development and learning in adolescents (27). How a school chooses to address implementing problem-solving and/or social skills education will vary due to resources and a school's individual culture, however it is essential that schools provide students with these skills, which may help control their behavior in a productive manner when faced with a challenging situation.

The Centers for Disease Control and Prevention (2) suggest the following guidelines regarding curriculum concerning safety education and instruction that helps students develop appropriate attitudes and behavioral skills needed to get through difficult situations:

1. Choose a prevention program and curricula that are grounded in theory or that have scientific evidence of effectiveness.

2. Implement unintentional injury and violence prevention curricula consistent with national and state standards for health education.
3. Use active learning strategies, interactive teaching methods, and proactive classroom management to encourage student involvement in learning about violence prevention.
4. Provide adequate staffing and resources, including budget, facilities, staff development, and class time to provide violence prevention education to all students.

Programs that have utilized social skills training include the Resolving Conflict Creatively Program (RCCP), which is one of the longest and largest-running programs for conflict resolution in the country, and the Promoting Alternative Thinking Strategies (PATH) curriculum. Both of these programs are evidence-based programs and have been found to have a positive impact on students, however, these are only two of the many that are available for use in schools. A school should adopt a problem-solving program that fits their school culture and their resource availability. For more information about such programs please refer to the U.S. Department of Education's Action Guide's additional resources section (5).

Discipline

Just as educating students about socially appropriate ways to deal with difficult situations is an important component of a positive school climate, the disciplining of students may be just as important because discipline is one process by which appropriate behaviors are taught (2). Disciplinary policies must be explicitly stated, use language that is easy to understand, applied fairly, and above all be applied consistently (2,7,10), in order to avoid creating an environment of favoritism and bias. Research has found that the best approach to disciplining students is a proactive and positive approach used by all staff and faculty (2,7,5). Such an approach focuses on such things as intervening before an argument escalates to a physical fight, identifying and intervening when faced with a bullying situation, teaching problem-solving skills, teaching conflict resolution strategies, and teaching socially appropriate behaviors (2,5). Research also suggests that disciplinary approaches avoid emphasizing punishment (5,7). Humiliating, harassing, scolding, nagging, physically aversive punishment, and other behavior-corrections that disrupt the flow of instruction should be prohibited (2). Research has found that when these correction methods are used, behavioral problems in adolescents increase (44).

Physical Environment

Another component of a safe school and one that frequently gets ignored is the physical environment of the school (28). Although most research concerning the physical environment of the school does not directly discuss the physical environment as it relates to suicide, research has found that flaky ceilings, graffiti-tainted walls, scuffed-up floors, dirty bathrooms, crumbling sidewalks, and leaky toilets all contribute to a "why bother, no-one cares attitude" among students (1,4). This "why bother" attitude may facilitate feelings of isolation and a lack of connectedness, which could contribute to a student's suicidal risk. Schools that have an aesthetically pleasing environment, however, motivate students to take more pride in their school (1). Negativism about a school has also been found to decrease the quality of teaching, the extent of learning, school attendance, and the rate of school completion (29). Although research is lacking on the influence of the physical environment on suicidal behaviors and thoughts, schools should examine the safety of their schools in order to avoid unintentional injuries as well as other problems, such as violence and bullying, which have been shown to be risk factors for suicidal behaviors and thoughts (12,13,20).

Security

One of the most obvious aspects of the school environment, which a school should certainly address, is ensuring that the school is free from weapons. Security cameras and metal detectors have been used effectively in order to keep weapons off school property (33,34). How a school chooses to prevent weapons on school grounds will vary,

School Climate continued

however, all schools should comply with the Gun Free Schools Act (GFSA), which requires each educational agency to expel any student who brings a firearm to school for at least one year and that any student who does so should be referred to the criminal justice system. Research suggests that schools should work with parents and community agencies in order to supervise students and reduce the likelihood that they will bring a weapon to school; this may also reduce the likelihood that students will have access to a weapon (1,2,4,5,6,11,32). Schools may also find it helpful to use parents and community agencies in order to broaden the web for identifying students at-risk for suicidal behaviors, thoughts and for those who may be at-risk for other violent behavior. An essential part of any safe school is a well-established system of community links and parental involvement (1-7,10,11,21,24,32). For more on the necessity of community and family links please refer to Issue Brief 9: "Community Partnerships." Other physical characteristics that a school may wish to address besides firearm/weapon control includes the following:

- Number and types of exits
- Adequate lighting
- Comfortable rooms and furnishings in order to communicate to students that they are important and their comfort is considered
- Locker use, visibility, and supervision
- Parking areas
- Positive posters, bulletins, and signs
- Patterns of supervision
- Density of traffic patterns during different parts of the day
- Isolated areas, which may be ideal areas for bullying to take place
- Location and design of bathrooms
- Guardrails on stairways
- Hallway design
- A closed campus to limit truancy and contact between students and outsiders (research suggests that a large number of outsiders intimidate and sell drugs to students).

Research suggests that schools should conduct comprehensive safety assessments at least once a year (30) and that more frequent assessments may be necessary for certain areas of the school such as playgrounds (31). For more information about a safe physical environment, schools should refer to and comply with OSHA regulations for safety. The Centers for Disease Control and Prevention's NIOSH branch has compiled a CD-ROM that provides information about OSHA regulations in schools. Schools may also wish to utilize California's Department of Education guide, which provides reasons why and specific methods for examining the aforementioned physical characteristics (7).

In order for a school to provide a safe learning environment and positive school climate, schools should:

- Provide staff with in-service training that addresses the importance of acting in a caring and nurturing manner to students, remaining attentive to students' needs and wishes, recognizing signs of distress in students, and being able to recognize and intervene in a bullying situation.
- Ensure that there are established policies explicitly focused on harassment and bullying.
- Provide opportunities for staff to share their concern about students who may be displaying worrisome behavior.
- Emphasize positive relationships between students and all staff.
- Have a system in place to refer students suspected of abuse/neglect.
- Treat students with equal respect, support, and care.
- Continually monitor the safety and cleanliness of the physical aspects of the school such as the halls, restrooms, and floors.
- Consistently enforce disciplinary, harassment, and civil rights policies.
- Inform students about who they may contact within the school if they do not feel safe.
- Help students feel safe about approaching an adult when they are confronted with a potentially dangerous situation.

School Climate continued

- Address problem-solving and/or social skills strategies either by incorporating these strategies into existing curriculum or by focusing directly on these strategies.
- Ensure high academic standards.
- Make sure that students are involved in school decisions and that they have an equal opportunity to help in school activities.
- Develop links to the community (police agencies, environmental health professionals, mental health agencies, or crisis centers).
- Encourage and utilize parental involvement.
- Educate students on issues such as tolerance, harassment, bullying, and the importance of respecting others.
- Ensure a safe physical climate exists by conducting safety assessments at least once a year.
- Ensure that there are policies and procedures in place that focus on weapons in the school. It is recommended that these policies utilize outside resources such as parents or law enforcement.
- Develop after school activities or events to foster student connectedness.
- Use a positive and pro-social approach and avoid an approach that emphasizes punishment.

Three examples of school climate programs include Halfmoon Bay “Growing Pains” project, The School Transition Environment Program (STEP), and the Alberta Safe and Caring Schools Initiative. For more on safe school programs refer to the US Department of Education.

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Notes

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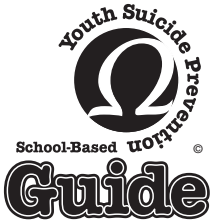

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Risk Factors

Risk and Protective Factors, and Warning Signs

Suicide is an extremely complex interaction involving a number of factors that all contribute to the expression of suicidal behaviors. There are numerous risk factors for suicide, any one of which may be present or absent in an adolescent at-risk for suicide. Researchers have identified a number of factors associated with a higher risk for suicide. Protective factors that may reduce the likelihood of suicidal behavior have also been found.

Suicide does not lend itself easily to an identifiable period of symptoms that occur before the disease…however, research does show that roughly nine out of ten adolescents who die by suicide give clues to others before their suicidal attempt (5). Being able to recognize these clues and knowing the risk factors associated with adolescent suicide may help school staff prevent a student at-risk for suicide from attempting and/or completing suicide. The importance of risk and protective factors can vary by age, gender, and ethnicity (13).

There is no tangible, all encompassing method for determining if an adolescent will attempt or die by suicide. Many students will present some of the factors mentioned in the checklist of risk factors that follow…however, not all will feel, act, or have ideas about suicide. By using this checklist, school administrators and staff may be able to recognize a student at-risk for suicide and who may need help. By recognizing a teen who is potentially at-risk for suicide, staff and administration take the first, and the most important step for alleviating and reducing the risk for suicide. Only after a student has been identified as at risk can he or she get help and intervention, which is of paramount importance for preventing a student from attempting or dying by suicide.

The impact of some risk factors can be reduced by interventions such as providing treatment for depression or substance abuse. Those risk factors that cannot be changed (such as a previous suicide attempt) can alert others to the heightened risk of suicide during periods of the recurrence of a mental or substance abuse disorder, or following a significant stressful life event (11).

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3a

Issue Brief

Youth Suicide Prevention School-Based Guide ©

Prepared By:
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Design & Page Layout: Bill Leader

Developed by…
The Louis de la Parte Florida Mental Health Institute at the University of South Florida, funded by the Institute for Child Health Policy at NOVA Southeastern University through a Florida Drug Free Communities Program Award.

Risk and Protective Factors, and...

continued

Research has shown that the following are risk factors for suicide in adolescents: previous suicide attempt or gesture (2,4,6,7,9,10); mood disorder or psychopathology (2,4,7,8,9,10); substance abuse disorder (2,4,7,8,9,10); family history of suicidal behavior or mental illness (4,8,10); relationship, social, work, or financial loss (3,4,8,10); access to firearms (3,4,8,10); contagion or exposure to individuals who have attempted or completed suicide with exposure through media, television, and direct contact (8,10,11); history of physical or sexual abuse (6,7,10); conduct disorder (7,10); juvenile delinquency (7,10); sexual orientation, which has been shown to be correlated with identified risk factor's for suicide and is less of a factor after controlling for these risk factors (2,4,8,10); stressful life events (7,10); chronic physical illness (2,4,8); impulsive or aggressive tendencies (3,4); living alone/runaways (7,10); and school problems (2).

Measures that enhance resilience or protective factors are as essential for preventing suicide as reducing the factors that increase risk for suicide.

Positive resistance to suicide is not permanent, so programs that support and maintain protection against suicide should be ongoing (11). The following factors have shown to be protective for suicide: parental/family support and connectedness (2,4,7,11,12), good social/coping skills (11,12), religious/cultural beliefs (2,4,11,12), good relationships with other school youth/best friends (7,12), lack of access to means (10,11), support from relevant adults/teachers/professionals (7,11,12), help-seeking behavior/advice seeking (12), impulse control (7), adaptive problem solving/conflict resolution abilities (11), social integration/ opportunities to participate (7,12), positive sense of worth/confidence (7,12), stable environment (7), access to and care for mental/physical/substance disorders (11), responsibility for others/pets (7), and perceived connectedness to school (2).

The following checklist presents risk and protective factors that have been found to be associated with adolescent suicide. This checklist is intended for use by school staff in order to help identify a student who may be at-risk for suicidal behavior.

Risk Factors

- Previous suicide attempt or gesture
- Feelings of hopelessness or isolation
- Psychopathology (depressive disorders/mood disorders)
- Parental psychopathology
- Substance abuse disorder
- Family history of suicidal behavior
- Life stressors such as interpersonal losses (relationship, social, work) and legal or disciplinary problems
- Access to firearms
- Physical abuse
- Sexual abuse
- Conduct disorders or disruptive behaviors
- Sexual orientation (homosexual, bisexual, and trans-gendered youth)
- Juvenile delinquency
- School and/or work problems
- Contagion or imitation (exposure to media accounts of suicidal behavior and exposure to suicidal behavior in friends or acquaintances)
- Chronic physical illness
- Living alone and/or runaways
- Aggressive-impulsive behaviors

Protective Factors

- Family cohesion (family with mutual involvement, shared interests, and emotional support)
- Good coping skills
- Academic achievement
- Perceived connectedness to the school
- Good relationships with other school youth
- Lack of access to means for suicidal behavior
- Help-seeking behavior/advice seeking
- Impulse control
- Problem solving/conflict resolution abilities
- Social integration/opportunities to participate
- Sense of worth/confidence
- Stable environment
- Access to and care for mental/physical/ substance disorders
- Responsibilities for others/pets
- Religiosity (a controversial topic currently)

Warning Signs

continued

Also included is a list of warning signs, which may indicate that the adolescent is thinking about suicide. Again, it must be noted that these factors and warning signs do not provide a definitive method for determining if a student is or is not suicidal, but rather presents a method to help identify potentially suicidal adolescents.

In 1997 the American Academy of Child & Adolescent Psychiatry adopted a list of symptoms and warning signs for adolescents who may try to kill themselves. The list was updated in November 1998. Suicide Awareness Voices of Education (SAVE) has also compiled a list of teen symptoms of depression and warning signs of suicide.

Three state suicide prevention program guideline manuals were consulted and used to update the following list of warning signs: Maine Youth Suicide Prevention Program, Washington State's Youth Suicide Prevention Program (YSPP), and the Virginia Guidelines for Suicide Prevention manual. Items from all three lists are combined and appear in this section.

Evidence has shown that approximately nine out of ten adolescents at-risk for suicide will give definite signals that they feel suicidal. The key to prevent suicide is to know these warning signs and know what to do when faced with a student who presents these signs so that they may get the help they need. Many of the symptoms of suicidal feelings are similar to those of depression. Parents and educators should be aware of the following signs adolescents who feel suicidal may express. Many of these signs are similar to the signs for depression. Usually these signs will persist for more than two weeks or more in adolescents potentially at-risk for suicide…however, some youths behave impulsively and act out suicidal behaviors or express suicidal thoughts quickly.

Early Warning Signs

- Withdrawal from friends and family
- Preoccupation with death
- Marked personality change and serious mood changes
- Difficulty concentrating
- Difficulties in school (decline in quality of work)
- Change in eating and sleeping habits
- Loss of interest in pleasurable activities
- Frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- Persistent boredom
- Loss of interest in things one cares about

Late Warning Signs

- Actually talking about suicide or a plan
- Exhibiting impulsivity such as violent actions, rebellious behavior, or running away
- Refusing help, feeling "beyond help"
- Complaining of being a bad person or feeling "rotten inside"
- Making statements about hopelessness, helplessness, or worthlessness.
- Not tolerating praise or rewards
- Giving verbal hints with statements such as: "I won't be a problem for you much longer," "Nothing matters," "It's no use," and "I won't see you again"
- Becoming suddenly cheerful after a period of depression-this may mean that the student has already made the decision to escape all problems by ending his/her life
- Giving away favorite possessions
- Making a last will and testament
- Saying other things like: "I'm going to kill myself," "I wish I were dead," "or "I shouldn't have been born."

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Risk Factors: Risk and Protective Factors, and Warning Signs

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Risk Factors

3b

Issue Brief

How Can a School Identify a Student at-Risk for Suicide?

Every school will be faced with different challenges when attempting to implement suicide prevention programs. The resources available will vary between schools and the ability of a school to address suicide will depend upon resources such as time and funding. However, it is essential that every school provide some type of prevention program and that students experiencing suicidal thoughts or behaviors are recognized in order to get them help. One of the most important and essential components of a program is how to identify students who are at risk for suicidal thoughts and behaviors. Research has focused primarily on three ways for identifying an at risk adolescent:

1. **Suicide Awareness Curriculum**
2. **Gatekeeper Training**
3. **Screening**

Suicide Awareness Curriculum

Suicide awareness curriculum refers to educating students about suicide. Curriculum generally focuses on the warning signs and risk factors for suicide, reviews statistics about suicide, and provides a list of community resources where students can turn to for help in a suicidal crisis. Curriculum approaches may also attempt to increase students' self-esteem and their likelihood that they will seek help if they are in need. The rationale behind programs that utilize the curriculum component is that by educating students on suicide, students should feel more comfortable about self-disclosing suicidal thoughts; students who know the risk factors for suicide may also be more likely to identify and refer at-risk peers to an appropriate adult. Research has shown that adolescents are more likely to turn to peers than adults when facing a suicidal crisis (1,2,3,4,27). By educating peers about risk factors, a school may more effectively reach those at risk.

Research has shown that a curriculum approach intended to raise awareness about suicide can lead to a significant improvement in students' knowledge gain (2,6,5,12,9,10,55,62), particularly about how to seek help for oneself and for others (9,10). Studies have also shown

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How Can a School Identify a Student at-Risk for Suicide? continued

that students exposed to suicide curriculum improve in their attitudes about suicide (9,10,56,13,2,62), that is, they hold more accurate and positive attitudes concerning suicide, such as suicide is not a normal reaction to an overwhelming amount of stress. When curriculum concerning suicide are taught in a gradual, sensitive, and educational manner, students have shown gains in knowledge, positive attitudes, and have also shown a reduction in suicidal feelings (40,2,10,12).

Importance of Curriculum Length

Research shows that the exposure dose or length of time the curriculum is administered is extremely important. Studies have shown that a curriculum approach may potentially not have any impact on students or may even produce harmful effects on students (9,57,14). These studies found that a limited number of students who had previously attempted suicide and were exposed to a curriculum were more likely to view these programs as unsettling and may see suicide as a possible solution to overwhelming problems.

Three considerations must be noted with respect to the harmful effects found in such studies on suicide curriculum.

First, the harmful effects were only found in males and a large proportion of those males were black males.

Second, these negative results were found primarily in students who had reported having made a previous suicide attempt. The authors of these three studies state that students who had attempted suicide previously would be expected to be the most concerned with suicide at the time of the programs and would be expected to see these classes in a negative way. They also later state that that the programs that they evaluated and found to be potentially harmful to a small number of students, focused on the stress model for suicide, a model that attempts to destigmatize suicide. The stress model for explaining suicide has recently been found to be ineffective and potentially dangerous because it "normalizes" suicidal behavior, making suicide more acceptable (15,10,4,24,26).

Third, these studies that have found harmful effects utilized brief (2-4 hour), one-shot sessions that emphasized a stress model for suicide, which states that suicide is a reaction to an extreme amount of stress. It must also be noted that brief one-shot sessions have been found to be ineffective (30,60).

Therefore, if schools wish to use a curriculum approach in order to address suicide and identify students who may be at-risk for suicide, they must avoid using a one-shot approach that focuses on suicide as a reaction to extreme stresses. Also, they must address suicide in a more prolonged approach, refraining from saturating students with a one-shot, 2-4 hour class, which may overwhelm students and which studies have found to be potentially harmful for students who have previously attempted suicide.

Studies have shown that a more appropriate method when utilizing a curriculum approach is one that presents suicide curriculum to students in a more prolonged fashion. Research has shown that curriculum length of anywhere from three classes (40–45 minutes each) to a semester-long class are effective at significantly reducing suicidal ideations, hopelessness, and depression in adolescents (2). These classes have also shown to significantly increase knowledge about peers at-risk for suicide, increasing positive attitudes toward help seeking, and increasing the likelihood of intervening with troubled peers (6).

Exemplary Programs

Exemplary school-based suicide prevention programs that have been found to be effective and have utilized a prolonged curriculum approach include Bergen County, New Jersey (2), and Dade County, Florida (35).

These exemplary programs have also incorporated curriculum that focused suicide prevention awareness into existing programs that deal with issues such as substance abuse, tobacco restriction, problem-solving, help-seeking, and decision making. Because such programs have focused on risk factors,

How Can a School Identify a Student at-Risk for Suicide? continued

such as substance abuse and protective factors, such as help-seeking, they may provide a more comprehensive approach to suicide awareness curriculum.

Suicide awareness curriculum that focuses on protective factors, such as social competence, problem-solving, coping strategies, decision making, and family connections (social support) dramatically decreases risk behaviors for adolescent suicide, such as substance abuse, school delinquency, violent behavior, and problem sexual behavior, e.g. teen pregnancy (16–19). These aforementioned programs have also been shown to reduce suicidal thoughts and plans (20,21). These programs represent an efficient use of school resources because they lend themselves to incorporation into already existing curriculum that may focus on issues, such as substance abuse, tobacco use and sexually transmitted diseases.

Exemplary programs that have utilized this approach in conjunction with other approaches (gatekeeper training) and have been evaluated and disseminated include Adolescent Suicide Awareness Programs (22) and Lifelines (2,30), which have recently been combined into Lifelines/ASAP (30). Other programs that have utilized a similar approach for preventing adolescent suicide include programs in Miami, Florida (35) and Washington State (23).

Mental Health Approach

Curriculum that avoids using a stress model approach and instead utilizes a mental health approach may also be more appropriate (10,58,59,24,15,26,48). Such a program would discuss mental illness as it relates to suicide within the curriculum. Research has shown that when a suicide prevention awareness curriculum focuses on suicide as it relates to mental illness, there is a reduction in suicide rates and an increased awareness about mental illness, which may help some students to seek help (10,63,22).

Research suggests that school psychologists are some of the most highly trained mental health professionals in the school (64). It only seems logical that their evaluation of school-based prevention programs may provide important suggestions for the effectiveness of these programs. Recent research has found that school psychologists rated suicide awareness curriculum and staff in-service training as an acceptable method for a prevention program (43), which is reassuring since they are both considered to be important parts of a comprehensive suicide prevention program (2,43,62).

Student education and curriculum that addresses adolescent suicide should only be provided after protocols are established and school personnel have been educated.

Conclusions about suicide awareness curriculum. If a school chooses to use suicide awareness curriculum as a method for identifying suicidal youth they should:

- Avoid using a brief (2–4 hour) one-shot approach in assembly presentations or classes
- Use a more prolonged approach when using curriculum delivered to students
- Avoid a curriculum approach that emphasizes suicide as a reaction to stress
- Avoid curriculum which includes media depictions of suicidal behavior
- Avoid presentations by youth who have previously made a suicidal attempt because participants may identify with presenter and copycat suicidal behavior
- Consider implementing suicide awareness curriculum within the context of established classes such as a health class or a life-management skills class
- Consider incorporating problem-solving skills, coping skills, and self-esteem building skills into the curriculum
- Provide students with a list of crisis intervention services and resources that are available in the community
- Have established policies and procedures on how to deal with a suicidal adolescent

How Can a School Identify a Student at-Risk for Suicide? continued

- Have established community links that may provide assistance in a suicidal crisis
- Have staff who know what to do if a student expresses concern about a potentially suicidal peer or expresses suicidal thoughts themselves

Gatekeeper Training

Gatekeeper training refers to training school staff about how to recognize a student potentially at-risk for suicide, how to appropriately intervene and communicate with a student potentially at-risk for suicide, how to determine the level of risk, and how to refer a student who is potentially suicidal (24,25,26,27).

Gatekeeper training is universally advocated and supported by research as an essential and effective component to a suicide prevention program (27,28,29,30,26,4,33,34,36,24,35). Research suggests that gatekeeper training can produce positive effects on an educator's knowledge, attitude, and referral practices (24,36,37,38,39).

Gatekeeper training has also been found to increase an educators confidence that they have the ability to recognize a student potentially at risk for suicide by more than four times that of teachers who don't receive training (40). Research has found that more than 25% of all teachers sampled in a study reported that they had been approached by suicidal teens (61). In the past, gatekeeper training focused primarily on educators and administrators, however recent research suggests that it is more beneficial to train all school staff (e.g., coaches, cafeteria workers, bus drivers, nurses) about adolescent suicide, particularly on how to identify, intervene, and refer students potentially at-risk for suicide (27,37,25,38).

Research suggests that a one, brief two-hour program should be sufficient in order to substantially increase an educator's knowledge about the warning signs, risk factors, and community resources available for adolescents at-risk for suicide (24, 31).

Research also suggests that while providing students with a brief (two hour) one-shot class may be harmful, providing a brief two-hour program to staff does not result in the same potentialities (43,30,65).

In-service training programs have been shown to be an effective method of gatekeeper training and were a major component of a study that had a positive impact on student's suicidal behavior (35). Principals have also expressed that in-service training programs are an acceptable method for educating staff (42,33).

A caveat to school staff gatekeeper training is that it should also include parent training. Parent gatekeeper training should be similar in content to staff gatekeeper training, and should facilitate disseminating information about warning signs and risk factors, available school and community resources to help an adolescent potentially at-risk for suicide, and how to intervene with a youth potentially at-risk for suicide (40,32,30).

A one and one-half hour presentation coupled with other presentations, such as alcohol abuse and tobacco use in schools is probably the most efficient and effective method for disseminating information about adolescent suicide to parents (30). This presentation should also include a brief presentation on means restriction strategies, or how to limit access to methods and tools used for suicide (45,33,15,27,28,25,24,30). Restricting access to means of suicide, especially firearms, has been shown to be an effective method for decreasing the likelihood of adolescent suicide (33,41,15,24,45).

Programs that have utilized gatekeeper training and consider the training an essential component include:

- Maine's Youth Suicide Prevention Program,
- Colorado's Safe Communities-Safe Schools Program, and
- Washington's Youth Suicide Prevention Program (YSPP).

How Can a School Identify a Student at-Risk for Suicide? continued

Other programs that utilize gatekeeper training but have yet to be evaluated are:

- Bridges Program (New Jersey),
- New Mexico School Mental Health Initiative,
- Project SOAR (Texas), SAVE (Minnesota),
- Suicide Prevention Unit-Los Angeles Unified School District,
- Team-up to Save Lives-CD ROM (Illinois),
- Adolescent Suicide Awareness Program (ASAP), and
- Yellow Ribbon Suicide Prevention Program (Minnesota).

For more information about programs please refer to the Resources section of The Guide, which specifically focuses on suicide prevention programs.

Conclusions about gatekeeper training. If a school chooses to use gatekeeper training as a method for identifying suicidal youth they should:

- Provide staff with the most current information about adolescent suicide
- Have policies and procedures in place for identifying and referring potentially suicidal students
- Have established community links (police, ambulance service, hospitals, youth services, mental health facilities) in order to have a reliable referral service
- Encourage all staff to collaborate with one another to increase assistance among teachers in recognizing at risk students
- Educate all staff about the risk factors for adolescent suicide
- Educate all staff about the warning signs for adolescent suicide
- Educate all staff on how to make referrals for a potentially suicidal student
- Educate all staff about to whom they should refer a potentially suicidal student
- Utilize a brief in-service training program for staff and faculty. A two-hour program should be sufficient
- Provide in-service training materials to parents
- A brief one and one-half hour presentation coupled with other presentations should be a sufficient amount of time to train parents

Screening

Screening refers to a method of identifying adolescents potentially at-risk for suicide through the use of self-reports and individual interviews. Generally, screening consists of asking students directly about whether they are experiencing symptoms associated with depression, currently or previously had suicidal ideations or behaviors, and whether they possess risk factors for suicide (46). Many researchers suggest that school-based suicide prevention programs can be quite effective when they are targeted to a particular high-risk group of students who have been identified through direct assessment (47,48).

Studies have been conducted in order to assess the effectiveness of screening programs and have found them to be an effective and potentionally efficient method for identifying students who are at-risk for suicide (46,47,48,49,50). The rationale behind screening programs is that research suggests that adolescents will honestly state if they are suicidal when asked (15). While many researchers advocate screening programs (45,48,51,52) and consider screening to be a critical component of an effective approach for preventing suicide (4,15,48), many school programs fail to use them (4,26) despite moderate support from teachers and administrators (53).

Although research seems to indicate that screening programs are effective ways of identifying students who may be at-risk for suicide, there are some concerns about using screening to identify students at-risk. Since suicidality fluctuates in adolescents (29), repeated screening must be done to measure the changes in suicidality and to avoid missing a student who is not suicidal at one time but becomes suicidal over time (28,29,36). Screening may also identify as much as 10% of the adolescent at school

How Can a School Identify a Student at-Risk for Suicide? continued

as being at-risk, creating a costly need to follow-up those identified as at-risk for suicide (26).

In order for schools to initiate a screening session they must have cooperation and consent from parents and research shows that active parental consent runs about 50% (29).

Currently there are numerous screening methods available to schools that have been shown to be effective in identifying students who may be at-risk for suicide. Four of these include:

1. **The Suicidal Ideation Questionnaire**, which has been used in a two-stage screening and assessment process (47) and has thus far been shown to be efficacious (43). The questionnaire is then followed by the Suicidal Behavioral Interview, which should be done by an experienced professional.
2. **The Suicidal Risk Screen** (50), which has been used in a three-stage screening process for identifying, among high school dropouts, youths that require referral to prevention or treatment programs for potentially suicidal teens.
3. **The Columbia Teen Screen** (54), which has been used in a three-stage screening process for students at-risk of suicidal behavior.
4. **Signs of Suicide** (**SOS**), which has been implemented in approximately 600 schools during the 2001–2002 school year.

Although there are a number of other screening tools available for use in schools, these four methods have been shown to be relatively successful. If a school is interested in screening as a way to identify students at-risk for suicidal behavior these tools may be useful. For more information on screening tools please refer to Goldston (66), which provides an excellent, comprehensive list of approximately 50 screening tools that schools can use to identify students at-risk for suicidal behaviors or ideations, students at-risk for depression and psychiatric disorders, and instruments used for assessing intent and lethality of a student that is potentially suicidal.

Information on mass screening can be found in two reports: Eggert and colleagues (6) from Seattle, Washington and Reynolds (47) from Florida.

After a student has been screened, if he or she screens positive for suicidal potentiality then direct assessment by trained clinicians should be done within seven days (50). How a school chooses to assess a student will vary: some schools may simply contact and utilize a community mental health professional or others may choose to utilize the Measure of Adolescent Potential for Suicide (MAPS) instrument, which has been found to be an effective assessment tool for determining if a student is currently suicidal. MAPS has also been found to be an effective way of reducing a student's suicidality although how MAPS does this is unknown. For more information about MAPS please refer to Eggart and Thompson article for contact information. MAPS is just one assessment tool that a school may choose to utilize in determining if a student is suicidal, however when MAPS is given to students in isolation with no other intervention students do show reduced suicide-risk behaviors, increased self-esteem, and reduced related risk-factors for suicide (6).

Conclusions about screening. If a school chooses to use screening as a method for identifying suicidal youth they should:

- Use a questionnaire or other screening instrument that research has shown to be effective and valid such as the three presented above
- Get parents consent before presenting students with the screening instrument
- Have established referral systems in place so that when a student screens positive for suicidal potential he or she can be given the help they need as soon as possible
- Communicate to staff and parents that empirical research has found that screening will NOT create suicidal ideations and behaviors in teens who are not suicidal. Screening will not implant suicidal thought in those non-suicidal before exposure to the screening

How Can a School Identify a Student at-Risk for Suicide? continued

- Staff and practitioners should be made aware that screening is not perfectly precise for determining whether a student will express suicidal thoughts or behaviors
- Every school psychologist and counselor should be aware of valid suicidal screening tools
- Conduct repeated screenings, possibly once or twice every school year

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Risk Factors: How Can a School Identify a Student at-Risk for Suicide?

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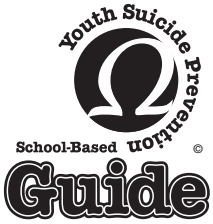
Notes



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Administrative Issues

4

Issue Brief

Youth Suicide Prevention School-Based Guide ©

Why a School-Based Suicide Prevention Program?

As the third leading cause of death among 15–19 year olds in the United States in 2000 (1), adolescent suicide is a serious and preventable tragedy, which has the potential to affect a large number of families and communities across the country (1,2). The United States Surgeon General has declared suicide, particularly adolescent suicide, a serious public health concern and has initiated a call to action for every state to address the issue of adolescent suicide (3). Research has found that schools provide an ideal and strategic setting for preventing adolescent suicide (4,5). Research suggests that schools contain the largest ratio of suicide attempts-to deaths by suicide (6) and the fact that school education codes include the mandate to not only educate, but to protect students (7), it seems only reasonable and prudent to implement, maintain, and evaluate prevention programs in schools, the places where adolescents spend more than one-third of their day.

Research has found that teachers and staff view identifying a potentially suicidal student as one of the most important things they can do as a teacher and feel that addressing students' mental health is part of their role as an educator (8). Not only do educators feel some responsibility towards preventing adolescent suicide, but they also have shown satisfaction with training addressing adolescent suicide (9,10). Schools must avoid neglecting the issue of adolescent suicide for a fear of indifference by faculty. Research suggests that while teachers are being asked to teach a number of educational programs dealing with a number of social issues (safe sex, substance abuse, and family violence), they often find themselves ill equipped to deal with such issues (42). In fact teachers' resistance to suicide prevention programs may have more to do with a sense of fear and helplessness from not having enough information than unwillingness or indifference (51). In order to effectively combat adolescent suicide, schools, administrators, and policy makers must understand that adolescent suicide is a real and serious threat and that this threat is not isolated to "other schools and/or districts". No school is immune to adolescent suicide; by implementing and maintaining an effective, comprehensive school-based prevention

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program a community may be able to make a positive and efficient impact on adolescent suicide.

Implementation

Research on school districts has found that one of the major questions about implementing prevention/intervention programs was on how to begin a school-based suicide prevention program (16).

Although each school and school district should initiate a suicide prevention program that will "fit" well within the culture of their school and will be dictated by the resources available, research suggests that meetings with district leaders, school principals, educators, and potentially a parent group could help facilitate "reconnaissance and relationship development" (11). The meeting may involve a discussion about the prevention program ahead of time with various members of the group in order to determine what resources, barriers, and concerns each may have about implementing a prevention program (12).

By allowing meeting members to express their concerns, suggestions, and voice any foreseeable barriers, a school will be in a better position to resolve potential barriers, identify strengths and resources available in the school to build on, and recognize potentially helpful community resources, all of which can be done before program development, thereby making the program more effective and less difficult to implement and maintain (15). Another reason for such a meeting is to assess what suicide prevention strategies are currently being utilized to address the issue of adolescent suicide in order to avoid inadvertently duplicating resources (2).

Given the numerous programs suggested for schools to implement and the various responsibilities frequently placed on the shoulders of schools, suicide prevention strategies already in place may simply be overlooked. Research has suggested that superintendents and administrators for schools with some type of prevention program in place were not aware that there were such programs in place, suggesting a lack of knowledge about programs as opposed to a true lack of programs, which could advocate for periodic updates for staff, faculty, and administrators about school policies (12,16). By involving various members of the educational system, schools and school districts may avoid squandering necessary resources by duplicating services already provided. If a school does currently have a suicide prevention program, then it is essential that the program is re-evaluated to ensure that it reflects current, research-based, suggestions for what constitutes an effective prevention program (13,17). Research has found that when policymakers and program planners act hastily, without evidence-based knowledge, regardless of how well intentioned the program may be, it may lead to ineffective, inefficient, and potentially dangerous results (14).

Developing Policies and Procedures

Once a school/school district has held such a meeting (if they choose to do so), developing policies and procedures is the next likely and appropriate step. Establishing policies and procedures focused on issues, such as how to respond effectively to a student who may be expressing suicidal behaviors or threats, how to respond to the aftermath of a suicidal attempt or a death by suicide, and the various roles school personnel may play in preventing, intervening, and coping with a student who may be suicidal are essential components of any effective suicide prevention program (12,13,16-25).

Such policies form the heart of a school crisis response plan, an essential component of any effective school-based suicide prevention program. School policies formally recognize the school's commitment to preventing adolescent suicide and increase the likelihood that a program will be implemented, maintained and proactive in scope (4,26,27).

Administrative Issues continued

Although each school should adopt a policy that "fits" appropriately with the culture and emotion of their school, research (12,18,25,30) has suggested that schools may want to be aware of the following propositions for what policies may wish to address:

- Formally state that the school considers suicide prevention a priority.
- Formally state and express to others what prevention efforts a school will utilize to address adolescent suicide (curriculum, gatekeeper training, screening, peer groups). See Issue Brief 5: "Suicide Prevention Guidelines" for more information.
- Maintain a crisis management handbook, which should provide information about suicidal behavior, risk factors, protective factors, suicide contagion (imitation), and prevention guidelines.
- Describe what staff, faculty, or students should do if they suspect that a student may be potentially at risk for suicidal ideations and/or behavior (this will entail education on referral practices).
- Describe how to respond to a student overtly expressing suicidal ideations and/or behaviors.
- Describe and recognize a school crisis response team.
- Detail the roles and responsibilities of each crisis response team member.
- Describe criteria for assessing the lethality of a student potentially at risk for suicidal behavior.
- Describe how a school and its staff members will respond to a suicidal crisis (attempt at school or death by suicide).
- Describe how a school will evaluate the program.
- Should be clear and detailed.
- Should be consistently defined at the school level and at the district level.

Policies are only effective if they are disseminated and recognized as important (2,8,12,14,41,74). It is essential that once policies are established and are agreed upon by administrators, staff, and community professionals (counselors, psychiatrists) as comprehensive and empirically sound methods for addressing the issue of suicide, it is important that these policies are provided to all faculty and staff, most of whom should support the policies as well as any prevention efforts that a school may wish to undertake. It is also important that school staff be explicitly informed about who in the school and/or the community they may contact when confronted with a potentially suicidal student.

For more information on types of prevention methods (such as gatekeeper training and screening) please refer to Issue Brief 5: "Prevention Guidelines". For information about how to refer a potentially suicidal student please refer to Issue Brief 6a: "Establishing a Community Response".

A caveat to the issue of establishing and implementing policies concerning adolescent suicidal behavior is that these policies should define the goals and objectives for their prevention program. Defining goals and objectives of a prevention is one of the first issues to address when designing or re-defining a suicide prevention program.

What is it that you hope to accomplish? Will the program increase the number of referrals? Will it decrease the incidence of suicidal behaviors? Will it increase the number of calls to area crisis centers? (41). These are just some of the goals and objectives a school may wish to address when developing a suicide prevention program. By setting goals and objectives, it makes it easier to evaluate the effectiveness of a prevention program and any results from evaluation will be more believable to others (42).

Program Support and Maintenance

Research has found that three of the most important factors that determine if a prevention program is maintained are having support from administrators, teachers, and parents (16,28,29). Research has also found that support from superintendents in particular may be essential for effective programs (16). Eliciting endorsements from school principals has also been found to be an indication that a prevention program will be adopted (12). Without administrative support, prevention policies and their corresponding programs will lack institutionalization and efforts to prevent adolescent suicide will therefore be formally ignored. Research suggests that supportive administrators ensure a good program fit into the school and the community, provide ongoing support, and help to ensure that the program is incorporated appropriately into existing budgetary, policy, and schedule structures (12).

Supportive and informed teachers have been found to make good informants concerning student mental health, provide support for one another, are able to reach a high level of mastery of a complex prevention program, and are likely to obtain skills and materials from suicide prevention programs that are transferable to other elements of their repertoires (12, 31–33). Research has found that when schools communicate and involve parents with school activities and programs, parents are more likely to cooperate with the school and help the school maintain these programs (34,35). When schools involve and gain support from parents, students feel more competent and less confused because by working with parents, schools ensure that students receive consistent messages (36).

In order to gain support from administrators, educators, and parents some suggest educating these individuals about the severity of adolescent suicide, warning signs and risk factors for adolescent suicide, and about the ability to prevent adolescent suicide (29). Research shows that one of the main barriers for effectively implementing and institutionalizing a suicide prevention program is that the issue of suicide is often met with fear, resistance, and anxiety by members of a community, who more likely than not ascribe to and maintain false ideas concerning suicide (40,42).

Myths such as “talking about suicide may cause it to occur” or outright denial of adolescent suicide (“suicide does not happen in my school” or “suicide is not a problem here”) act as barriers for program implementation and may also increase the likelihood that a school and community will fail to recognize a student who may need help (30,40–42). Research has found talking about suicide with students will not “plant the idea of suicide” in their head and that by talking about suicide, schools give students the opportunity to express their feelings and concerns, which may help a student get help or refer another student for help (30,43,44). The Centers for Disease Control and Prevention overtly state, “there is no evidence of increased suicidal ideation or behavior among program participants” (45). Research has also found that persons who are educated about adolescent suicide are more likely to have a positive impact on students than those not educated (37–39).

In order for a school and/or school district to ensure that a school-based prevention program will be effectively adopted and maintained, research suggests that schools gain support from parents, administrators, educators, and various community members and that these persons are aware of the prevalence and risk of suicide in their community (12,14,16,18,25,27,29,30,34,35,52,54,74). These persons should also understand how myths, or fictitious beliefs lacking scientific merit, might undermine a community’s ability to help a troubled adolescent. For more information on myths behind suicide please refer to Issue Brief 2: “Information Dissemination”. Also included in the Guide is a True and False Test for Myths and Evidence-based Facts about adolescent suicide.

Research has found that if someone (a parent, educator, administrator, school counselor, or superintendent) chooses to “take control” and “champion” a suicide prevention effort, this effort is more likely to become institutionalized and maintained; what may be significantly important is for someone just to get the ball rolling (52,53). Once a dedicated, informed, and motivated person (particularly a school administrator) champions a suicide prevention program, it seems that other persons in the community and in the school, if properly educated, will be likely to assume some responsibility for preventing adolescent suicide.

It is also essential that schools, regardless of what prevention methods they choose to utilize, openly and periodically communicate with community agencies and professionals in order to help ensure that a potentially suicidal adolescent gets the help that he or she may desperately need. Community partnerships are discussed in greater detail in Issue Brief 8: "Family Partnerships" and in Issue Brief 5: "Suicide Prevention Guidelines." What must be mentioned here is that a comprehensive and effective program cannot function without support from the community and that established agreements between a school and various community agencies such as the police and mental health agencies are critical (10,17-19,25,30,47). Establishing working links to the community also provides the school with additional help and expertise. Research has found that mental health professionals are willing to help schools at little or no cost and may provide other valuable services such as training and educating staff and faculty about how to recognize, intervene, and refer a student potentially at risk for suicidal behaviors (46).

Crisis Response Team

In order for a school to effectively intervene with a student potentially at risk for suicidal behavior, schools must develop, train, and support a school crisis response team (10,13,15,19,25,49,50,75,76).

A school's crisis response plan should detail the roles and responsibilities of each member of the team, such as mobilizing the team when needed, controlling rumors, responding to the media, contacting community links, providing first aid if necessary, contacting parents of a student experiencing a suicidal crisis, scheduling response team meetings, and providing training to school staff and faculty (48,49).

The crisis response plan should also designate a crisis team leader and backup leader, who should have support from the administration and should be given the authority to coordinate team member assignments while keeping an open channel with school administrators (49,50). For more on crisis response teams please refer to Issue Brief 6b: "Crisis Intervention and Crisis Response Teams."

What must be noted here is that in order for a crisis team to be effective, it must be supported by the administration and should be acknowledged as a highly valuable resource within the school.

Evaluating Programs

An important element of suicide prevention efforts, that current research is desperately lacking information on and one that may be extremely helpful to schools, is how a school will evaluate suicide prevention efforts.

Resources, time, and efforts to implement and maintain suicide prevention activities should be praised and those who take the initiative to support such programs should be lauded for their efforts, but strategies meant to evaluate the effectiveness of suicide prevention efforts must not overlooked for many reasons, one of which is replication.

If a school's efforts have been demonstrated to be effective at preventing adolescent suicide then without explicit documented strategies of their specific prevention strategies and policies, there is no way to replicate effective designs. Although many suggest that evaluating the impact of suicide prevention strategies is essential and such methods may be appropriately placed in the crisis response plan, little empirical research has been done to critically evaluate the impact of such strategies (2,12,18,25,42,51,54). That is not to say that such evaluations have not been done. Some examples, which only represent evaluations that have been published, disseminated to enough persons to validate results, and have been maintained over an extended period of time to reduce effects of time trends, have all demonstrated positive effects such as a reduction in youth suicide rates (12,18,55) or a reduction in suicidal ideation and less favorable attitudes towards suicide (56-58).

Other research, which focused evaluation on a one-shot, 3–4 hour curriculum showed that a small restricted group of students, those who had attempted suicide, expressed more maladaptive coping skills and increased levels of hopelessness following the classes (60,61). The authors of these studies, however subsequently stated that such one-

shot, limited in duration, classes should be avoided. This idea is consistent with other research that classes can have a positive effect on attitudes, knowledge, and referral practices, but only when offered for a longer period than one, 3–4 hour session. Additionally, such a long period of time, (3–4 hours) could have influenced how well received these classes were in this small group. For more information on these studies, and on curriculum in general please refer to Issue Brief 5: "Prevention Guidelines," pg. 3.

What schools should seek to achieve is long-term maintenance of suicide prevention efforts as opposed to a quick-remedy. Although short-term efficacy in the form of increased awareness, ability to make a referral, and more appropriate attitudes towards suicide is expected in properly instituted programs, long-term follow-up, retraining, and evaluation is recommended by many researchers in order to determine the long-term effects on students and to recognize students that may fluctuate between being non-suicidal and suicidal (2,25,30,41,62-64).

Additionally, most research suggests that an effective prevention program should include an evaluation component and that this program may wish to address the issue of evaluation in a formal document, possibly in the initial prevention program policy or crisis plan in order to make sure that the prevention, intervention, and postvention strategies are effective at reaching their goals (2,25,42,62-64). A method to evaluate the prevention program done before implementation, based on the goals of the program, will increase the school's prevention program credibility and will increase the likelihood that such a program if shown to attain its goals as dictated in policy will serve as a model for other schools.

Schools may wish to evaluate the effectiveness of their suicide prevention efforts by monitoring morbidity (number of suicidal behaviors) or mortality (number of deaths by suicide) before and after suicide prevention efforts, the number of crisis center hotline calls received before and after prevention efforts, the number of internet help site hits before and after prevention efforts, the number of students screened, the number of students provided suicide curriculum, or the number of gatekeepers trained.

Due to the low incidence rates of deaths by suicide, if a school chooses to use death by suicide as a means for evaluating their program, then results from the effectiveness of prevention efforts may not be evident for many years because there will be so few number of "cases" to make any appropriate comparisons from before implementing the prevention program to after implementing the program. Even then, schools may not be able to attribute the success of the program to the program itself with certainty.

Other factors may have had an impact on rates of suicidal behavior or indicators of suicidal behavior, such as a decreasing number of students engaging in substance abuse or more students with mental illness getting effective outside therapy after program implementation than before implementation. These trends could hide the true effect of the program. In order to evaluate the effectiveness of suicide prevention efforts it is important to keep in mind what the goals of the program are: if the school intends to reduce the number of suicide attempts then morbidity and mortality statistics may be appropriate but if the goal of prevention efforts is to increase the number of students getting help for crisis situations then the number of crisis calls or the number of community referrals may be appropriate.

Usually schools will have more than one objective and will differ in their ability to evaluate the effect of any prevention efforts. However, without some method to measure the effect of these efforts, schools may unknowingly contribute to suicidal behavior in those students potentially at risk for suicidal behavior or may have little or no impact on students' suicidal ideations or behaviors, in which case prevention resources may be better suited for other activities.

Duty, Responsibility, and Liability

An important issue for schools and one that many administrators, teachers, and school board members consider to be of paramount importance is the issue of liability. Whether a school district will be held liable and/or responsible for a student's death will depend on whether the legal claim is based on negligence or a constitutional claim based on due process (65). Negligence is established when a legal duty is owed, to the student (by teacher or school), the duty was breached, there was a sufficient causal connection between the breach and the student's injury or death, and that an actual loss or damage was suffered by the student as a result (65,67).

Put simply, negligence results from some sort of wrongful action on the part of one person, which results in injury to another person (66). Usually the first two elements are vital and the first step is proving that a legal duty existed, in which case proving if the teacher or school had a duty to protect the student from suicidal behavior. If duty can be proven, then the case proceeds to prove the remaining elements.

Courts generally recognize that school administrators, educators, and board members have a duty to exercise reasonable care when students are at school and have an obligation to ensure safety while at school. Courts have also held that "a school owes to its charges to exercise such care of them (students) as a parent of ordinary prudence would observe in comparable circumstances (68). Although it is difficult if not impossible to predict how a jury and/or judge will rule on a case involving school liability some points should be mentioned:

1. The school must provide supervisory care to students at the same level as a concerned parent.
2. Failure to prevent suicide because of a lack of action when a school administrator, educator, or faculty member has knowledge that a student is a potential risk for suicide may be found liable. Courts have also found that if most school administrators or staff members who had not received formal training related to suicide could recognize a potential threat of suicidal behavior in a student, then any teacher may be held liable under the same circumstances if he or she fails to act.
3. Failure to notify a parent when faculty or staff have reason to believe that a student is at an increased risk for suicidal behavior has led to a school district being found liable in the state of Florida (69). The School Health Services Act (FL Stat. 402.32) provided that guidelines indicating that school personnel were to immediately notify parents or guardians of any serious emergency that occurred during the school day.
4. Educators may be found liable if they violate a statute that is intended to protect a student potentially at risk for suicide. An example of this violation would be releasing confidential information about a student, which may contribute to that student engaging in suicidal behavior. Under the Family Educational and Privacy Rights Act of 1974 (FERPA), educators must protect the privacy of student records such as grades, health information, counselor's reports, teacher observations, and disciplinary actions to name a few. There is one exception to maintaining confidentiality: If a student is believed to be experiencing a suicidal crisis or has expressed suicidal thoughts then confidentiality must be breached in order to protect the student. Students should be told that in order to ensure that they get the appropriate care it is essential that someone who may be in a better position to help should be contacted.

Overall, school districts, administrators, educators, and staff may be held liable for a student's suicidal behavior when there is knowledge that a student could potentially harm himself and when action is not taken to prevent such a tragedy. Liability may also be found if the educator or administrator violated some statute meant to protect a student or if the educator or administrator created the situation that placed the student at a greater risk for suicidal behavior.

Administrative Issues continued

Research evaluating information on school liability suggests that it is wise for districts to develop programs to train (or retrain) their personnel at a minimum and may wish to train students to detect suicidal behavior and provide them with information on where to get help (66). Some also suggest that involving parents, developing prevention policies, and disseminating this information to staff and parents are also necessary components to any effective program (66,70).

Researchers state that the best "insurance against legal difficulties is a written school policy that is known and followed by all school personnel" and should include issues such as confidentiality, suicide prevention methods, intervention strategies, and postvention strategies (71). It is also recommended that this policy should be written in conjunction with and reviewed by an attorney (66,71).

Another important way that a school district, administrator, or staff member may protect themself from liability is to keep accurate and up to date records about students potentially at risk for suicidal behavior and explicitly indicating any actions that were taken by the school or educator (66,71,72).

Florida schools and staff should be aware and particularly informed about the Florida's Mental Health Act (The Baker Act). Put simply this act recognized that some mentally ill persons (children and adolescents included) may need to be involuntarily admitted to a mental health facility for evaluation and short-term treatment. Only Arkansas and New Jersey provide for commitment of a person who is potentially at risk for suicidal behavior, without a requirement that this person have a mental illness (71). In Florida however, an adolescent may be admitted involuntarily "only if there is reason to believe he is mentally ill and that without care and treatment, he is likely to suffer from substantial harm or he is more likely than not to inflict serious, unjustified harm to another person" (73).

According to Florida Statute 394.455, mentally ill means: " an impairment of the emotional processes of the ability to exercise conscious control of one's actions, or of the ability to perceive reality or to understand, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology; except that for the purpose of this act, the term does not include retardation or developmental disability as defined in Chapter 393, simple intoxication, or conditions manifested only by anti-social behavior of drug addiction". The adolescent must have:

1. Refused voluntary admission or is unable to determine for him/herself whether such admission is necessary.
2. Without care he or she is likely to suffer neglect or refuse to care for him/herself; such that this neglect poses a real and present threat of substantial harm to his/her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services. The adolescent may also be taken involuntarily if it is more likely than not that in the future he/she will inflict serious, unjustified bodily harm on another person, as evidenced by behavior causing, attempting, or threatening such harm, including at least one incident thereof within 20 days prior to the examination.

Every state will differ in their rules, regulations, policies, and procedures for responding to an individual potentially at risk for harming them-self, harming another, or not having the ability or the capability to care for themself. Regardless of how your state chooses to define and respond to a person who may be at risk for harming themselves or others, it is important that your school and its staff have some knowledge about legislation in order to make them feel more secure about issues, such as liability and for the important reason that by being aware of such legislation may help educators more effectively respond to an adolescent at risk for suicidal behavior.

It is essential that administrators implement prevention strategies that "fit" well within their school's culture, that policies and procedures explicitly state how and when to intervene with a student that is potentially at risk for suicidal behavior, that these policies and procedures are disseminated to all staff members, that administrators consult a lawyer when establishing a prevention program, who should inform administrators and educators about state and federal laws related to issue of liability, and that parents and community members (organizations) all are involved in any suicide prevention efforts.

Administrative Issues continued

Your school may wish to establish a crisis response team and facilitate the “championing” of the program by these concerned individuals, all of whom should have the support of administration and who should be recognized for their courageous efforts.

Adolescent suicide is a real and preventable public health issue, which has the tragic ability to destroy the lives of many in our communities. The death of an adolescent permeates the entire community with a sense of loss and anguish; friends, family, educators, and even strangers feel the loss of a life truncated by suicide. Our schools are at the forefront of the battle to prevent the loss of an adolescent and should therefore recognize what resources they have to enlist in their efforts.

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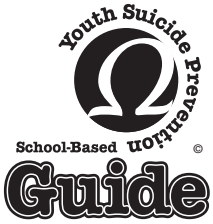

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Suicide Prevention Guidelines

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Issue Brief

Youth Suicide Prevention School-Based Guide ©

Suicide was the third leading cause of death among 15–19 year olds in the United States in 2000 (1). A typical US high school classroom includes one boy and two girls who have attempted suicide in the past year (2). Adolescents spend one-third of their day in school, the institution that has the largest responsibility for educating and socializing youth (3). For this reason, schools provide an ideal setting for suicide prevention strategies for adolescents (4). School education codes include the mandate not only to educate, but to protect students (5). It seems that schools not only have a moral obligation to address adolescent suicide, but a potentially legal one as well. School districts have and can be sued for inadequate suicide-prevention programs (5,6,7).

School practitioners may also face liability in some situations by being held personally responsible (7). It is incumbent upon school administrators to make sure that the issue of adolescent suicide is addressed and given adequate time and resources in order to protect students and avoid tragedy for the community.

Policies and Procedures

One of the first steps that is essential for any suicide prevention program is establishing policies and procedures focused on such issues as, how to respond effectively to a student who may be expressing suicidal behaviors or threats, how to respond to the aftermath of a suicidal attempt or a death by suicide, and the various roles school personnel may play in preventing, intervening, and coping with a student who may be suicidal (8-14,15,16,17,18,29). Such policies not only demonstrate that a school places a priority on protecting its students, but increases the likelihood that a school suicide prevention program will be effectively implemented and maintained (13,14,15,19). Only after policies and procedures are in place can schools expect to effectively address adolescent suicide.

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Gatekeeper Training

Once policies have been established, schools should consider training staff and faculty about adolescent suicide. Staff and faculty training, sometimes referred to as gatekeeper training, has been found to be an essential component for any suicide prevention program and is universally advocated as a necessary element of a school-based prevention program (3,7-10,12-14,17,20-27,29). Gatekeeper training usually consists of training any adult that interacts or observes students to be able to identify any students who may be at-risk for suicide, determine the level of risk, know where to refer a potentially at-risk student, how to contact these referral sources, and what school policies are in place that relate to suicidal crisis situations (17,22,25,28). Although teachers are expected to act as gatekeepers and know how to identify a student potentially at risk for suicidal actions, they should be informed that they are not meant to take on an additional role as a mental health counselor, but are simply meant to act as a watchful eye and "sound the alarm" (28).

Research has found that while teachers are in ideal positions to identify and refer students potentially at risk for suicide (4), only approximately 9% of health teachers (teacher with some experience with suicide curriculum) felt confident that they could identify a student at-risk (31). This is somewhat disturbing when one considers that research has found that more than 25% of all teachers sampled in a study reported that they had been approached by suicidal teens (32). What this means is that despite the fact that teachers are the most likely adults to come into contact with a potentially suicidal student, they do not feel very confident about being able to recognize a troubled teen. Research findings suggest that this lack of confidence could be the result of lack of education and training (33,34).

It is essential that schools that wish to provide a comprehensive suicide prevention program include gatekeeper training as one component of their program. Gatekeeper training has been found to produce positive effects on staff members' knowledge, referral practices, attitudes, and confidence about identifying a potentially suicidal student (14,21,23,27). Research has found that teachers who are trained are more likely to implement programs and are more likely to have a positive impact on students than are teachers who are not trained (42-44). Gatekeeper training has also been shown to be well received by staff and accepted by administrators as an efficient method for preventing suicidal behavior in students (28).

Research has found that teachers and staff view identifying a potentially suicidal student as one of the most important things they can do as a teacher and feel that addressing students' mental health is part of their role as an educator (30). Not only do teachers feel some responsibility towards preventing adolescent suicide, but they also have shown satisfaction with training (22,28). How a school chooses to structure such a training program will vary, however, research has found that one, 2-hour presentation to educators resulted in significant increases in knowledge of treatment resources, awareness of the risk factors and warning signs for suicidal behaviors, and a heightened willingness to make referrals to mental health professionals (23,34). In-service training programs have also been found to be an acceptable method by administrators and staff for training staff about adolescent suicide (35). Research has suggested that "booster" gatekeeper training be provided to staff approximately every 2–3 years in order to maintain competence (3,36).

Although the school, and teachers in particular, are continually inundated with new programs to implement, one, two-hour presentation by a mental health professional within the community should be considered an efficient method for helping to protect students, families, and community members from the pain and tragedy of adolescent suicide.

For more information on specific methods for conducting gatekeeper training, please refer to the following sources: Suicide Information and Education Center (SIEC), the Suicide Prevention Training Program (SPTP), and Keep Yourself Alive (Australia), Project SOAR (Dallas, TX), Adolescent Suicide Prevention Program (Virginia), STAR (Pittsburgh, PA), and BRIDGES (Piscataway, NJ). Although The Guide does not endorse any of these programs, these have been heavily cited and represent just a sample of effective programs.

Educating Parents and Community Members

An interrelated prevention guideline and technique is training parents and community members about suicide prevention. Although it may be beyond the scope of responsibility for schools to actually train community members in the same way school staff members are trained (3), schools should make sure that there are established agreements between the school and crisis service providers such as the police, clergy, mental health agencies, and ambulatory agencies (3,8,10,14,28). These agreements should outline prevention and intervention services that will be provided to the school, such as educating staff about crisis intervention, accepting student referrals, and assisting staff when responding to a suicidal crisis (8). Only when these links are in place can a perceptive and educated staff member make an effective referral for a student potentially at-risk. These links also increase the likelihood that students will receive clear, consistent messages about suicide, which studies have shown increases a student's feeling of competence (39). Schools should also provide information to parents about warning signs, risk factors, protective factors, community resources, and what to do following a suicidal crisis (3,10). Research has found that when schools communicate and involve parents with school activities and programs, parents are more likely to cooperate with the school and help the school maintain these programs (37,38). Research suggests that parent training can be coupled with other presentations such as alcohol use and drug prevention and that a 1.5-hour presentation is sufficient. An important point to make concerning parent education is that research suggests that an essential aspect of any prevention strategy and one that is often overlooked is restricting access to potentially lethal weapons (3,7,20,24,25,28,40,49). Restricting access to means of suicide, especially firearms, has been shown to be an effective method for decreasing the likelihood of adolescent suicide (7,15,22,23,41). Given the fact that ease of access to guns in the home is a key risk factor for adolescent suicide and that the most common method for death by suicide in the United States is by firearms (45), it seems only reasonable to target a source of access, such as the home. A common concern among parents and educators is that decreasing access to particular methods will only lead to adolescents using some other method. However, research has found that by limiting access to particular methods of suicide there is not only a decrease in the number of people who use those methods, but also that there was no increase in the use of alternative methods (41,46-48). Despite evidence from numerous studies that suggest that restriction of access to lethal means is an effective prevention component for suicide, as well as interpersonal violence among youth, when the Department of Health and Human Services reviewed suicide prevention programs in the United States, there were none that included a component for addressing restricting access to means for suicide (28). Means restriction could possibly be the most under-appreciated method for preventing suicide.

Student Curriculum Addressing Suicide

Another prevention method for adolescent suicide that has received a great deal of attention is suicide curriculum and education. Suicide curriculum is generally focused on dispelling myths and increasing correct knowledge about adolescent suicide, increasing the ability of students to recognize another student potentially at risk for suicidal behaviors, encouraging students to seek help, and providing students with the knowledge concerning school and community resources that are available should they need help or should they encounter a peer who needs help (50,28,34). One study found that subjects high at risk (previous suicide attempters) who were given a "green card" with explicit instructions about who to contact should they feel suicidal again demonstrated fewer suicide attempts than previous attempters who were not given a resource card (100). Research on curriculum approaches to suicide prevention has provided cloudy and at times inconsistent results.

Several studies have found that curriculum approaches may have no effect on students or may be potentially dangerous for certain students (51–53). These studies found that certain students showed less desirable attitudes about suicide after

class, were less likely to seek help, were less likely to refer a friend or recommend the class to other students, and were more likely after the class to view suicide as a reasonable response to intense stress (52,53). Although these results are alarming, some important comments must be made in reference to these studies. First, the studies were conducted by the same researchers. Second, the authors stated that their curriculum approach focused on destigmatizing suicide, which is most commonly done by expressing to adolescents that suicide is commonly a reaction to extreme stress (53,54). Research has shown, and the authors of these previously mentioned studies also acknowledge, that curriculum which presents suicide as a reaction to the common stressors of adolescence is not only ineffective, but may be harmful because it normalizes the behavior and reduces protective taboos, thereby making suicide more acceptable (7,20,23,55,56). Third, these studies primarily used one time curriculum approaches: the classes were given only one time and lasted anywhere from 2–4 hours. Research has suggested that such one-shot approaches not be used and could be potentially harmful to students (3,23,57). Fourth, these results were found primarily in isolated groups, such as students who had previously attempted, who as a group we would expect to express such negative reactions. These results were further restricted to males (primarily black males). For a more critical review of some of the problems associated with these studies please see Tierney and Lang (99).

For schools that wish to utilize a curriculum approach to address adolescent suicide, it is recommended that they utilize a model that identifies suicide as a complicated, abnormal reaction to a number of overwhelming factors. These programs should also emphasize the association between suicide and mental illness. Research has shown that over 90% of suicides are associated with mental illness including alcohol and substance abuse disorders (58,59).

It is also recommended that schools avoid a "one-shot" approach with students, which focuses only on suicide and may saturate students. It is more beneficial, and does not carry the potential to harm, if schools use a more prolonged method for addressing adolescent suicide, such as incorporating suicide lessons into already existing semester or year long classes (health classes, English classes, gym classes, etc.).

Research has found that when curriculum addresses suicide in a manner consistent with empirical evidence and is taught in a sensitive and educational manner, students show improvements in attitudes concerning suicide (40,50,51,55,60,61). Students expressed more accurate and positive attitudes concerning suicide following curriculum (suicide as not a normal reaction to an overwhelming amount of stress but rather the result of a number of complicated and interwoven factors including mental illness) than they did before curriculum. Research has also found that students show an increase in knowledge about suicide (warning signs and risk factors), particularly about where and how to get help for themselves or a peer (40,50,53,55,60,62-64).

These results have important implications when one considers that adolescents who are considering suicide and other violent actions first confide in peers (20,24,50,65,66). Students that learn how to recognize peers potentially at-risk for hurting themselves or others and know who to contact in such circumstances may be extremely helpful in preventing a tragedy at school. The potential direct impact of suicide curriculum on suicide rates has also been shown. A 10-year follow-up study on a prevention program that utilized educating students documented a reduction of suicide rates (16).

Similar findings have been published for programs that used a mental health model instead of a stress model (55). One recent study that provided gatekeeper training for high school peers in suicide risk assessment found that peer helpers showed significant gains in knowledge about suicide and skills for responding to suicidal peers immediately after training (101). There were also significant improvements in positive attitudes towards intervening with students potentially at risk for suicidal behavior.

Schools that wish to use suicide curriculum as a preventive method should utilize a method that has been shown to be effective and should utilize this approach, not in isolation, but in conjunction with other preventative strategies such as gatekeeper training, screening, establishing community links, and skills training. Schools, however, should not avoid using this approach due to a fear that talking about suicide and teaching students about suicide will only provide students with ideas and methods for suicidal behaviors, because this is simply not true (Please

refer to Issue Brief 1: Information Dissemination," and for the True and False Myth Test for more information).

Although there are numerous suicide education programs that have been used and used effectively, this guide will provide only six: Washington's Youth Suicide Prevention Program (YSPP), Adolescent Suicide Awareness Programs (22) and Lifelines (2,30), which recently have been combined into Lifelines/ASAP (30) Miami, Florida (35), Adolescent Suicide Awareness Program (ASAP), Project SOAR (Dallas, TX), and Reconnecting Youth (64).

Teaching Adaptive Skills to Students

A preventative method that is related to the suicide curriculum is curriculum that focuses on educating students on proper social skills, problem-solving strategies, and coping skills, and help-seeking skills. The rationale behind this method is that students who are potentially at risk for suicidal behaviors/ thoughts have deficits in these areas (67,68).

Research has found that when students are taught such skills it may provide a sort of protective factor against suicidal behavior (22). Evaluation studies that have examined the effectiveness of skills training programs have found reductions in completed and attempted suicides (9) and improvements in attitudes and emotions (62,69). Empirical evaluations of programs that have focused on skills training strategies have also found an increase or enhancement of factors that protect adolescents from suicide while reducing the risk factors for suicide in these adolescents (64,70-72).

These strategies have also been suggested as ways to reduce depression, hopelessness, and drug abuse in adolescents, all risk factors for suicidal behaviors and/or thoughts (22). These skills can be taught by focusing on social skills and problem-solving skills directly through lessons or indirectly by incorporating these skills into existing classes such as a health class, drivers education class, physical education class, or a reading class (73).

Strengthening social skills has also been found to have a positive effect on cognitive development and learning in adolescents (74). Suicide prevention programs that attempt to teach problem solving skills, coping skills, social skills, and help-seeking skills may not only potentially prevent suicidal behaviors from occurring, but may also help prevent unintentional injuries and violence in schools (75-80). These skills are necessary, not just to prevent adverse events in adolescents, but also in the development of a well-balanced and productive adult.

Programs that have utilized social skills training include the Resolving Conflict Creatively Program (RCCP), which is one of the longest and largest-running programs for conflict resolution in the country, and the Promoting Alternative Thinking Strategies (PATH) curriculum. Both of these programs are evidence-based programs and have been found to have a positive impact on students, however, these are only two of the many that are available for use in schools. CASEL (Collaborative for Academic, Social, and Emotional Learning) is an organization that has found a positive effect on decision-making abilities and coping skills through education to improve social and emotional competence. For more information about this program please refer to www.casel.org. Although The Guide does provide examples of programs that schools may wish to use as a reference for their own program,The Guide does not endorse any one program over another. A school should adopt a problem-solving program that fits their school culture and their resource availability.

Peer Support Groups

Research suggests that students who are potentially at risk for suicidal behaviors are more likely to confide in and feel comfortable with peers rather than adults (20,24,50,65,66). Some suggest that not only should the school train students to recognize potentially suicidal peers, but should also provide an opportunity for vulnerable students to meet with other students in a comfortable group climate (12,28,49,81). The rationale behind these support groups is that they help youths at risk develop peer relationships and more appropriate coping skills, thereby reducing feelings of isolation, antisocial behavior, substance abuse, and other early risk factors while enhancing important protective factors (49,82). Research has found results that suggest that these programs can increase a student's knowledge

about suicide and increase the likelihood that students at risk will get help from school counselors (83,84). Although research does suggest that these programs can be effective at preventing suicide, schools may wish to use these programs in conjunction with screening programs in order to identify students at risk. They should not be used as a substitute for professional counseling or therapy (82,12,28).

Screening

Screening is a prevention strategy that is intended to identify students who are potentially at risk for suicide through interviews and self-reports on questionnaires (54,85-87).

Screening tools typically consist of asking students directly about whether they are experiencing symptoms associated with depression, currently or previously had suicidal ideations or behaviors, and whether they possess risk factors for suicide (54).

Screening can be done in two ways. The first way is a broad approach, which seeks to identify students potentially at risk for suicide by screening all students in the school. Although this could provide valuable information about large numbers of students and could identify those students "quietly disturbed" (29), such a large undertaking would take a great deal of time, effort, and coordination (7). The relatively scant amount of research evaluating screening studies, which have shown effective results through screening (85,54), have utilized mass screening as a first step in identifying students.

After a student has been screened, if he or she screens positive for suicidal potentiality, then direct assessment by trained clinicians should be done within seven days (86). Focused screening on the other hand would utilize screening in combination with other methods for identifying students at risk for suicidal actions, such as using gatekeepers or peers. Once identified and referred by gatekeepers or peers, these students potentially at risk would be screened and subsequently evaluated by a mental health professional. The underlying rationale behind these programs is that since suicide is a low incidence event, prevention may be more effective and efficient if only those students that are potentially at risk for suicide are identified and referred (28).

Research has shown that adolescents will honestly state if they are suicidal when directly asked (7). What must be noted about these screening approaches is that a broad approach will identify more students than a focused approach (the quietly disturbed), but will take more resources to implement and maintain. Focused approaches will not be as "costly," but may miss some students potentially at risk.

While many researchers contend that screening is an essential and critical component of any effective suicide prevention program (7,25,49,56,88), many school programs fail to use them (17,20) despite moderate support from teachers and administrators (89). This lack of utilization could arise from three concerns. First, since suicidality fluctuates in adolescents (26), repeated screening must be done to measure the changes in suicidality and to avoid missing a student who is not suicidal at one time, but becomes suicidal over time (21,25,26). Second, screening may identify as much as 10% of the adolescents at school as being at-risk, creating a costly need to follow-up those identified as at-risk for suicide (17). Third, in order for schools to initiate a screening session, they must have cooperation and consent from parents.

Research has found that active parental consent runs close to 50% (26), which means that schools may only be able to screen half of the students, thereby possibly missing students potentially at risk before screening even begins.

Although there are numerous screening tools available for use in schools, the following five have been widely utilized and have been suggested as effective components of a suicide prevention program. If a school chooses to use one of these methods, please refer to the appropriate citation for more information. If a school would like to utilize a method other than one of these five, please refer to Goldston (90), who provides an excellent, comprehensive list of approximately 50 screening tools that schools can use to identify students at-risk for suicidal behaviors or ideations, students at-risk for depression and psychiatric disorders, and instruments used for assessing intent and lethality of a student that is potentially suicidal.

Suicide Prevention Guidelines continued

Five Examples of Widely Used Screening Tools:

1. The Suicidal Ideation Questionnaire, followed by the Suicidal Behavioral Interview (85).
2. The Suicidal Risk Screen (86).
3. The Columbia Teen Screen (54,91)
4. Signs of Suicide (92)
5. Measure of Adolescent Potential for Suicide (64)*

*The measure of Adolescent Potential for Suicide or MAPS is a screening interview that has been shown, for reasons unknown, to have a potential positive effect on suicide-risk reduction when provided to students and when no other prevention method or treatment is provided. It seems that by just providing students with this interview educators can have a positive impact on suicide risk in students.

While there are many screening tools available that a school may choose to implement and maintain, it is important that schools use screening tools that have been evaluated as effective methods for identifying students potentially at risk for suicide. Screening is just one component of a suicide prevention program. Schools should not rely solely on screening in order to effectively address adolescent suicide. An effective program is a comprehensive program.

Postvention (Strategies for Responding to a Suicidal Crisis)

A comprehensive program will include postvention guidelines and procedures (9,13,22,24,25,28,49,83). Postvention guidelines are intended to provide a timely and proper response to a suicidal crisis (suicidal threat, attempt, or death by suicide). Appropriate postvention programs can be viewed as a form of prevention since, if carried out correctly and successfully, they can reduce potential cluster (copycat) suicides (93).

By not having an adequate postvention program in place, schools may unknowingly contribute to further suicidal behaviors or copycat suicides. Postvention programs in schools not only reduce subsequent morbidity and mortality of suicide in fellow students, but also reduce the onset and degree of debilitation of psychiatric disorders, such as posttraumatic stress disorder (22). It is not enough for a suicide prevention program to implement and maintain “before the fact” prevention elements, designed at preventing a suicidal event from occurring, but a program must have an established method of responding to a suicidal crisis.

One such method, necessary for any adequate response, is utilizing an established response team, made up of school staff members and various members of the community (10,13,14,49). Research suggests that many schools lack a preplanned postvention program and tend to respond to a suicidal crisis in an unorganized fashion (13). By having postvention guidelines in place, schools can provide a more timely, effective, and appropriate response to a suicidal crisis.

For more information on postvention guidelines and steps to follow after a suicidal crisis, please refer to Issue Brief 7a: Preparing and Responding to a Death by Suicide.

Suicide Prevention Guidelines continued

Crisis Centers and Hotlines

All of the aforementioned components of an effective prevention program place the primary responsibility on the schools. One such method that does not place the burden of responsibility solely on the shoulders of school staff and personnel is the crisis hotline. The main benefit crisis hotlines offer is that since suicidal behavior is most often associated with a crisis (94,95), and since hotlines provide immediate, accessible, and confidential support, they may be an ideal resource for the prevention of adolescent suicidal behavior (22). Although research on the effectiveness of hotlines for decreasing suicide is inconsistent (96), what research suggests is that hotlines:

1. Reach an important and usually underserved population (28)
2. Help those students that use them (94)
3. Have been associated with decreases in suicide rates among white females under 25, the most frequent users of hotlines (49)
4. Are endorsed by youth as a more acceptable resource than mental health centers (50)
5. Can serve as "drop in" centers, providing immediate intervention as well as acting as referral agents to mental health services in the community (25)

Despite recommendations from some researchers that a comprehensive suicide prevention program will utilize crisis centers and hotlines (25,49), research has also suggest that hotlines are only minimally effective (88) at preventing suicide. What research seems to state is that although schools are not directly responsible for crisis center and hotline procedures, schools are encouraged to inform students about such services in their community and should make sure that students potentially at risk are aware of these resources.

School Climate

Schools should also ensure that their school maintains a positive and safe school climate. School climate refers to both the physical and aesthetic qualities of the school, as well as the emotional and psychological qualities of the school.

Fostering a feeling of connectedness between the students and the school, providing an opportunity for students to become involved in school activities, and ensuring an overall safe environment for students are just some of the essential components of a safe and positive school climate, which has the potential to have a dramatic impact on adolescent suicide (10,11,14,62,73,81,97,98).

For more information on the impact of a school's climate as well as what constitutes a positive and safe school climate, please refer to Issue Brief 2: School Climate.

A comprehensive school-based suicide prevention program will utilize various approaches and should not rely on one prevention method. Rather, programs should implement and maintain numerous prevention strategies in order to effectively prevent adolescent suicide.

Suicide Prevention Guideline Tips

- Establish written policies and procedures for responding to students who may be at risk for suicide.
- Establish written policies and procedures that explicitly detail how to appropriately respond to a suicidal crisis (postvention strategies).
- Establish in-school response teams that are qualified to respond to students potentially suicidal.
- Establish collaborative relationships with community agencies such as mental health centers, crisis centers, the police department, and the clergy.
- Provide parents with opportunities to become involved in suicide prevention strategies offered by the school.
  - Provide training to school staff and faculty about suicide.
  - Provide staff with the most current information about adolescent suicide.
  - Encourage all staff to collaborate with one another to increase assistance among teachers in recognizing at-risk students.
  - Educate all staff about the risk factors for adolescent suicide.
  - Educate all staff about the warning signs for adolescent suicide.
  - Educate all staff on how to make referrals for a potentially suicidal student.
  - Educate all staff about to whom they should refer a potentially suicidal student.
  - Utilize a brief in-service training program for staff and faculty. A two-hour program should be sufficient.
  - Provide in-service training materials to parents.
  - A brief one and one-half hour presentation coupled with other presentations should be a sufficient amount of time to train parents.
- Provide curriculum to students that addresses adolescent suicide (myths, facts, risk factors, and warning signs).
  - Avoid using a brief (2-4 hour), one-shot approach in assembly presentations or classes.
  - Use a more prolonged approach when using curriculum delivered to students.
  - Avoid a curriculum approach that emphasizes suicide as a reaction to stress.
  - Avoid curriculum which includes media depictions of suicidal behavior.
  - Avoid presentations by youth who have previously made a suicidal attempt because participants may identify with presenter and copycat suicidal behavior.
  - Consider implementing suicide awareness curriculum within the context of established classes such as a health class or a life-management skills class.
- Provide students with information about proper coping skills, problem-solving skills, social skills, and where and when to seek help for themselves or for a peer.
  - Focus on social skills and problem-solving skills directly through lessons.
  - Teach indirectly by incorporating these skills into existing classes, such as a health class, drivers education class, physical education class, or a reading class.
- Provide screening programs in order to identify students potentially at risk for suicidal behavior.
  - Use a questionnaire or other screening instrument that research has shown to be effective and valid, such as the previously three presented examples.
  - Get parents consent before presenting students with the screening instrument.
  - Have established referral systems in place so that when a student screens positive for suicidal potential he or she can be given the help they need as soon as possible.
  - Communicate to staff and parents that empirical research has found that screening will not create suicidal ideations and behaviors in teens that are not suicidal. Screening will not plant suicidal thought in those non-suicidal before exposure to the screening.
  - Make staff and practitioners aware that screening is not perfectly precise for determining whether a student will express suicidal thoughts or behaviors.

Suicide Prevention Guideline Tips continued

  - The school psychologist and counselor should be aware of valid suicidal screening tools.
  - Conduct repeated screenings, possibly once or twice every school year.
- Provide peer assistance programs to students potentially at risk.
  - Ensure that these programs are not used as a substitute for professional counseling or therapy.
- Provide students with information about community agencies, such as crisis centers and hotlines that they may use.
- Ensure that your school maintains a positive and safe school climate (refer to Issue Brief 2 for more information).
- Inform parents on the importance of restricting access to potentially lethal weapons.
- Ensure that your staff and personnel are supportive and feel comfortable with the prevention strategies in place at your school.

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Youth Suicide Prevention School-Based Guide ©

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Intervention Strategies

6a

Issue Brief

Establishing a Community Response

Too often the burden of responsibility falls solely upon the shoulders of the school when responding to a crisis situation. While it is critical for the school to have procedures in place for responding to a crisis and for educting staff on how to effectively respond to a suicidal crisis, schools may find it extremely helpful to share the responsibility for successful and comprehensive intervention with the community (5,6,7,8).

A comprehensive suicide prevention program cannot function properly without outside support from the community and this is especially true when addressing intervention (9). Research has suggested that one of the most essential components, if not the central component, for responding to a student potentially at risk for suicide is to have established relations and links to agencies within the community such as mental health agencies, crisis centers, law enforcement agencies, youth health service agencies, psychiatric facilities, the clergy, or the community health department (1,2,4-8,10-12).

Because most educators are not adequately trained, (nor do they have the time), to counsel students longer than would be necessary for an immediate crisis response, only by establishing positive relationships with community agencies in advance will schools be able to effectively respond to a student's suicide attempt or threat (13). Utilizing community agencies increases the people-power necessary to effectively respond to the immediate crisis as well as its long-term consequences (5).

Once these critical links have been established, it is necessary that schools inform staff, as well as students, about the services that these community links provide. This will ensure that should a student experience suicidal thoughts, or should an educator come in contact with (or experience suicidal thoughts themselves) a potentially suicidal adolescent, each will have contact information that could provide critical intervention and potentially prevent a suicidal event from occurring. It is essential that educators in particular understand the importance of making an appropriate referral, as well as how to make an effective referral.

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When Making a Referral

Kalafat and Underwood (37) provide some suggestions when making a referral. The Guide has summarized these suggestions.

1. Make sure that you know what problems the student may be having. Although counseling may certainly be appropriate, if one of the student's problems is that he/she was abused by a therapist in the past, the referral to a counseling center should be carefully chosen. Inappropriate or poor referrals will waste time, resources, and may annoy the student so much that he/she refuses to cooperate further.
2. Give the student the opportunity to talk about any reluctance or apprehension he/she may have about accepting the referral. This can usually provide a good opportunity for you to access how compliant the student will be with regards to treatment.
3. Involve the parents in the referral. This will help you make an appropriate referral. If the counseling center for instance, is forty minutes away, and the family lacks transportation, this referral may not be the best. Also, use a referral that matches the family's and student's background (religious affiliation, cultural background, payment system). It may not be the best idea to refer a low-income family to an expensive, specialized psychiatrist with stringent, expensive services.
4. Limit the number of referrals to one or possibly two. You do not want to overwhelm an already overwhelmed adolescent or his/her family.
5. Provide the family with as much information about the referral as possible. Contact name and number, address, directions, information about cost or insurance coverage. The more information you provide and the easier you make it, the more likely the family is to actually get necessary help.
6. Follow up with both the referral agency and the family. Oftentimes, because of rules of confidentiality, a service provider cannot deny or confirm anything about anyone, unless the student or his/her parents sign a release of information form. This signed form will allow you to check on the progress and compliance of the student.

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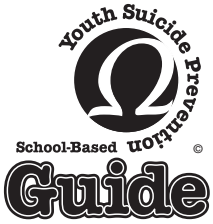

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Intervention Strategies

Crisis Intervention and Crisis Response Teams

An effective plan will establish and detail the roles of a crisis intervention team (1,4,5-8,10,14,18). Members of the school crisis team should include a diverse group of individuals within the school, such as the principal, guidance counselor, school psychologist, teacher, and school nurse (5,8).

Although some schools may feel that they do not have the time nor the resources to develop and maintain a crisis team, most cannot afford to risk not being able to respond (2). Schools may wish to co-ordinate with other schools, as well as community members (social workers, psychologists, spiritual leaders, or crisis service providers), when developing the crisis response team (2,6,10). In this way, schools will ensure that at least some of the team members will have had supplemental and specialized training in the area of suicidal assessment and intervention.

How a school proceeds with developing a crisis response team will vary based on resources, but some suggest that school administrators identify two staff members that are interested and motivated in taking part in a crisis response team and having these two recruit a core team of about 4-8 others (2). Once this has been done, the crisis team should be trained how to effectively respond and intervene with a student potentially at risk of suicide (it may be necessary at this stage to utilize community agencies to provide such training).

After training has been completed by all of the crisis team members, it is the responsibility of the team leader, to schedule team meetings, preferably once every two to three months (2). Every crisis response team should have a designated leader as well as a backup leader just in case the leader is unavailable during a suicidal crisis (2,5,6,19,20). A good crisis team leader will have support from the administration and should be given the authority to coordinate team member assignments, while keeping an open channel with school administrators (5,6).

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Issue Brief

Youth Suicide Prevention School-Based Guide ©

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Developed by...
The Louis de la Parte Florida Mental Health Institute at the University of South Florida, funded by the Institute for Child Health Policy at NOVA Southeastern University through a Florida Drug Free Communities Program Award.

Crisis Intervention and Crisis Response Teams continued

Team member assignments may include mobilizing the team when needed, controlling rumors, responding to the media, contacting community links, providing first aid if necessary, contacting parents of student experiencing suicidal crisis, scheduling response team meetings, and providing training to school staff and faculty (2,5).

Another important responsibility of a crisis response team and one that gets overlooked frequently is defining what exactly constitutes a suicide crisis situation.

It is not always going to be as obvious as overt suicidal threats or behaviors. Some students may passively communicate through homework or insinuate to a friend that he or she is considering suicide. Although school crises tend to be in the eye of the beholder, the school should rely on the crisis team to define exactly what constitutes a crisis and when the school's crisis plan should be initiated. Any crisis team member that believes a crisis may be occurring could contact other members of the team and the team as a whole would vote on whether or not the situation should be considered a crisis (2). If the members do decide that a crisis is occurring the crisis response plan would be initiated. If not, the team would still need to determine what intervention to take or which community resources should be utilized in order to provide help to a student, who although not in immediate danger, may still need help.

Team Support

In order for a crisis team to be effective, it must be supported by the administration and should be acknowledged as a highly valuable resource within the school. Without such support, a crisis team will fall to the wayside, thereby greatly reducing the chances that the school will be able to effectively intervene with a student at risk for suicide. For more information on the structure of a crisis response team and for more specific information on the roles for each member of a crisis response team, please refer to the Community Action For Youth Survival Project or SAVE, which is just one source of information regarding crisis response teams (6).

In order for the crisis teams to run effectively, they must be alerted that a suicide crisis is occurring. Given the amount of contact with students that teachers and faculty have, the alarm is likely to be sounded by a teacher or other faculty member, such as a coach. Teachers are in ideal positions for identifying and intervening with a student expressing suicidal threats or gestures (21). Despite this situation, most educators do not receive training on how to identify or how to intervene with a student potentially at risk for suicidal threats or behaviors. This could be, in part, the reason that in a survey of teachers' confidence level for identifying an at risk student, only 9% of those surveyed stated that they felt confident about being able to recognize a student at risk for suicidal threats or behaviors (22,23). If educators do not feel confident recognizing at risk students, that they certainly will be at a loss for how to effectively intervene with a potentially suicidal student.

As mentioned in other sections of The Guide (Issue Brief 3: Risk Factors, and Issue Brief 5: Prevention Guidelines), research has found that more than 25% of all teachers sampled in a study reported that they had been approached by suicidal teens (24). In order to maintain and implement an effective school-based prevention program, schools must train staff on how to identify a student potentially at risk for suicidal threats or gestures and staff must have some training on how to intervene once a student at risk has been recognized.

Training faculty, staff, and administrators to be able to identify students who are at risk for suicide, determine the level of risk, know where to refer a potentially at-risk student, how to contact these referral sources, and what school policies are in place that relate to suicidal crisis situations is a universally advocated method for preventing suicide in schools (1,4,8,10,17,25-33). It is widely recognized that training staff about the warning signs, risk factors, protective factors, and where to refer a student at risk is critical to prevent adolescent suicide.

For more on risk factors and warning signs refer to Issue Brief 3: Risk Factors. For more on community partnerships refer to Issue Brief 8, Family Partnerships, and Issue Brief 6a: Establishing a Community Response.

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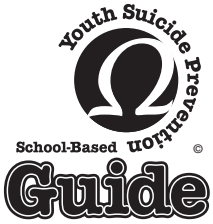

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Intervention Strategies

6c

Issue Brief

Responding to a Student Crisis

Planning how to respond to a suicidal crisis refers to how a school and its staff respond to a student that threatens or attempts suicide. A suicidal crisis occurs any time when the risk for suicide is raised by any peer, teacher, or other staff member that identifies a student as potentially suicidal (1).

A student may make a statement about suicide in writing assignments, in a drawing or indirect verbal expression, or overtly voice suicidal threats or behaviors (2). Although the most ideal intervention strategy for suicidal behavior is prevention, sometimes prevention efforts fail to identify or detract a student from voicing suicidal thoughts or expressing suicidal behaviors (3). If such prevention efforts fail, skills and procedures for intervening with a student potentially at risk for suicide are essential for administrators, faculty, and staff. School-based suicide intervention strategies consist of those school-related activities that are designed to appropriately and effectively handle a student presently making a suicidal threat and/or attempt (4).

Staff should be made aware of established intervention procedures that a school will take when a student expresses suicidal ideations (thoughts) or demonstrates suicidal behavior (1,7,8). Some recommend that these policies and procedures be contained in a crisis management guide that provides information about warning signs, risk/protective factors, and suicide prevention guidelines (gatekeeper training, curriculum, or screening) (17). An effective crisis response will be guided by a response plan developed in advance of a suicidal crisis, which identifies step-by-step what to do should a student threaten or attempt suicide (5,8,9,14,).

Most schools tend to respond to a suicidal crisis in an unorganized fashion and a contributing factor for this unorganized response is due to the lack of an established plan of action when faced with a suicidal crisis (4). By acting in an unorganized way, schools may not be successful at intervening with a student experiencing a suicidal crisis, which could result in a tragic loss of a life, or in some cases, may contribute to further copycat behaviors by other students (15). A clearly written plan will help facilitate an organized and more effective response to a suicidal crisis (16).

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Responding to a Student Crisis

Although each suicidal crisis situation is unique there are some commonly held do's and don'ts when responding to a student that may be experiencing a suicidal crisis and is need of help. The following checklist was created by synthesizing materials from several sources, all of which discussed ways for responding to a student threatening suicide or actually attempting suicide (1,2,5–7,34–39).

What to DO

When Faced with a Student Experiencing a Crisis

■ **Always ensure a students safety.**
The main goal when encountering a student expressing suicidal thoughts or behaviors is to prevent the act from happening (9). One way to do this is to ask whether the student has a plan in mind: "Have you thought about how you would kill yourself?" or "have you made any plans or preparations?" If the student does have a plan, then does he or she have access to a method for completing/attempting this plan: "Do you have access to a gun" or "Do you have the pills". It would also be important to find out if the student has a time or location, when or where he or she plans on attempting suicide.

- If the student does have a plan and has access to a method or just seems unsafe, remain with the student until a crisis team member arrives.

■ **Send someone for help.**
This is essential. Most often the crisis team member in the building or closest to the building where the crisis is occurring should be notified first.

■ **Listen.**
- Acknowledge feelings and problems in the student's terms. Try to avoid complicated language.
- Allow the student to express feelings- a teacher may want to openly communicate giving the student permission to express his or her feelings.

What NOT to DO

When Faced with a Student Experiencing a Crisis

■ **Don't ever dare a student to attempt suicide.**

■ **Don't debate with the student about whether suicide is right or wrong.**

■ **Don't promise secrecy or confidentiality.**
It may advisable just to let the student know that you don't want to see him or her kill themselves and that you just want to make sure that he or she gets the best help possible, and that maybe you are not the best person to provide such care. Limitations to confidentiality should be explained to the student without pushing him or her away. Issues such as danger to self or others and physical and sexual abuse will not be kept secret. If an educator knows, or reasonably suspects, abuse or neglect, he or she must inform the United States Department of Human Services by calling 1-800-452-1999. In Florida educators can call 96ABUSE (962-2873). Educators must also inform the school administrator, who will document the suspected or known incident.

■ **Don't panic.**

■ **Don't rush or lose patience with the student.**
Realize that you may need to spend some time with this student in order to ensure that he or she will remain safe. Try to have as much privacy as possible when talking to the student.

■ **Don't act shocked.**
If you do so, the student is likely to feel that the situation is so bad that no one can help. This will destroy any chance for rapport and is likely to put distance between you and the student.

What to DO continued

When Faced with a Student Experiencing a Crisis

- Try to avoid giving advice or opinions. Try and repeat back the feelings that you hear the student expressing ("you sound frustrated" or "you feel hopeless").
- Listen for warning signs such as hopelessness or a fixation with death.

■ **Be Direct.**
Talk openly about suicide. Do not be afraid to say the word suicide. Do not worry about planting the idea in the student's head. Suicide is a crisis of non-communication and despair; by asking about it you allow for communication to occur and provide hope (34).

■ **Remain calm.**

■ **Be empathetic.**

■ **Always take the student seriously.**

■ **Know what resources are available in your school before hand.**
Know who your nearest crisis team member and where to find them.

■ **Be honest.**
Offer hope, but do not offer condescending or unrealistic reassurance.

■ **Know your limits.**
If you feel that you are in way over your head, or if you feel uncomfortable, minimize your level of involvement. Make a referral to someone else that may be in a better position to help. If you feel the student is in immediate danger, escort the student to the referral yourself. If you do not feel that the student needs an escort, you still should check to see if the referral was followed up on. Usually a simple phone call to the person you referred the student should be sufficient.

■ **Make sure that at each stage of the intervention the student knows what is going on.**
Do not surprise the student by escorting him/her to a room with a ten-member crisis team waiting. Make sure that you explain to the student what events and responses they can expect. Remember a suicide crisis is a chaotic and confusing situation. By not providing and communicating structure in your response, you may unintentionally create more chaos and confusion, thereby increasing the likelihood that the student will refuse to cooperate.

What NOT to DO continued

When Faced with a Student Experiencing a Crisis

■ **Don't be judgmental.**
Avoid offering opinions of right vs. wrong or ethical vs. unethical. The main aspect of communication is just to listen and show concern.

■ **Don't preach to the student.**
Avoid discussing the value of life and how such a tragic act would affect his family and friends. These people may be contributing to the student's suicidal crisis and the student may wish to hurt these people through suicide.

■ **Never leave the student alone or send the student away.**
This may just reinforce feelings of isolation and hopelessness.

■ **Don't worry about silence during discussion.**
Just let the student know that you are there, and you are willing to listen.

■ **Don't under-react or minimize.**
By under-reacting, you communicate that you don't really respect the student's feeling and don't believe that the student is serious. By doing this, you just reinforce the student's feeling that no one understands or cares. Assuming that a student is attention seeking is usually the reason behind under-reacting. Even if a student is seeking attention, you should act. The benefits could certainly out way the costs.

■ **If a student is threatening suicide and does have a weapon, never try to physically take the weapon from the student.**
This could endanger your life, the life of the student, and the lives of other persons in the school.

What to DO continued

When Faced with a Student Experiencing a Crisis

■ **Inform Parents.**
Parents/caretakers must always be informed when their adolescent son or daughter has been identified as experiencing a suicidal, or for that matter, any crisis.

- The school must inform the parents about community agencies, such as mental health providers before, during, and after a suicidal crisis. School should also work with parents to develop a plan of action for getting the student help.
- Schools should also inform parents, before a suicidal crisis, about the risk factors and warning signs for suicide. This could be done briefly and possibly in a PTA meeting or other parent teacher meetings. During this time schools should also inform parents about the necessity of restricting access to lethal means, as well as informing them about community resources that may be available should they suspect that their adolescent may need help. For more on parent education, please refer to Issue Brief 5: Prevention Guidelines.
- Reassure the parents that they student is currently safe.
- Explain to the parents what has happened and the reason for the school's response.
- More importantly, the school must explain the seemingly obvious necessity of restricting access to lethal means that the student has available. Parents must be told that an extremely effective way to prevent their adolescent son or daughter from dying by suicide is to make sure there is no way their adolescent son or daughter has any way of getting the weapon.

Responding to Various Levels of Risk

In order to make an appropriate referral it is important that someone who is trained in lethality and risk determination assess the risk of the student (1,5,6,8,9,38). Although it is beyond the scope of educators and or administrators to directly assess risk, some important notes must be made and should be disseminated to all school staff. In all of these situations remember the dos and don'ts when responding to a student experiencing a suicidal crisis.

Level 1
Low or moderate risk

- Staff member observes behaviors or warning signs that indicate that a student may be at risk.
- Student may have verbalized suicidal thoughts, but does not have a plan and does not have access to a potentially lethal weapon.

In a low risk situation, the crisis team member nearest the situation should be notified. The crisis team member will meet with student to determine extent of the problem, and if the possibility of harm is not imminent then the parents should be notified. The crisis team member should also follow-up periodically (once a week maybe for first month or two and then less frequently). If, however, in the assessment, there is a potential that the student may harm him/herself, then risk is increased to level two or severe risk situation.

Level 2
Severe risk

- Student has overtly voiced the intent to engage in a suicidal act.
- Student has gone beyond mere thoughts and has thought of actual actions.
- Student does have a suicidal plan, but does not have the means to carry out his/her plan.

In a severe risk situation, the crisis team member nearest the situation should be notified, as well as school administration that a student has expressed the intent to engage in suicidal behavior. The student should be kept under constant supervision until student is under the care of a community professional or until parent(s) take the child home. Before leaving, however, it is critical that the parent(s) attend a brief intervention meeting where the crisis team, the parent(s), and the student agree upon a treatment plan. It is also essential that parents be informed about the importance of restricting or hiding any potentially lethal means. If parents do not appear willing to take any steps to intervene school crisis team member and/or school administrators have the option of calling the Division of Youth and Family Services (DYFS) in order to help ensure that the student will remain safe. Follow up must be done by the crisis team in order to make sure the student is progressing and that treatment is being maintained.

Level 3
Extreme risk

- Student has voiced the intent to engage in a suicidal act.
- Student has the access to lethal means needed to carry out this act.
- Student may have access to lethal means on person.

In the extreme risk situation, the crisis team member nearest the station should be notified of the situation. The crisis team and various community links should be mobilized. The parents of the student must be notified and informed about the observations and seriousness of the situation. If the student does possess potentially lethal means on person, do not attempt to take the weapon by force. Calmly talking to the student and allowing the student to express feelings is essential when intervening. Once the student has given up the potentially lethal weapon, crisis team members should intervene in similar fashion to a severe risk situation.

Responding to Various Levels of Risk continued

*In all of these afore mentioned situations it is essential that the student not be left alone and that he/she receives some sort of intervention or appropriate care.

Two other points must be made about a suicidal crisis. First, it is critical that other students in the school are kept as safe and clear from any potentially harmful situation (1, 9). For those students who may have witnessed the situation, allow them to express their fears, concerns, and feelings of responsibility or guilt. These students should also be assured the student who was experiencing the crisis is receiving help, but maintain confidentiality and keep the details of the crisis to a minimum. Inform the students about where they may receive help in the school or community. The school should also monitor friends of the student who experienced the crisis, as well as other students potentially at risk for suicidal behavior in order to prevent copycat behavior. Second, all staff and faculty involved in the crisis should be given opportunities to discuss their reactions and offered necessary support (1, 2, 6, 8). Staff and faculty should be allowed to express and process their feelings, their worries, concerns, or even their suggestions about what was done well and what could have been done better (8).

Although The Guide does not endorse any program over another, the following programs are simply meant to provide schools with some samples of programs that have used intervention strategies as part of their program. What components a school chooses to use and from what programs these components come from is the decision that each school will have to make. The important point is to provide an effective and comprehensive program that has the greatest potential to help and the least likely chance to harm. A brief sample of programs that have utilized intervention strategies include the Adolescent Suicide Awareness Program (ASAP), Lifelines Program, Youth Suicide Prevention Program for Virginia, the BRIDGES program (Building Skills to Reach Suicidal Youth), the Department of Crisis Intervention in Miami, FL, Project SOAR (Suicide: Options, Awareness, and Relief), the Maine Youth Suicide Prevention Program, the Oregon Plan for Youth Suicide Prevention, and UCLA's Center for Mental Health Services.

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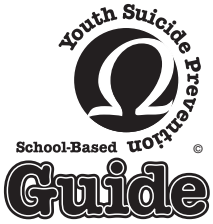

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Preparing for and Responding to a Death By Suicide

7a

Issue Brief

Youth Suicide Prevention School-Based Guide ©

Steps for Responding to a Suicidal Crisis

An effective suicide prevention program should be comprehensive; it should not limit its scope to include only preventative and intervention measures but should also address postvention measures, or measures that are taken after a suicide crisis (1,2,7,8). The school community must address suicide attempts and deaths by suicide in order to provide appropriate support for students and staff.

What is done after a suicide crisis (threats, attempts, or deaths by suicide) is just as important as what is done before one.

The best way to address the needs of the school is to be prepared with a comprehensive and recognized plan of action. Unfortunately, however, many schools lack a preplanned postvention program and tend to respond to a suicidal crisis in an unorganized fashion (4). Appropriate postvention programs can be viewed as a form of prevention since, if carried out correctly and successfully, can reduce potential cluster (copycat) suicides (5). By not having an adequate postvention program in place, schools may unknowingly contribute to further suicidal behaviors or copycat suicides.

The rationale behind postvention programs in schools is not only to reduce subsequent morbidity and mortality of suicide in fellow students, but also to reduce the onset and degree of debilitation by psychiatric disorders, such as posttraumatic stress disorder (3). After a suicidal crisis, friends and family are at an increased risk of developing posttraumatic stress disorder, as well as relying more heavily on alcohol and drug use to numb the pain (6). A comprehensive postvention plan increases the likelihood that a school can decrease the risk of copycat

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FMHI Louis de la Parte Florida Mental Health Institute

INSTITUTE FOR CHILD HEALTH POLICY

USF UNIVERSITY OF SOUTH FLORIDA

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The Louis de la Parte Florida Mental Health Institute at the University of South Florida, funded by the Institute for Child Health Policy at NOVA Southeastern University through a Florida Drug Free Communities Program Award.

Steps for Responding to a Suicidal Crisis continued

suicides and provide a much-needed service to those left behind following a suicide.

It is not enough for a suicide prevention program to implement and maintain "before the fact" prevention elements, designed at preventing a suicidal event from occurring, but a program must have an established method of responding to a suicidal crisis. An effective postvention plan may also decrease the chance that an acute stress reaction caused by the suicide will lead to a more chronic and debilitating reaction for those left traumatized and grieving. This could be prevented through counseling and utilizing community links to get those individuals help.

The Checklist 7a: Preparing for and Responding to a Suicidal Crisis, presents a brief overview of some of the necessary components of a postvention plan. It must be noted that the checklist is flexible and should be used in a way that is complementary to the schools' needs and abilities.

Steps for responding to a suicidal crisis include:

1. The school principal should contact the police or medical examiner in order to verify the death and get the facts surrounding the death. It is important to know the facts in order to reduce imitative behaviors and to place focus on means restriction strategies for parents, as well as the school.
2. The superintendent of the school district needs to be informed of the death. He or she should also be involved in the school's response to the suicide through information dissemination with other school districts and media contacts.
3. Prepare and activate procedures for responding to the media. Suicide is newsworthy and as such can be expected to attract the media. Utilize a designated media spokesperson and remind staff not to talk with press or spread rumors and if asked refer to media spokesperson. For more information refer to Issue Brief 7b: Responding to and Working with the Media.
4. Notify and activate the school's crisis response team (for more information on crisis response teams refer to Issue Brief 6b: Crisis Intervention and Crisis Response Teams.
5. Contact the family of the deceased. Find out if the deceased has any siblings enrolled in other districts. If so, then notify the principals of those schools.
6. Schedule a time and place to notify faculty members and all other school staff. This meeting should be arranged as soon as possible. After this has been done, staff can provide critical and appropriate support for students.
   - Inform all staff about the facts behind the suicide.
   - Allow time for staff to ask questions and express feelings.
   - Ensure that all staff have an updated list of referral resources.
   - Review the process for students leaving school grounds and tracking student attendance.
   - Announce to staff how the school will interact with the media and inform staff who will act as the school's media spokesperson. Remind staff not to talk with the press and refer any questions to the designated media spokesperson.
   - Review planned in-class discussion formats and disclosure guidelines for talking to students. Prepare staff for student reactions.
   - Compile a list of all students who were close to the deceased.
   - Compile a list of all staff members who had contact with the deceased.
   - Update and compile a list of students who may be at-risk for suicide (see Issue Brief 3a: Risk Factors for more information on risk factors).
   - Remind staff about the risk factors and warning signs for adolescent suicide.
   - Provide staff counseling opportunities and supportive services available to them.

Steps for Responding to a Suicidal Crisis continued

7. Contact community support services, which should be supervised by the school's crisis response team leader. Community support services include local mental health agencies, other school counselors, community crisis hotline agencies, and clergy members.
8. Arrange a meeting for parents.
   - Provide parents with warning signs for adolescents who may be suicidal.
   - Provide information about supportive services available to students at the school.
   - Provide information about community resources they may wish to utilize.
   - Provide information about how to respond to students' questions about suicide.
   - Remind them of their child's special needs during this time.
   - Avoid a large parent meeting and try to keep the number of parents at a minimum. Communicate with other students' parents through telephone or written notice.
9. Meet with all students in small groups (classrooms).
   - Notify students as early as possible following the staff meeting.
   - Make sure all teachers announce the death of the student to their first class of the day. It is preferable to describe the deceased as "having died by suicide," rather than as "a suicide," or having "committed suicide." The latter two expressions reduce the person to the mode of death, or connote criminal or sinful behavior.
   - Disclose all relevant facts pertaining to the student's death. Do not provide morbid details ,such as method or exact location of suicide.
   - Allow students an opportunity to express their feelings. "What are your feelings and how can I help?" should be the mantra behind the structure of discussion.
   - Explain and predict what students can predict as they grieve (feeling angry, guilty, shocked, anxious, lonely, sad, numb, or experiencing physical pain). Express to students there is no one right way to grieve. What is important is to recognize feelings and communicate them.
   - Inform students of the available support services in the school (and outside the school) and encourage them to use them.
   - Reorient students to ongoing classroom activities.
   - Avoid assemblies for notification and do not use impersonal announcements over the public address system. Notify students in small, individual classrooms through faculty members or crisis team members.
10. Provide additional survivor support services. A school may want to invite friends of the deceased to join a support group so they can be counseled separately with more focused attention. Provide individual counseling to all students identified as at-risk.
11. Members of the school's crisis team should follow the victim's classes throughout the day providing counseling and discussion to assist students and teachers. This could also help to identify and refer students who may be at-risk.
12. Establish support stations or counseling rooms in the school and make sure that everyone including faculty, students, and other school staff members know where these are located. There should be more than one location and should be set up in small to mid-size rooms.
13. De-brief staff (including members of the crisis team) at the end of the day for approximately five days following the suicidal crisis.
14. Reschedule any immediate stressful academic exercises or tests if at all possible.
15. Avoid flying the school flag at half-mast in order to avoid glamorizing the death. Memorialization should be consistent with other types of deaths of students.
16. Memorialization should focus on prevention, education, and living. Encourage staff and students to memorialize the deceased through contributions to prevention organizations such as Mothers Against Drunk Driving, a suicide hotline, or a suicide survivors group.

Steps for Responding to a Suicidal Crisis continued

17. Inform local crisis telephone lines and local mental health agencies about the death so that they can prepare to meet the needs of students and staff.
18. Provide information about visiting hours and funeral arrangements to staff, students, parents, and community members. Funeral attendance should be in accordance with the procedures for other deaths of students.
19. The family of the deceased should be encouraged to schedule the funeral after school hours to facilitate the attendance of students.
20. Arrange for students and staff to be excused from school to attend the funeral if necessary.
21. Follow up with students who are identified as at-risk and provide on-going assessment and monitoring of these students. Follow-up should be maintained as long as possible.

Seven major sources were utilized and synthesized into developing steps for dealing with a suicidal crisis:

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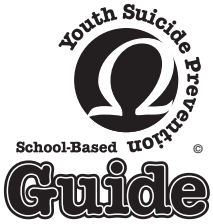

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Preparing for and Responding to a Death by Suicide

7b

Issue Brief

Youth Suicide Prevention School-Based Guide ©

Responding to and Working with the Media

Suicide is often newsworthy, especially in smaller, more rural areas. After a suicide occurs, it is extremely likely that the event will be reported. Research has shown that media coverage has an influence on whether, following a suicide, copycat or imitation suicides will occur (1,2,3). Evidence suggests that exposure to suicide through the media can lead others to take their life or attempt suicide (4), an effect sometimes referred to as suicide contagion or suicide imitation/modeling (5).

Given the fact that this imitation effect is most prominent among adolescents (3,6,7) and that the school is the first place that the media will go for information following a suicide, it seems only prudent that schools be prepared and willing to assist reporters in reporting the appropriate information in order to avoid potentially harming other students.

Preliminary research has shown that following the implementation of media guidelines in Austria, suicide rates declined by 7% in the first year, nearly 20% in the 4-year follow-up. These studies also found that subway suicides (a focus of the media campaign) decreased by approximately 75% (8,9,10).

The following guidelines can assist schools in effectively responding to and working with the media. These guidelines are based upon those formulated by the Annenberg Public Policy Center of the University of Pennsylvania, the American Association of Suicidology (AAS), the American Foundations for Suicide Prevention (AFSP), and the Centers for Disease Control and Prevention (CDC). More examples of media education programs and information include: The Canadian Association for Suicide Prevention (CASP) and the Suicide Attempt Follow-up Education and Research (SAFER) from Vancouver, BC.

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Responding to and Working with the Media

What to DO

When Responding to and Working with the Media

Recommendations for dealing with the media include:

- Have an established set of procedures in place for dealing with the media.
- Before approaching a reporter write down key points that you want to get across.
- Have an established person that will act as the media spokesperson and who will act as a liaison between the school and the media.
- The media spokesperson should try to ascertain what questions the media will ask. Common questions include:
  - How many students attend the school?
  - What prevention tools does the school currently have in place?
  - What does the school plan to do following the suicide?
  - What feedback has there been from families, friends, other students, and community agencies?
- State appropriate concern for the victim and his or her family.
- Provide the appropriate factual information about the student such as age and grade.
- The suicide of the student should be honestly acknowledged, but do so very succinctly and avoid discussing the method (firearm, overdose).
- Encourage news reporters to provide information that increases public awareness of risk factors and warning signs.
- Always provide information on state, local, and school resources available for suicide prevention and crisis intervention.
- "No comment" is not an appropriate response to media representatives who are covering a story about suicide. Use a media request for information as an opportunity to influence the contents of the story.
- Assist news professionals in providing accurate and responsible information.

What NOT to DO

When Responding to and Working with the Media

Caveats when dealing with the media include (these guidelines should be communicated to the media and should probably be done by a crisis response member through the designated media spokesperson):

- Avoid presenting simplistic explanations for suicide. Suicide is never the result of a single factor or event, but rather from a complex interaction between many factors. There is no research evidence that will corroborate a simple attribution of responsibility.
- Avoid sensationalizing, romanticizing, or glorifying the suicide. Do not report or show pictures of flags at half-mast or a permanent public memorial such as planting a tree, establishing a scholarship fund, or presenting a plaque. Such displays have been found to increase the likelihood of imitation suicides.
- Avoid dramatizing the impact of suicide through descriptions and pictures of grieving friends, family, teachers, or classmates. This could lead other adolescents to see suicide as a way of getting attention or, as a form of retaliation against others.
- Avoid using adolescents on TV or in print media to tell their suicide attempt story. Other students may identify with these students and imitate their behavior.
- Avoid engaging in repetitive, prominent, or excessive reporting of the suicide. Repetitive or prominent coverage of a suicide tends to promote and maintain preoccupation among at-risk persons. This preoccupation has been linked to imitation suicides.
- Avoid placing the story on the front page and using large headlines.
- Avoid reporting "how-to" descriptions of the suicide. Do not describe the technical details about the suicide, such as detailed descriptions or pictures of the location where the suicide took place and the "weapon" used.

Responding to and Working with the Media

What to DO

When Responding to and Working with the Media

- Communicate to news professionals the dangers of suicide imitation and how inappropriate reporting may contribute to more suicidal behavior.
- Acknowledge the deceased person's problems and struggles, as well as the positive aspects of his or her life, which will contribute to a more balanced picture and will decrease the chance for imitation.

What NOT to DO

When Responding to and Working with the Media

- Do not present suicide as a tool for accomplishing certain ends. Do not present suicide as a means of coping with personal problems. Although such factors may precipitate a suicidal act, other psychological predispositions are almost always involved.
- Avoid focusing only on the positive characteristics of the youth that attempted or died by suicide. News professionals should acknowledge that the person had problems and struggles along with the positive aspects of his/her life. This will contribute to a more balanced picture and may make suicide appear less attractive to other students at risk.
- Avoid using language that may contribute to more suicides.
  - Avoid referring to suicide in the headline. The cause of death should be reported in the body of the story, not the headline.
  - In the body of the story, describe the deceased as having "died by suicide" rather than as "a suicide" or having "committed suicide". The latter two expressions connotate criminal or sinful behavior.
  - Contrasting "suicidal deaths" with "non-fatal attempts" is preferable to using terms such as "successful", "unsuccessful", or "failed".

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Family Partnerships

8

Issue Brief

Fact or Myth?

" Parents are often aware of their child's suicidal behavior."

Answer: This is a Myth. Parents are usually not aware of their child's suicidal behavior.

Parents are often struggling just to learn how to raise their children, and find it very difficult to understand the emotional journeys their children are going through. Parents seem to be more equipped to understand the issues of a high fever, spots on the skin or broken bones. But, when it comes to unusual behavior, they are at a loss. In fact, studies have shown that as many as 86% of parents were unaware of their child's suicidal behavior.

With all that is happening at the schools, it is difficult for teachers to be aware of and respond to the different crises that the students bring. Very often, teachers see some of the difficult behaviors, while the parents are the last to know. The parents may feel that the social stigma of mental crisis and challenges are "not what happens to my child". Mental health problems or suicide happens to someone else's child. When there is a behavioral problem, often there is not an easy answer or a place to turn. There are few places or answers. There are few discussions that take place regarding these issues. There are few support groups that are available. Where do we turn?

Many teachers fear discussions of suicide being raised in schools due to the perceived risk that it might trigger suicidal behavior among the students. However, research has shown this not to be true. What is the liability of the school and the teacher? What is the downside of not educating those within the school and, more importantly, the family? Sometimes it is difficult to get parents involved in regular school activities such as PTAs. Today, the percentage of parents who are involved in the student's activities is very small. Often, parents of students who have issues, including traumas of sexual, emotional or physical abuses, are not available.

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Youth Suicide Prevention School-Based Guide ©

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The Louis de la Parte Florida Mental Health Institute at the University of South Florida, funded by the Institute for Child Health Policy at NOVA Southeastern University through a Florida Drug Free Communities Program Award.

Family Partnerships continued

The importance of educating the family is highlighted by a recent study of the Youth Risk Behavioral Surveillance Survey 2001. Students in the U.S. replied yes to the following questions:

- ☐ Have you seriously considered suicide? 19.0%
- ☐ Have you attempted suicide? 8.8%
- ☐ Have you attempted suicide that required medical attention? 2.6%

It is very important to present the facts and information to the family. But how do we involve them when there is a lack of commitment on a regular basis?

An effort must start by educating all concerned. It starts with the School Board, then to each school in the district to include middle and high school. A crisis plan must be in place for the school district. Guidance counselors at each school must be well educated in suicidality and its signs. A developed program to educate the faculty and staff at each school is a must. This would include warning signs and risk factors and what to and not to do when confronted with a student in crisis. (See Issue Briefs 3a, 3b, and 6c) Suicide prevention education could take place in the Life Skills Management classes for Florida students. Some schools may produce a school-wide suicide prevention program.

But, the most important aspect is trying to reach out and inform the family. The following are some ideas to involve parents and families (Also see Issue Brief 9: Culturally and Linguistically Diverse Populations):

- Present to the school's Parent-Teacher Association or School Advisory Council,
- Print articles to parents in the school's newsletter and develop handouts in parent's native language emphasizing the importance of parental involvement,
- Schools usually have a working relationship with the local newspapers for school news, so provide educational information to the media,
- Provide articles to the local newspapers for general stories on suicide prevention,
- Schedule a parent workshop night to discuss students' changing behaviors,
- Reach out to faith-based communities (where parents are involved) to offer educational programs,
- Offer after-school programs or support groups where parents can join with students for peer and family counseling,
- Contact local survivor or suicide prevention advocacy groups (e.g., Suicide Prevention Action Network [SPAN]),
- Teacher to parent contacts should occur frequently. Make sure that you know what problems the student may be having,
- Parent to teacher contacts should be facilitated by letting parents know the best time to contact teachers,
- Inform parents well in advance of their child's participation in school activities such as assemblies and programs, and
- Expand the concept of "volunteerism" and actively recruit parents as classroom volunteers during registration process. (1)

The toughest task is titling the program to avoid the stigma of "it is not my child".

Research has found that when schools communicate and involve parents with school activities and programs, parents are more likely to cooperate with the school and help the school maintain these programs (2,3). When schools involve and gain support from parents, students feel more competent and less confused because by working with parents, schools ensure that students receive consistent messages (4).

Although each school and school district should initiate a suicide prevention program that will "fit" well within the culture of their school and will be dictated by the resources available, research suggests that meetings with district leaders, school principals, educators, and potentially a parent group could help facilitate "reconnaissance and relationship development" (5).

Research has found that three of the most important factors that determine if a prevention program is maintained are having support from administrators, teachers, and parents (6,7,8).

Family Partnerships continued

In order for a school and/or school district to ensure that a school-based prevention program will be effectively adopted and maintained, research suggests that schools gain support from parents, administrators, educators, and various community members and that these persons are aware of the prevalence and risk of suicide in their community (9,10,6,11,12,13,8,14,15,16,17,18,19). These persons should also understand how myths, or fictitious beliefs lacking scientific merit, might undermine a community's ability to help a troubled adolescent. For more information on myths behind suicide please refer to Issue Brief 2: "Information Dissemination". Also included in the Guide is a True and False Test for Myths and Evidence-based Facts about adolescent suicide.

Education is the key. Take every opportunity to discuss and educate. Tell the facts and show that this is of high concern to our students. Education and understanding are the keys to providing the students with a good quality of life and an opportunity to learn and not suffer alone. The family **must** be educated, and parental partnerships with the schools, students, and other parents will benefit all parties involved.

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Culturally and Linguistically Diverse Populations

9

Issue Brief

Youth Suicide Prevention School-Based Guide ©

Schools in America are becoming more culturally, etnically, and linguistically, diverse with students from "minority cultures" comprising more than 50% of the population in at least 5 states (1). In order to address the changing demographics of the country, schools must strategically plan for the systematic incorporation of culturally and linguistically competent suicide prevention strategies and interventions. For many cultures and ethnically diverse populations, stigma, limited English proficiency, different cultural norms about suicide, the causes of mental illness, and what constitutes appropriate mental health interventions make it necessary to have a plan in place that functions effectively in cross-cultural situations.

Culture, broadly defined as a common heritage or set of beliefs, norms and values, is also applicable to shared values, beliefs and norms established in social groupings, such as religions, sexual orientation, or economic class. Given this more broadened consideration of culture, many students may consider themselves to have multiple cultural identities (2).

Consider these statistics:

- Between 1980 and 1995, the suicide rate among African American youth, ages 10–14, increased 233%. The suicide rate for comparable white youth increased by 120% (3).
- During the period from 1979–1992, suicide rates among young male Native Americans (includes American Indians and Alaska Natives), 15–24 years of age, accounted for 64% of all suicides by Native Americans (which is about 1.5% times the national rates) and is 2 to 3 times higher than the general U.S. rate (4).
- Asian Pacific Islander females consistently have the highest suicide rate of females between the ages of 15–24 and (6) Asian American/Pacific Islanders are the fastest growing ethnic minority group in the country (7).

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Culturally and Linguistically Diverse Populations continued

- For girls in grades 5–12, 30% of Asian American girls reported depressive symptoms, 27% Hispanic, 22% Non-Hispanic White and 17% African American. (8).
- In 1999, the Youth Risk Behavior Surveillance System, in a nationwide survey of high school students found that in the 12 months preceding the survey, Hispanic students (12.8%) were significantly more likely than White, Non-Hispanic or Black Non-Hispanic students (6.7% and 7.3%, respectively) to have reported a suicide attempt. Among females, Hispanic students (18.9%) were significantly more likely than White, Non-Hispanic or Black Non-Hispanic students (9.0% and 7.5%, respectively) to have reported a suicide attempt. (36)

Research has shown that about half of the youth who die by suicide have had previous contact with a mental health professional (9). According to the Report of the Surgeon General, mental health and mental illness are shaped by age, gender, race, and culture as well as other distinctions of diversity that can be found within all of these population groups—for example, physical disability or a person's sexual orientation. The consequences of not understanding these influences can result in unintended and negative effects. With minority youth more likely to express feelings of alienation, cultural and societal conflicts, academic anxieties, and feelings of victimization, it has become clear that careful attention must be paid to the needs of minority youth and their families within the context of their culture (10).

Culture affects attitudes about mental health and mental illness, coping strategies, help-seeking behavior, utilization of services and responsiveness to prevention and treatment interventions. For example, the symptoms of suicidal behavior in African American youth are often masked by extreme anger, acting out, and high-risk behaviors, making it more difficult for clinicians to assess suicidal intent (11). Feelings of distress may be expressed differently by diverse cultures. The Surgeon General's Culture, Race and Ethnicity Supplement to Mental Health report states that one example is somatization, or the expression of distress through physical symptoms, such as stomach disturbances, chest pain, dizziness, or a burning sensation in the hands and feet (2).

For ethnic or cultural minority students, school climate plays an increasingly important role in suicide prevention. Research has shown that students who feel connected to their school (e.g., felt teachers treated them fairly, felt close to people at school) are less likely to experience suicidal thoughts and experience emotional distress (12,13,14). In fact, one study found that a student's feeling of connectedness was the number one protective factor against suicidal behavior (15). Research has also shown that school problems can be a risk factor for suicide in adolescents (14), and many teenagers in one psychological autopsy study were found to have committed suicide after an acute disciplinary crisis or rejection or humiliation (9).

Students who feel victimized or bullied by other students or staff have an elevated risk of suicidal ideations and behaviors (16,17,18). Students at risk of being bullied include those that "don't fit in" (19,20), those perceived as homosexual, bisexual, or transgendered (21,22,23), those who are socially isolated or lack social skills (24), and those that differ from the majority of their classmates in regards to race, religion, or ethnicity (12). For sexual minority students, research has shown sexual orientation to be correlated with identified risk factors for suicide and is less of a factor after controlling for these risk factors (14,25,26,27).

Several surveys of high school adolescents have shown that there is a statistically significant increase risk of suicidal ideation and behavior among students who identify themselves as gay, lesbian, or bisexual. There are yet no empirical data on this population for completed suicides (36)**.**

Another growing group of concern is unaccompanied minors entering the United States as refugees, who are at a higher suicide risk than other refugees. For these youth who are more vulnerable to maladaptive behaviors, suicide may become an alternative for resolving issues of shame (28).

It is essential that schools train their staff how to identify harassing behavior and effectively intervene (12,21,29,30). Research also suggests that schools implement tolerance education into existing curriculum (if they do not already) and train school staff to teach tolerance in the classroom (21,31).

Culturally and Linguistically Diverse Populations continued

Some targeted prevention efforts in tribal and public schools have taken into account culture-specific risk factors, such as lack of cultural and spiritual development, loss of ethnic identity, cultural confusion, and acculturation (the socialization process by which minority groups gradually learn and adopt selective elements of the dominant culture) (2). An evaluation of The Zuni Life Skills Development Curriculum has shown positive gains. A culturally tailored intervention program for the Zuni Pueblo, the curriculum was developed in collaboration with the Zuni community (32).

Suicide prevention efforts may also be integrated into substance abuse prevention efforts. One study found that American Indian youth who are at high risk for suicide had problems with drug abuse, had or caused a pregnancy, believed that family is not caring, and had relatives or friends who had committed suicide (33). Native Americans continue to sustain the highest rates of alcohol and drug abuse. Substance abuse is a widely modeled means of coping with depression, anxiety, hostility, feelings of powerlessness, and stress reactions among Indians (34).

Linguistic Diversity of the U.S. Population Source 2000 Census

- 17.9% of the U.S. population (five years old and older) speaks a language other than English at home.
- Approximately 11% of the U.S. population is foreign born.

A comprehensive prevention program will plan for the provision of translation and interpretation services whenever necessary. Community partners, such as local colleges and universities or specific ethnic/cultural organizations, as well as national organizations, can be instrumental in developing a culturally and linguistically competent prevention program. The National Asian American Pacific Islander Mental Health Association (NAAPIMHA) provided guidelines for the use of interpreters. Three such guidelines are:

- Never use a child to interpret except in an absolute emergency.
- Identify the appropriate language, including knowing the proper dialect. Ask what language the person speaks, not where they are from, as this may be different.
- Use a trained interpreter to get accurate information (35).

The Suicide Prevention Resource Center (**SPRC**) lists the following links and resources for special populations on their website:

http://www.sprc.org/links/spoplinks.asp

Gay, Lesbian, Bisexual, Transgender Health Webpages — Seattle & King County

Provides direct services and education to the residents of King County, Washington. The Gay, Lesbian, Bisexual, Transgender (GLBT) Health Webpages are designed to address some of the issues that affect GLBT youth somewhat differently than other youth, including suicide.

http://www.metrokc.gov/health/glbt/youthsuicide.htm

The Gay, Lesbian and Straight Education Network (GLSEN)

The Gay, Lesbian and Straight Education Network strives to assure that each member of every school community is valued and respected regardless of sexual orientation or gender identity/expression. GLSEN brings together students, educators, families and other community members to reform America's educational system.

http://www.glsen.org

Culturally and Linguistically Diverse Populations continued

Healing of Nations

This site is dedicated to disseminating information about suicide prevention and crisis intervention among American Indian youth. The site places a special emphasis on community planning from a cultural perspective.

http://www.healingofnations.org/

Indian Health Service Injury Prevention Program Website

Seeks to raise the health status of American Indians and Alaska Natives to the highest possible level by decreasing the incidence of severe injuries and death to the lowest possible level and increasing the ability of tribes to address their injury problems.

http://www.ihs.gov/MedicalPrograms/InjuryPrevention/index.cfm

National Organization for People of Color Against Suicide

A non-profit organization, NOPCAS's goals are to bring suicide and depression awareness to minority communities that have historically been discounted from traditional awareness programs.

http://nopcas.com

The National Strategy for Suicide Prevention: Spanish language page

Provides Spanish language crisis lines, suicide prevention websites, and Internet resources.

http://www.mentalhealth.org/suicideprevention/espanol.asp

Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General (2001) lists the following national multicultural resources:

Association for Multicultural Counseling and Development
(703) 823-9800 or
(800) 347-6647
www.counseling.org

The Center for Multicultural and Multilingual Mental Health Services
(312) 271-1073
www.mc-mlmhs.org

DiversityRx
www.diversityRx.org

National Center for Cultural Competence
(202) 687-5387 or (800) 788-2066
www.gencd.georgetown.edu/nccc

National Minority AIDS Council
(202) 483-6622
www.nmac.org

Research Center on the Psychobiology of Ethnicity
(213) 533-3188
www.rei.edu/centers Ethnicity_Center.htm

Search Institute
(800) 888-7828
www.search-institute.org

The Society for the Psychological Study of Ethnic Minority Issues
www.apa.org/divisions/div45

Transcultural & Multicultural Health Links
www.lib.iun.indiana.edu/trannurs.htm

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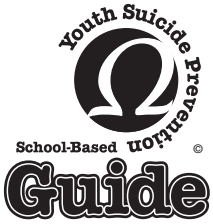
Notes



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Information Dissemination in Schools

Checklist 1

This checklist provides administrators and educators with an efficient inventory of what empirical research and best practice suggests as important considerations when evaluating the status of a school's ability to disseminate information about adolescent suicidal behavior and/or a suicide prevention program. This checklist can be used to quickly evaluate what services and policies your school already has in place (indicated by a "yes") or what services and policies your school may be lacking that may need to be implemented or revised (indicated by a "no"). This checklist corresponds to Issue Brief 1, which provides a more in depth and detailed discussion concerning Information Dissemination in Schools. The intent of this and every other Issue Brief is to provide research-based and best-practice suggestions for how a school may wish to address the issue of adolescent suicidal behavior and ideations. The intention is not to provide definitive declarations for what schools should do because each school will vary in their ability to implement and maintain suggestions mentioned in the Issue Brief.

Yes	No	
☐	☐	Does your school currently have a suicide prevention program in place?
☐	☐	Does your school provide training sessions to all staff, including coaches, bus drivers and cafeteria workers about adolescent suicide warning signs and risk factors, and what to do if approached by a student who may be at-risk for suicide?
☐	☐	If your school does provide training sessions, is there a designated trained individual or individuals who provide these training sessions and is there a targeted audience?
☐	☐	Are there currently written procedures in place that help guide faculty, staff, and students about how to respond to a suicidal threat or crisis?

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1 Checklist

Youth Suicide Prevention School-Based Guide ©

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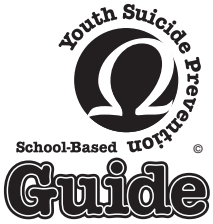
Developed by...
The Louis de la Parte Florida Mental Health Institute at the University of South Florida, funded by the Institute for Child Health Policy at NOVA Southeastern University through a Florida Drug Free Communities Program Award.

Checklist 1 continued

Yes	No	
☐	☐	Does your school staff know what to do and whom to contact (at your school) if they come in contact with a student who expresses suicidal thoughts or expresses suicidal threats?
☐	☐	Does your school have a list of community agencies and resources that could provide help and assistance to a student at-risk for suicide?
☐	☐	Is there a person within your school such as a guidance counselor or school psychologist that is assigned the responsibility of maintaining and reviewing student suicide information?
☐	☐	Is there a person within your school such as a guidance counselor or school psychologist that is assigned the responsibility of maintaining and reviewing suicide prevention efforts at the school?
☐	☐	Does your school staff know the warning signs and risk factors for suicide? (If no, see also Issue Brief 3a: Risk Factors: Risk and Protective Factors and Warning Signs.)
☐	☐	Does your school staff know the myths surrounding adolescent suicide?
☐	☐	Does your school staff know the facts about suicide?
☐	☐	Does your school staff know how legislation dealing with youth suicide impacts the responsibility of the school and the staff in addressing adolescent suicide?
☐	☐	Are there procedures in place that provide information to parents about adolescent suicide, such as at parent-teacher meetings or parent-teacher association meetings?



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Information Dissemination in Schools

1t

True/False

Youth Suicide Prevention School-Based Guide ©

The Facts about Adolescent Suicide

This document is a true and false test on adolescent suicide, which could be presented to staff as well as parents as a way of increasing their awareness and knowledge. By simply giving this true and false 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.

True/False Test

True	False		
☐	☐	1.	Adolescent suicide is an increasing problem in the United States.
☐	☐	2.	Most teenagers will reveal that they are suicidal or have emotional problems for which they would like emotional help.
☐	☐	3.	Adolescents who talk about suicide do not attempt or commit suicide.
☐	☐	4.	Educating teens about suicide leads to increased suicide attempts, since it provides them with ideas and methods about killing themselves.
☐	☐	5.	Talking about suicide in the classroom will promote suicidal ideas and suicidal behavior.
☐	☐	6.	Parents are often unaware of their child's suicidal behavior.
☐	☐	7.	The majority of adolescent suicides occur unexpectedly without warning signs.
☐	☐	8.	Most adolescents who attempt suicide fully intend to die.

— next page

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The Facts about Adolescent Suicide

True/False Test continued

True	False		
☐	☐	9.	There is a significant difference between male and female adolescents regarding suicidal behavior.
☐	☐	10.	The most common method for adolescent suicide completion is drug overdose.
☐	☐	11.	Because female adolescents complete suicide at a lower rate than male adolescents, their attempts should not be taken seriously.
☐	☐	12.	Not all adolescents who engage in suicidal behavior are mentally ill.
☐	☐	13.	Suicidal behavior is inherited.
☐	☐	14.	Adolescent suicide occurs only among poor adolescents.
☐	☐	15.	The only one who can help a suicidal adolescent is a counselor or a mental health professional.
☐	☐	16.	Adolescents cannot relate to a person who has experienced suicidal thoughts.
☐	☐	17.	If an adolescent wants to commit suicide, there is nothing anyone can do to prevent its occurrence.

— next page for answers

The Facts about Adolescent Suicide continued

Answers to True/False Test continued

1. Adolescent suicide is an increasing problem in the United States (**True**). While the suicide rate for the general population has remained relatively stable since the 1950s, the suicide rate for adolescents has more than tripled. Presently, the suicide rate for 15-24 year olds stands at 13.8 per 100,000. From 1980 to 1992, the suicide rate for 15-19 year olds and 10-14 year olds increased 28% and 120%, respectively.
2. Most teenagers will reveal that they are suicidal or have emotional problems for which they would like emotional help (**True**). Most teens will reveal that they are suicidal and although studies have shown that they are more willing to discuss suicidal thoughts with a peer than a school staff member, this disposition that most teens have towards expressing suicidal ideations could be used for screening adolescents through questionnaires and/or interviews.
3. Adolescents who talk about suicide do not attempt or commit suicide (**False**). One of the most ominous warning signs of adolescent suicide is talking repeatedly about one's own death. Adolescents who make threats of suicide should be taken seriously and provided the help that they need. In this manner, suicide attempts can be averted and lives can be saved.
4. Educating teens about suicide leads to increased suicide attempts, since it provides them with ideas and methods about killing themselves (**False**). When issues concerning suicide are taught in a sensitive, educational context they do not lead to, or cause, further suicidal behaviors. 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. 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. Furthermore, 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.
5. Talking about suicide in the classroom will promote suicidal ideas and suicidal behavior (**False**). 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.
6. Parents are often unaware of their child's suicidal behavior (**True**). Studies have shown that as much as 86% of parents were unaware of their child's suicidal behavior.
7. The majority of adolescent suicides occur unexpectedly without warning signs (**False**). Nine out of ten adolescents who commit suicide give clues to others before their suicide attempt. Warning signs for adolescent suicide include depressed mood, substance abuse, loss of interest in once pleasurable activities, decreased activity levels, decreased attention, distractability, isolation, withdrawing from others, sleep changes, appetite changes, morbid ideation, offering verbal cues (i.e., "I wish I were dead"), offering written cues (i.e., notes, poems), and giving possessions away. In addition, the following risk factors place an adolescent at increased risk for suicidal behavior: having a previous suicide attempt, having a recent relationship breakup, being impulsive, having low self-esteem, being homosexual, coming from an abusive home, having easy access to a firearm, having low

Answers to True/False Test continued

grades, and being exposed to suicide or suicidal behavior by another person. Moreover, most suicidal adolescents attempt to communicate their suicidal thoughts to another in some manner. Not surprisingly, an effective way to prevent adolescent suicide is to learn to identify the warning signs that someone is at risk.

8. Most adolescents who attempt suicide fully intend to die (**False**). Most suicidal adolescents do not want suicide to happen. 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.
9. There is a significant difference between male and female adolescents regarding suicidal behavior (**True**). Adolescent females are significantly more likely than adolescent males to have thought about suicide and to have attempted suicide. 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. Adolescent males are 4 to 5.5 times more likely than adolescent females to complete a suicide attempt. While adolescent females complete one out of 25 suicide attempts, adolescent males complete one out of every three attempts.
10. The most common method for adolescent suicide completion is drug overdose (**False**). Guns are the most frequently used method for completing suicides among adolescents. In 1994, guns accounted for 67% of all completed adolescent suicides while strangulation (via hanging), the second most frequently used method for adolescent suicide completions, accounted for 18% of all completed adolescent suicides. Having a gun in the house increases an adolescent's risk of suicide. 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. 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.
11. Because female adolescents complete suicide at a lower rate than male adolescents, their attempts should not be taken seriously (**False**). One of the most powerful predictors of completed suicide is a prior suicide attempt. Adolescents who have attempted suicide are 8 times more likely than adolescents who have not attempted suicide to attempt suicide again. Between 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.
12. Not all adolescents who engage in suicidal behavior are mentally ill (**True**). The majority of adolescents have entertained thoughts about suicide at least once in their lives. Although there are cases of some adolescents attempting and completing suicide as a result of a mental disorder, most are in fact not suffering from a mental disorder. Studies involving psychological autopsies of adolescents who completed suicide suggest that most adolescents are relatively rational and coherent at the time of their death. However, other research does suggest that identifying at-risk youth, by utilizing depression scales and psychopathology inventories, through screening and treating those individual who test positive for mental illness can benefit from counseling by a trained professional.
13. Suicidal behavior is inherited (**False**). There is no specific suicide gene that has ever been identified. Studies involving twins have found higher concordance rates for suicide in monozygotic twins than in dizygotic twins; meaning that an identical twin would be more likely than a fraternal twin to engage in suicidal behavior if his/her co-twin committed suicide. However, no study to date has examined the

Answers to True/False Test continued

concordance for suicide in monozygotic twins separated at birth and raised apart, a requirement necessary to be met as a means to indicate inheritance of psychiatric illness. Such a study could assess the effects that parental rearing style and familial environment have on suicidal behavior. Interestingly enough, when compared to control subjects, adolescent suicide victims have been found to have had significantly less frequent and less satisfying communication with their parents.

14. Adolescent suicide occurs only among poor adolescents (**False**). Adolescent suicide occurs in all socioeconomic groups. Socioeconomic variables have not been found to be reliable predictors of adolescent suicidal behavior. 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.
15. The only one who can help a suicidal adolescent is a counselor or a mental health professional (**False**). Most adolescents who are contemplating suicide are not presently seeing a mental health professional. Rather, most are likely to approach a family member, peer, 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.
16. Adolescents cannot relate to a person who has experienced suicidal thoughts (**False**). Data from the 1997 Youth Risk Behavior Surveillance Survey (YRBS), which surveyed 16,262 high school students, found that one in five students (24.1%) had seriously considered attempting suicide in the previous year. A population study of 5,000 teenagers from a rural community showed that 40% had entertained ideas of suicide at some point in their lives. Some researchers have estimated that it is more realistic that greater than half of all high school students have experienced thoughts of suicide. Furthermore, a mid-western survey of over 400 junior and senior high school students found that almost half of the students reported having a friend who had attempted suicide.
17. If an adolescent wants to commit suicide, there is nothing anyone can do to prevent its occurrence (**False**). One of the most important things an individual can do to prevent suicide is to identify the warning signs of suicide and recognize an adolescent at increased risk for suicide. School professionals should, therefore, be aware of these risk factors and know how to respond when a student threatens or attempts suicide. The existence of a school crisis intervention team may assist with this process.

Notes

Notes

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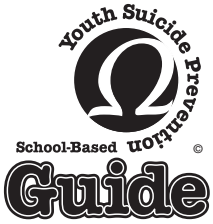

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School Climate

Checklist 2

This checklist provides administrators and educators with an efficient inventory of what empirical research and best practice suggests as important considerations when evaluating the status of a school's climate as it may relate to and influence adolescent suicidal behavior. This checklist can be used to quickly evaluate what services and policies your school already has in place (indicated by a "yes") or what services and policies your school may be lacking that may need to be implemented or revised (indicated by a "no"). This checklist corresponds to Issue Brief 2, which provides a more in depth and detailed discussion concerning school climate as it relates to and influences adolescent suicidal behavior. The intent of the Issue Brief is to provide research-based and best-practice suggestions for how a school may wish to address the issue of school climate as it relates to adolescent suicidal behavior. The intention of the Issue Brief is not to provide definitive declarations for what schools should do because each school will vary in their ability to implement and maintain suggestions mentioned in the Issue Brief.

Yes	No	
☐	☐	Are school service staff members accessible to students?
☐	☐	Are there methods in place that inform students about who to contact if they do not feel safe?
☐	☐	Does your school involve students' families in regular meetings or get-togethers so that families can voice their concerns about their children?
☐	☐	Does your school help support families in getting help they may need in order to effectively address adolescents with behavioral or conduct concerns?
☐	☐	Does your school have established links to the community for assessment and referral of students in crisis?
☐	☐	Does your school provide extracurricular opportunities for students such as after school clubs, activities, and student organization meetings?
☐	☐	Does your school provide regular meetings in which staff and faculty are given the opportunity to discuss students who may be displaying worrisome behavior?

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Checklist

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Checklist 2 continued

Yes	No	
☐	☐	Does your school have established policies that define anti-harassment and bullying?
☐	☐	Are there policies that state explicitly how to deal with a student(s) who bully and/or harass other students?
☐	☐	Does your school provide curricula to students focusing on harassment, bullying, tolerance, and problem-solving skills?
☐	☐	Does your school provide training to staff to help them recognize harassment, bullying, and warning signs of students who don't feel safe?
☐	☐	Does your school discuss safety issues openly?
☐	☐	Does your school treat students equally and enforce disciplinary, harassment, and civil right's policies consistently?
☐	☐	Are there specific safety procedures in place to support the personal safety of students, faculty, and staff?
☐	☐	Does your school provide clean and safe school buildings and grounds?
☐	☐	Does your school have in place a system for referring students who are suspected of being abused and/or neglected?
☐	☐	Does your school conduct regular safety and hazard assessments?
☐	☐	Does your school ensure that the school environment, including buses and bathrooms, is free from weapons?
☐	☐	Does your school ensure high academic standards?
☐	☐	Does your school stress to staff the importance of a positive relationship with students and how such a relationship can prevent dangerous situations from occurring?
☐	☐	Does your school treat all students with respect, care, and support?

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Administrative Issues

Checklist 4

This checklist provides administrators and educators with an efficient inventory of what empirical research and best practice suggests as important considerations when evaluating administrative issues surrounding adolescent suicide that the school currently has in place or may wish to consider implementing. This checklist can be used to quickly evaluate what services and policies your school already has in place (indicated by a "yes") or what services and policies your school may be lacking that may need to be implemented or revised (indicated by a "no"). This checklist corresponds to Issue Brief 4, which provides a more in depth and detailed discussion concerning administrative issues concerning adolescent suicide and the school's suicide prevention program (if one already exists). The intent of this and every other Issue Brief is to provide research-based and best-practice suggestions for how a school may wish to address the issue of adolescent suicidal behavior and ideations. The intention is not to provide definitive declarations for what schools should do because each school will vary in their ability to implement and maintain suggestions mentioned in the Issue Brief.

Yes	No	
☐	☐	Does your school provide information to staff and faculty about the impact and prevalence of adolescent suicide?
☐	☐	Does your school have policies and procedures in place concerning suicide issues?
☐	☐	Does your school have support from superintendents, principals, and teachers for a suicide prevention program?
☐	☐	Does your school have established links to the community that may offer help and assistance when a school is confronted with a student potentially at risk for suicidal behavior?
☐	☐	Does your school have an established crisis response plan?

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Checklist

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Checklist 4 continued

Yes	No	
☐	☐	Does your school's crisis response plan detail what actions to take (interventions) if a student does threaten, attempt, or dies by suicide?
☐	☐	Do all staff members and faculty know how your school will respond to a suicidal crisis situation?
☐	☐	Does your school educate and inform all staff members on who they should contact in the community or in the school should a student express or demonstrate any signs of suicidal behavior (verbal threats, written warnings, or overt suicidal behaviors)?
☐	☐	Does your school have an established crisis response team?
☐	☐	Does your school's crisis response team have administrative support?
☐	☐	Does your school have an established crisis response team that is formally recognized for its contribution to the school's mission?
☐	☐	Does your school's crisis response team meet with one another and with other staff members on a regular and consistent basis?
☐	☐	Does your school's staff, faculty, and administrators know about the challenges and potential roadblocks for implementing and maintaining a school-based suicide prevention program?
☐	☐	Does your school provide parents with a list of community resources or agencies that they may contact should they suspect that their son/daughter is considering suicide or has expressed suicidal thoughts or behaviors?
☐	☐	Does your school actively communicate with parents, informing them about risk factors and the importance of disposing of or restricting access to lethal means (such as firearms)?
☐	☐	Does your school inform parents about what the school is doing to prevent or address the issue of suicide?
☐	☐	Does your school provide a way to measure or evaluate the impact and maintenance of your suicide prevention program?
☐	☐	Are your school's administration and staff aware of legislation concerning liability as it relates to suicidal behavior in students?

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Suicide Prevention Guidelines

Checklist 5

This checklist provides administrators and educators with an efficient inventory of what empirical research and best practice suggests as important considerations when evaluating the status of a school's suicide prevention program. This checklist can be used to quickly evaluate what services and policies your school already has in place (indicated by a "yes") or what services and policies your school may be lacking that may need to be implemented or revised (indicated by a "no"). This checklist corresponds to Issue Brief 5, which provides a more in depth and detailed discussion concerning particular prevention guidelines and issues mentioned in this checklist. The intent of the Issue Brief is to provide research-based and best-practice suggestions for how a school may wish to address the issue of adolescent suicidal behavior and what research suggests about each strategy available to schools. The intention of the Issue Brief is not to provide definitive declarations for what schools should do because each school will vary in their ability to implement and maintain suggestions mentioned in the Issue Brief.

Yes	No	
☐	☐	Does your school have written policies and procedures in place to effectively respond to students who may be at-risk for suicidal behaviors and/or thoughts?
☐	☐	Does your school have established collaborative relationships with community agencies, such as crisis centers or mental health centers?
☐	☐	Does your school provide training for all school personnel about suicide prevention?
☐	☐	Does your school have an established in-school response team that is qualified to respond to a student potentially at-risk for suicidal behaviors and/or thoughts?
☐	☐	Does your school provide opportunities for parents to become involved in the suicide prevention practices and activities your school provides?

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5 Checklist

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Checklist 5 continued

Yes	No	
☐	☐	Does your school educate students about the facts of suicide?
☐	☐	Does your school provide information to students about social skills, coping skills, and appropriate problem solving strategies?
☐	☐	Does your school educate students about help seeking (when to seek help for themselves or someone else and who they should contact for help)?
☐	☐	Does your school screen students in order to identify students who may be at-risk for suicide, in order to get them help?
☐	☐	Does your school provide peer assistance programs for students?
☐	☐	Does your school provide students with information about community agencies, such as a crisis center that they may use if they feel unsafe or potentially suicidal?
☐	☐	Does your school provide a safe environment for students?
☐	☐	Does your school provide opportunities for student to become involved in school activities?
☐	☐	Does your school attempt to foster a feeling of connectedness between the school and the students?
☐	☐	Does your school have policies and procedures in place that explicitly detail what to do following a suicidal crisis in order to avoid copycat behaviors?
☐	☐	Does your school inform parents on the importance of restricting a students access to weapons, particularly firearms?
☐	☐	Does your school have policies in place that provide guidelines on how to effectively deal with the media should a suicidal event take place?
☐	☐	Does your school have the support of administrators, teachers, parents, and community professionals?
☐	☐	Does your school provide a comprehensive prevention plan: one that utilizes more than one prevention strategy and one which provides an established response plan should a suicidal crisis occur?

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Intervention Strategies

Checklist 6

This checklist provides administrators and educators with an efficient inventory of what empirical research and best practice suggests as important considerations when evaluating the status of a school's ability to effectively intervene with a student potentially at risk for suicidal behavior. This checklist can be used to quickly evaluate what services and policies your school already has in place (indicated by a "yes") or what services and policies your school may be lacking that may need to be implemented or revised (indicated by a "no"). This checklist corresponds to Issue Brief 6, which provides a more in depth and detailed discussion concerning intervention strategies. The intent of the Issue Brief is to provide research-based and best-practice suggestions for how a school may wish to address the issue of intervening with a student potentially at risk for suicidal behavior. The intention of the Issue Brief is not to provide definitive declarations for what schools should decide to do specifically but present what research suggests as effective ways to intervene; we assume that each school will vary in their ability to implement and maintain suggestions mentioned in the Issue Brief.

Yes	No	
☐	☐	Does your school have established links to crisis intervention services in the community?
☐	☐	Does your school have a crisis response plan in place to respond to potential crisis situations?
☐	☐	Do all staff members know about the crisis response plan and how your school will respond to a crisis situation?
☐	☐	Does your school educate and inform all staff members on who they should contact in the community or in the school should a student express or demonstrate any signs of suicidal behavior (verbal threats, written warnings, or overt suicidal behaviors)?

— next page

6b-Suggested Citation: Doan, J., Lazear, K., & Roggenbaum, S. (2003). *Youth suicide prevention school-based guide (c/p/r/s)—Checklist 6: Intervention strategies: Crisis intervention and crisis response teams.* Tampa, FL: Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Series Publication #219-6)

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6 Checklist

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The Louis de la Parte Florida Mental Health Institute at the University of South Florida, funded by the Institute for Child Health Policy at NOVA Southeastern University through a Florida Drug Free Communities Program Award.

Checklist 6 continued

Yes	No	
☐	☐	Does your school provide all staff with training about how to effectively intervene with a student who has directly or indirectly expressed suicidal thoughts and/or behaviors, or has demonstrated other warning signs consistent with suicide (see Issue Brief 3 for list of warning signs)?
☐	☐	Does your school train all staff members on the warning signs of adolescent suicide?
☐	☐	Does your school define what type of event warrants a school-based crisis response?
☐	☐	Does your school have an established crisis response team?
☐	☐	Does your school have an established crisis response team that is formally recognized for its contribution to the schools mission?
☐	☐	Does your school have an established crisis response team whose members know their roles for responding to a suicidal crisis?
☐	☐	Does your school have an established crisis response team with an established leader as well as a backup leader?
☐	☐	Does your school have an established method for following up with a student who has gone through a suicidal crisis?
☐	☐	Does your school have procedures in place to help other students during a suicidal crisis?
☐	☐	Does your school have established methods for identifying close friends and other vulnerable students?
☐	☐	Does your school provide support to close friends of a student who attempts or dies by suicide and other vulnerable students?
☐	☐	Does your school provide parents with a list of community resources or agencies that they may contact should they suspect that their son/daughter is considering suicide or has expressed suicidal thoughts or behaviors?
☐	☐	Does your school provide parent education regarding risk factors and the importance of disposing of or restricting access to lethal means (such as firearms)?
☐	☐	Does your school "debrief" all staff members or school faculty that may have been involved or impacted by a suicidal crisis?

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Preparing and Responding to a Death by Suicide

7a Checklist

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Checklist 7a

This checklist provides administrators and educators with an efficient inventory of what empirical research and best practice suggests as important considerations when evaluating the status of a school's ability to prepare and respond to a death by suicide. This checklist can be used to quickly evaluate what services and policies This checklist can be used to quickly evaluate what services and policies your school already has in place (indicated by a "checked box") to respond to a death by suicide or what services and policies your school may be lacking that may need to be implemented or revised (indicated by a "blank box"). This checklist corresponds to Issue Brief 7a, which provides a more in depth and detailed discussion concerning how to prepare for and respond to a death by suicide. The intent of the Issue Brief is to provide research-based and best-practice suggestions for how a school may wish to prepare and respond to a death by suicide. The intention is not to provide definitive declarations for what schools should do when responding to a death by suicide because each school will vary in their ability to implement and maintain suggestions mentioned in the Issue Brief.

What to DO following a suicide:

Do

- ☐ Utilize and follow the school's guidelines for dealing with a suicidal crisis. If the school does not have guidelines please refer to "Steps for Responding to a Suicidal Crisis" found on Page 2 in this Issue Brief 7a.
- ☐ Respond to the suicide within 24 hours of the suicide.
- ☐ Act in a concerned and empathetic manner.

— next page

Suggested Citation: Doan, J., Roggenbaum, S., & Lazear, K.. (2003). *Youth suicide prevention school-based guide (c/p/r/s)—Checklist 7a: Preparing for and responding to a death by suicide: Steps for responding.* Tampa, FL: Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Series Publication #219-7a)

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Checklist 7a continued

Do

- ☐ Inform all staff members about the suicide and provide a debriefing session where staff may voice their concerns, apprehensions, and any questions they may have.
- ☐ Inform school board members.
- ☐ Make sure all teachers announce the death of the student to their first class of the day. It is preferable to describe the deceased as "having died by suicide," rather than as "a suicide," or having "committed suicide." The latter two expressions reduce the person to the mode of death, or connote criminal or sinful behavior.
- ☐ Provide counseling sites throughout the school for students.
- ☐ Avoid any glorification of the suicide such as holding a memorial for the student or in some way honoring that student.
- ☐ Assign a school liaison to handle all media inquiries in order to avoid sensationalistic stories concerning the suicide.
- ☐ Continually monitor the school's emotional climate (Has there been an increase in fights or school delinquency following a death by suicide?).
- ☐ Evaluate all activities done following a death by suicide (How did your school respond? What worked and what did not work?).
- ☐ Utilize an established linkage system or community network in order to make referrals to the appropriate services as well to exchange information concerning the appropriate steps for treating those affected by the suicide.
- ☐ Utilize an established school response crisis team, which should include a diverse group of school professionals, such as the principal, counselor, teacher and possibly the school nurse.
- ☐ Follow the steps outlined later in this section.

What NOT to do following a suicide crisis:

Do Not

- ☐ Behave in a quiet and overly conservative manner.
- ☐ Plant a tree or object in order to honor the student.
- ☐ Hold a memorial service for the student at the school.
- ☐ Describe in great detail the suicide (method or place).
- ☐ Dramatize the impact of suicide through descriptions and pictures of grieving relatives, teachers or classmates.
- ☐ Glamorize or sensationalize the suicide.

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Preparing for and Responding to a Death by Suicide

Sample Forms for Schools 7b

- **Announcements for Students, Faculty, and Staff**
- **Notification Letter to Parents Following a Suicide**
- **Formal Statement to Notify Media of Suicide**
- **Sample Response Form for Incoming Calls from the Media**

The following announcements have been suggested for use when addressing students, faculty, and staff. These announcements should be presented in a small meeting room as soon as possible following the death. A member of the crisis team and possibly the principal should lead the meetings. The goals of the meetings are to inform the faculty, students, and staff and allow them time to express their emotions, and prepare them to meet and deal with a suicidal crisis. Faculty should be informed of the suicide first and they should be given time to express their emotions and concerns before informing their students. These sample forms were synthesized from three sources:

1. Underwood, M.M., Dunne-Maxim, K. (1997). Managing sudden traumatic loss in the schools: New Jersey adolescent suicide prevention project (revised edition). Piscataway, New Jersey: University of Medicine and Dentistry of New Jersey—University Behavioral Healthcare.
2. The Maine Youth Suicide Prevention Program. (2002). Youth suicide prevention intervention and postvention guidelines: a resource for school personnel. A program of Governor Angus S. King Jr. and the Maine Children's Cabinet.
3. Community Action For Youth Survival Project (SAVE). Retrieved May, 18, 2003, from the University of Illinois at Chicago: Institute for Juvenile Research, Department of Psychiatry. Funded by the Ronald McDonald House Charities.

Suggested Citation: Doan, J., Roggenbaum, S., & Lazear, K.. (2003). *Youth suicide prevention school-based guide (c/p/r/s)—Sample forms 7b: Preparing for and responding to a death by suicide: Responding to and working with the media.* Tampa, FL: Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Series Publication #219-7b)

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7b
Sample Forms

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Sample Forms for Schools 7b continued

Announcements to Students, Faculty, and Staff

Day 1

Sample Announcement For When a Suicide has Occurred

Morning, Day 1 "This morning we heard the extremely sad news that_____ died by suicide last night. I know we are all saddened by his death and send our condolences to his family and friends. Crisis stations will be located throughout the school today for students who wish to talk to a counselor. Information about the funeral will be provided when it is available, and students may attend with parental permission."

Sample Announcement For a Suspicious Death Not Declared Suicide

Morning, Day 1 "This morning we heard the extremely sad news that _____ died last night. This is the only information we have officially received on the circumstances surrounding the event. I know we are all saddened by _____'s death and send our condolences to his family and friends. Crisis stations will be located throughout the school today for students who wish to talk to a counselor. Information about the funeral will be provided when it is available, and students may attend with parental permission."

Sample Announcement Primary or Middle School

Morning, Day 1 "We want to take some time this morning to talk about something very sad. (Name)_____, an eighth grader, died unexpectedly last night. At this point, we do not officially know the cause of (his/her) _____ death. Death is a difficult issue for anyone to deal with. Even if you didn't know _____, you might still have some emotional reactions to hearing about this.

It is very important to be able to express our feelings about _____'s death, especially our loss and sadness. We want you to know that there are teachers and counselors available in the library all through the day to talk with you about your reaction to _____'s death. If you want to talk with somebody, you will be given a pass to go to the library where we have people who will help us through this difficult time."

End of Day 1 At the end of the first day, another announcement to the whole school prior to dismissal can serve to join the whole school in their grieving in a simple, non-sensationalized way. In this case, it is appropriate for the building administrator to make an announcement similar to the following over the loud speaker:

"Today has been a sad day for all of us. We encourage you to talk about _____'s death with your friends, your family, and whoever else gives you support. We will have special staff here for you tomorrow to help in dealing with our loss. Let us end the day by having the whole school offer a moment of silence for _____."

Sample Forms for Schools 7b continued

Announcements to Students, Faculty, and Staff continued

Day 2

On the second day following the death, many schools have found it helpful to start the day with another announcement by each teacher in their homeroom. This announcement can include additional verified information, re-emphasize the continuing availability of in-school resources and provide information to facilitate grief. Here's a sample of how this announcement might be handled:

"We now know that _____'s death has been declared a suicide. Even though we might try to understand the reasons for his/her doing this, we can never really know what was going on that made him/her take his/her life. One thing that's important to remember is that there is never just one reason for a suicide. There are always many reasons or causes and we will never be able to figure them all out.

Today we begin the process of returning to a normal schedule in school. This may be hard for some of us to do. Counselors are still available in school to help us deal with our feelings. If you feel the need to speak to a counselor, either alone or with a friend, tell a teacher, the principal, or the school nurse, and they will help make the arrangements.

We also have information about the visitation and funeral. The visitation will be held tomorrow evening at the _____ Funeral Home from 7 to 9 pm. There will be a funeral Mass Friday morning at 10 am at _____ Church. In order to be excused from school to attend the funeral, you will need to be accompanied by a parent or relative, or have your parent's permission to attend. We also encourage you to ask your parents to go with you to the funeral home."

Sample Forms for Schools 7b continued

Notification Letter for Parents Following a Suicide

Date: _____

Dear Parent(s)/Caretaker(s),

The death of a child is a sad and tragic event, and the sudden death of our student, _____ (name), has touched both students and faculty here at _____ High School.

Based on the information provided to us by the medical examiner and the family, _____ (name of student) died by suicide on _____ (day), _____ (month) _____ (date).

The funeral arrangements are as follows: _____. Mr. and Mrs. _____ (name) request that students _____ _____ attend/do not attend. In addition, donations may be sent in care of _____.

Since the news of the death, the school has implemented a crisis response plan to help the students and staff respond to this unfortunate death. In conjunction with colleagues from _____ (community agencies), the school continues to provide/has provided professionally staffed support stations available to all students. In addition, students continue to meet with staff from our counseling and social work departments.

In the days and weeks ahead, students may have questions and concerns relating to the death and are going to require your support at home and our continued support here at school as they work through their feelings and grief. Although we cannot predict how any child may react, we can be sensitive and aware, both at home and at school, of the common reactions experienced by grieving adolescents.

If you feel your child is having difficulty and may benefit from additional support, please feel free to contact _____, the Crisis Team Leader, your child's guidance counselor, or myself so the school can be aware of the needs of your child. We are also supported by local mental health professionals and can provide you with referrals as needed. In addition, if you are interested in attending a parent/caretaker meeting, please contact _____ at _____ (phone) for further information and registration.

As the school community continues to cope with the loss of _____ (name), we invite your participation in the healing process. Please feel free to contact the school at any time with questions or concerns.

Sample Forms for Schools 7b continued

Formal Statement to Notify Media of Suicide

_____ High School is sad to report that it has confirmed the death of one of its students, _____, with the medical examiners office and the deceased's family. _____ (first name), a____ -year-old (age) _____ (grade), died _____ (day) [died by suicide].

He/she was a resident of _____ and was active in _____ at the school. Funeral arrangements are not available at this time. School counselors and community mental health representatives are available to any student who wishes to talk about _____'s death.

- List community resources
- List ways the media can be helpful with postvention

Sample Response to Incoming Calls from Media

The school has designated a media spokesperson. Please feel free to contact _____ with your questions and concerns. We would like to respond to your questions in an organized manner. To assist you, _____(name) will be meeting with concerned members of the media at _____ (time) in _____ (place). At that time we will provide information about the school's response to our loss and identify additional resources in the community to support the bereaved.

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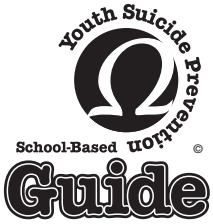

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Culturally and Linguistically Diverse Populations

9

Checklist

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Checklist 9

The cultural competence checklist is designed to provide school administrators with an opportunity to educate staff and gather information to help identify their strengths and the challenges they face in responding to the needs of their culturally diverse students and families. It will further enable your school to develop action steps for specific operational or policy changes necessary to progress toward the goals of cultural competence. This checklist can be used to quickly evaluate what services and policies your school already has in place (indicated by a "yes") or what services and policies your school may be lacking that may need to be implemented or revised (indicated by a "no"). This checklist corresponds to Issue Brief 9, which provides a more in depth and detailed discussion.

Yes	No	
☐	☐	Are school service staff members accessible to students?
☐	☐	Your school acknowledges that culture is an integral part of the physical, emotional, intellectual, and overall development and well-being of its students and their families.
☐	☐	Your school provides on-going opportunities for all students to experience feelings of "connectedness" to the school.
☐	☐	Your school has and enforces an anti-bullying program and staff intervenes in an appropriate manner when they observe students or other staff engage in behaviors that show cultural insensitivity, bias or prejudice.
☐	☐	Your school integrates tolerance education into existing curriculum and trains staff to teach tolerance in the classroom.
☐	☐	Your school makes the educational environment more welcoming and attractive based on families' cultural mores by displaying pictures, posters and other materials that reflect the cultures and ethnic backgrounds of students and their families.

— next page

Suggested Citation: Doan, J., Roggenbaum, S., & Lazear, K. (2003). *Youth suicide prevention school-based guide (c/p/r/s)—Checklist 9: Cultural and Linguistically Diverse Populations.* Tampa, FL: Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Series Publication #219-9)

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Checklist 9 continued

Yes	No	
☐	☐	Your school considers cultural factors such as language, race, ethnicity, customs, family structure, sexual orientation, and tribal and/or community dynamics when planning and designing and delivering programs and curriculums.
☐	☐	Your school respects the culture, diversity, and rights of its students and their families.
☐	☐	Your school respects the culture, diversity, and rights of all of its staff.
☐	☐	Your school's programs and practice acknowledge, respect, and respond to the various culturally defined needs of students and their families.
☐	☐	Your school's administrative policies and procedures acknowledge the need for services to culturally diverse families.
☐	☐	Your school's informative materials (such as letters home to parents, announcements) are designed in culturally and linguistically diverse print to meet the cultural diversity of students and their families.
☐	☐	Your school leadership and board support the provision of relevant cultural competence training for all school staff.
☐	☐	Your school leadership and board actively promote the recruitment of culturally diverse staff members.
☐	☐	Your school includes cultural competency requirements in staff job descriptions and discusses the importance of cultural awareness and competency with potential employees.
☐	☐	Your school staff members possess the knowledge and experience to work effectively with culturally diverse students.
☐	☐	Your school has enough staff who are proficient in writing and speaking the languages of its students and their families.
☐	☐	Your school makes bilingual service available when needed or requested by a student or family.
☐	☐	Your school works with culturally diverse communities and organizations to address multicultural issues and learns more about the effectiveness and responsiveness of its programs.
☐	☐	Your school seeks information from family members or other knowledgeable community members that will assist in the school's ability to respond to the needs and preferences of culturally and ethnically diverse students and families.
☐	☐	Your school considers whether the school's physical appearance (decorations, displays, etc.) is respectful of different cultural groups.
☐	☐	Your school collects and uses demographic information on the culturally diverse populations of the communities in its area.
☐	☐	Your school is knowledgeable about federal and state statutes and regulations that relate to culturally and linguistically diverse populations.
☐	☐	Your school provides all staff with continuous cultural competency training and information relevant to the diversity of its students and families.
☐	☐	Your school offers opportunities for staff to examine their own cultural beliefs and attitudes to gain a better understanding of the dynamics of cultural difference and interaction.
☐	☐	Your school is committed to creating an atmosphere of understanding, respect, and support for cultural diversity throughout its programs.

The Guide's checklist was adapted from the Child Welfare League of America's Cultural Competence Agency Self-Assessment Instrument (2002) (www.cwla.org), the National Association of School Psychologists' Provision of Culturally Competent Services in the School Setting (www.nasponline.org/culturalcompetence), and National Center for Cultural Competence, Georgetown University Center for Child and Human Development's Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Special Health Needs and Their Families (www.georgetown.edu/research/gucdc/nccc/nccc7).

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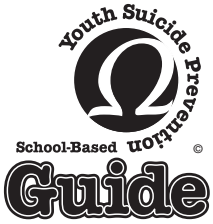

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Suicide Prevention Programs

P

Prevention Programs

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This Issue Brief is adapted from information from **The Best Practices Registry** (**BPR**). This Brief contains programs/projects/efforts included as of September 2009. Please go online to Suicide Prevention Resource Center's (SPRC's) Best Practices Registry (BPR) at **http://www.sprc.org/featured_resources/bpr/index.asp** for the most current listings and to obtain program descriptions and additional information about the BPR. This Issue Brief includes all youth and school-related programs (as of 9/09) on the BPR. While some are not specifically school-based, a number may have application to youth-focused intervention programs (e.g., clinical). An abbreviated program description is included in this Issue Brief for school-based interventions listed in Section 1b: List of SPRC Reviewed Evidence-Based Practices. More detailed descriptions are provided at the above link. It is the reader's sole responsibility to determine whether any of the information contained in these materials is useful to them. *No specific endorsement is implied with the inclusion of a given program*. Absence of a program does not presume negative judgment of its value.

Purpose and Structure of the BPR

The Best Practices Registry (BPR) for suicide prevention is a collaboration between the Suicide Prevention Resource Center (SPRC) and the American Foundation for Suicide Prevention (AFSP). The BPR is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of the BPR is to identify, review, and disseminate information about best practices that address specific objectives of the National Strategy for Suicide Prevention.

The BPR has three sections:

- **Section I: Evidence-Based Programs**
- **Section II: Expert and Consensus Statements**
- **Section III: Adherence to Standards**

The three sections are not intended to represent "levels" of effectiveness, but rather include different types of programs and practices reviewed according to specific criteria for that section. BPR listings include only materials submitted and reviewed according to the designated criteria and do not represent a comprehensive inventory of all suicide prevention initiatives. Each BPR listing on the website includes information about where to obtain the materials, related costs, and contact information for the program developer.

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

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Section I: Evidence-Based Programs

This section contains interventions that have undergone rigorous evaluation and have demonstrated positive and successful outcomes (generally, reductions in suicidal behaviors or risks) based on well-designed research studies. Section I includes listings from two sources: (a) interventions reviewed and rated by SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP); and (b) programs reviewed as part of the SPRC/AFSP Evidence-Based Practices Project (which stopped conducting reviews in 2005). This section is divided into two subsections:

Section 1a: SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP)
Section 1b: SPRC/AFSP Evidence-Based Practices Project

Section 1a: List of NREPP–Reviewed Suicide Interventions

Table 1 displays interventions addressing suicide currently listed on the NREPP registry. Programs listed on NREPP can be viewed on the BPR website or by going directly to the NREPP website (**www.nrepp.samhsa.gov**).

Section 1b: List of SPRC Reviewed Evidence-Based Practices

Twelve programs were reviewed and classified as evidence-based (either Effective or Promising) by SPRC/AFSP. A brief description of school-based programs reviewed are included below. The most current information along with each program description can be found at the BPR at **http://www.sprc.org/featured_resources/bpr/ebpp.asp**.

Table 1: Section 1: Evidence-Based Programs

BPR Section Ia and Ib Program Listing	Section 1a - NREPP[1]	Section 1b - EBPP[2]
American Indian Life Skills Development/Zuni Life Skills Development	X	X
CARE (Care, Assess, Respond, Empower)	X	X
CAST (Coping and Support Training)*	X	X
Columbia University TeenScreen	X	X
Emergency Room Intervention for Adolescent Females	X	
PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial)	X	
SOS Signs of Suicide	X	X
United States Air Force Suicide Prevention Program	X	X
Cognitive Behavioral Therapy for Adolescent Depression	X	
Dialectical Behavior Therapy	X	
Lifelines		X
Reconnecting Youth		X
ER Intervention for Adolescent Females		X
ER Means Restriction Education for Parents*		X
PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial)*		X
Psychotherapy in the Home		X
Reduced Analgesic Packaging*		X

*Effective programs that met a higher standard of effectiveness than Promising programs.
[1] National Registry of Evidenced-based Programs and Practices (NREPP)
[2] SPRC/AFSP Evidence-Based Practices Project

School Based Programs

A brief description of school-based programs from Section 1B (Table 1) are listed below.

C-Care/CAST

C-Care/CAST are listed as two programs on NREPP that also have been implemented together.

C-Care (Counselors-Care) provides an interactive, personalized assessment and a brief motivational counseling intervention.

CAST (Coping and Support Training) is a small group skills training intervention. Twelve one-hour sessions incorporate key concepts, objectives, and skills that are outlined in a standardized implementation guide.

Columbia University TeenScreen

The purpose of the Columbia TeenScreen Program is to identify youth who are at-risk for suicide and potentially suffering from mental illness and then ensure they receive a complete evaluation. While screening can take place in any number of venues, including juvenile justice facilities, shelters, and doctor's offices, the program has been primarily conducted in school settings.

Lifelines

Lifelines is a school-based suicide prevention curriculum comprised of four 45-minute lessons and also includes school-based model policies and procedures for responding to at-risk youth, suicide attempts, and completions; presentations for educators and parents; and a one-day workshop to train teachers to provide the curriculum.

Reconnecting Youth

Reconnecting Youth is a school-based selective/indicated prevention program that targets young people in grades 9–12 who show signs of poor school achievement, potential for school dropout, and other at-risk behaviors including suicide-risk behaviors. RY teaches skills to build resiliency with respect to risk factors and to moderate early signs of substance abuse, and depression/aggression.

SOS Signs of Suicide

SOS incorporates two prominent suicide prevention strategies into a single program, combining a curriculum that aims to raise awareness of suicide and its related issues with a brief screening for depression and other risk factors associated with suicidal behavior. SOS promotes the concept that suicide is directly related to mental illness, typically depression, and that it is not a normal reaction to stress or emotional upset. The basic goal of the program is to teach high school students to respond to the signs of suicide as an emergency, much as one would react to signs of a heart attack. Students are taught to recognize the signs and symptoms of suicide and depression in themselves and others and to follow the specific action steps needed to respond to those signs.

American Indian Life Skills Development/Zuni Life Skills Development

The Zuni Life Skills Development curriculum is a culturally tailored intervention that targets high school students. It is based upon social cognitive theory, which proposes that suicidal behavior is affected through the interaction of modeling influences (peer and community), environmental factors, and individual characteristics. By developing competency in a number of life skill domains, program participants decrease known risk factors while increasing protective factors.

Section II: Expert and Consensus Statements

Section II of the BPR lists expert and consensus statements that summarize the best knowledge in suicide prevention in the form of guidelines or protocols. These statements typically result from either a collaborative process involving key stakeholders or from a thorough review of the literature by a preeminent expert in that topic area.

Section II statements provide guidance and recommendations (including protocols) that practitioners can use while developing programs, practices, or policies for their own settings. Note that Section III also lists protocols; however, Section III protocols have been implemented in specific settings rather than serving as general guidance for the field. Several of the criteria used to review Section III materials are based on statements listed in Section II (i.e., the Safe and Effective Messaging Guidelines and the AAS Guidelines for School-Based Prevention Programs).

Section II: Expert and Consensus Statements (Listed alphabetically by title) are listed in Table 2.

The most current information along with each program description can be found at the BPR at **http://www.sprc.org/featured_resources/bpr/expert.asp**

Table 2: Section II: Expert and Consensus Statements

BPR Section II Program listing	Author
A Resource Guide for Implementing the Joint Commission's 2007 Patient Goals on Suicide	Screening for Mental Health, Inc.
Consensus Statement on Youth Suicide by Firearms	Youth Suicide by Firearms Task Force and the American Association of Suicidology
Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student	Jed Foundation
Guidelines for School Based Suicide Prevention Programs	American Association of Suicidology
National Guidelines for Seniors' Mental Health: The Assessment of Suicide Risk and Prevention of Suicide	Canadian Coalition for Seniors' Mental Health
Reporting on Suicide: Recommendations for the Media	Multiple Authors
Standards for the Assessment of Suicide Risk Among Callers to the National Suicide Prevention Lifeline	National Suicide Prevention Lifeline
Student Mental Health and the Law	Jed Foundation
Suicide Prevention Efforts for Individuals with Serious Mental Illness	National Association of State Mental Health Program Directors
Warning Signs for Suicide Prevention	American Association of Suicidology

Section III: Adherence to Standards

This section contains suicide prevention programs, practices, policies, protocols, and awareness materials that have been implemented in specific settings such as schools, communities, clinics, or campuses (the terms program and practice are used interchangeably to refer to all activities and/or materials posted in this section). The materials' content has been reviewed to assess adherence to current program development standards and recommendations in the field. The Section III listing includes only materials submitted to BPR and reviewed according to Section III criteria as of September 2009. Inclusion does not mean that the practice has been proven effective through evaluation (those programs are listed in Section I) or is "recommended" by SPRC or AFSP. However, adherence to standards is an important aspect of developing practices that are likely to be successful. The list is not a comprehensive inventory of all suicide prevention programs.

Programs, Practices, and Policies that Adhere to Standards (Listed by type of practice, then alphabetically) are included in Table 3.

The most current information along with each program descriptions can be found at the BPR at **http://www.sprc.org/featured_resources/bpr/standards.asp**

Table 3: Section III: Adherence to Standards

BPR Section III Program, Practices, & Policies Listing with Author	Awareness Materials	Educational & Training Programs	Protocols & Policies
After an Attempt: A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors, National Suicide Prevention Lifeline	X		
After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department, National Suicide Prevention Lifeline	X		
After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department, National Suicide Prevention Lifeline	X		
Depression and Bipolar Wellness Guides for Parents and Teens, Families for Depression Awareness	X		
Depression Wellness Guide for Adults with Depression and their Family and Friends, Families for Depression Awareness	X		
"Is Your Patient Suicidal?" Emergency Department Poster and Clinical Guide, Suicide Prevention Resource Center	X		
Applied Suicide Intervention Skills Training (ASIST), LivingWorks		X	
Ask 4 Help Suicide Prevention for Youth, Yellow Ribbon Suicide Prevention Program		X	
Assessing and Managing Suicide Risk: Core Competencies (AMSR), SPRC Training Institute		X	
At-Risk: Identifying and Referring Students in Mental Distress, Kognito Interactive		X	
Be A Link Suicide Prevention Gatekeeper Training, Yellow Ribbon Suicide Prevention Program		X	
Campus Connect: A Suicide Prevention Training for Gatekeepers, Syracuse University		X	
Connect/Frameworks Suicide Postvention Program, NAMI New Hampshire		X	
Connect/Frameworks Suicide Prevention Program, NAMI New Hampshire		X	
EndingSuicide.com, Clinical Tools, Inc.		X	
Healthy Education for Life (HELP), Heartline Oklahoma		X	

Table 3: Section III: Adherence to Standards continued

BPR Section III Program, Practices, & Policies Listing with Author	Awareness Materials	Educational & Training Programs	Protocols & Policies
Helping Every Living Person (HELP) Depression and Suicide Prevention Curriculum, Washington Youth Suicide Prevention Program		X	
High School Gatekeeper Curriculum, Gryphon Place		X	
Interactive Screening Program, American Foundation for Suicide Prevention		X	
LEADS for Youth: Linking Education and Awareness of Depression and Suicide, Suicide Awareness Voices of Education		X	
Making Educators Partners in Youth Suicide Prevention, Society for the Prevention of Teen Suicide		X	
Question, Persuade, Refer (QPR) Gatekeeper Training for Suicide Prevention, QPR Institute		X	
Response: A Comprehensive High School-based Suicide Awareness Program, ColumbiaCare		X	
Suicide Alertness for Everyone (safeTALK), LivingWorks		X	
Suicide Assessment Five-Step Evaluation and Triage (SAFE-T), Screening for Mental Health			X
Youth Suicide Prevention, Intervention, and Postvention Guidelines: A Resource for School Personnel, The Maine Youth Suicide Prevention Program			X
Youth Suicide Prevention School-based Guide Checklists, Louis de la Parte Florida Mental Health Institute, University of South Florida			X

Using the BPR

How to use the BPR as a resource for developing effective suicide prevention programs.

Even programs that have been evaluated and found effective will not work in every context or for all audiences. Program planners are encouraged to use the BPR in the context of a data-driven planning process. This process typically will involve multiple stakeholders in a process of assessing local needs, assets, and readiness and choosing interventions that match local problems and circumstances.

BPR listings can be used in a number of ways during this planning process. For example, planners can search Section I for proven suicide programs or practices that match identified needs, resources, and audiences. If no proven programs exist that match local needs, planners may consider adapting one of the programs listed in Section I, making revisions based on theory, local assessment, and audience research, while retaining key intervention ingredients.

It is important that the content of any program or policy be designed according to current standards in the field. Planners should consult Section II of the BPR to determine whether there are expert or consensus guidelines relevant to their planning efforts. Program planners can consult Section III to find examples of programs, practices, and policies for suicide prevention that include accurate information, are likely to meet objectives, follow safe messaging guidelines, and adhere to recommendations for prevention program design. While the programs and materials in Section III have not been reviewed for effectiveness, they can serve as examples of program content that meets specified standards. By following the content guidelines outlined in Section III, planners can increase the likelihood that their programs and practices will be effective.

Finally, planners are encouraged to build evaluation into their efforts to assess the effectiveness of their programs under local circumstances and build the knowledge base in the field. If you don't have evaluation expertise or capacity at your school or agency, you can often work with a local college or university to obtain assistance.

Notes

Notes

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Resources and Links

Resources

The following list of resources is intended to provide additional help and assistance to school administrators, staff, parents, community members, and students. This list is not all-inclusive but provides a place for schools and communities to start when additional information is needed or sought.

Crisis Lines

1-800-273-TALK (8255)

The National Suicide Prevention Lifeline, a free, 24-hour, 7 day a week hotline. Connects the caller to certified help from nearest crisis center.

1-800-850-8078

The Trevor Helpline, which can be reached by calling (800) 850-8078, is a national 24-hour toll-free suicide prevention hotline aimed at gay or questioning youth . The Trevor Helpline is geared toward helping those in crisis, or anyone wanting information on how to help someone in crisis. All calls are handled by trained counselors, and are free and confidential. http://www.thetrevorproject.org/

Florida Organizations

The Beth Foundation, Inc.

The Beth Foundation Inc. is a non-profit Florida organization dedicated to reducing the suicide rate in Florida through education and awareness. The Beth Foundation was established to provide training to increase the general knowledge about the nature of suicidal behavior, how to respond and refer a suicidal person for help and to provide a central clearinghouse for suicide prevention information and resources.

http://www.thebethfoundation.com

Suggested Citation: Doan, J., Roggenbaum, S., & Lazear, K.J. (2003). Youth suicide prevention school-based guide (c/p/r/s)—R: Resources and Links. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute. (FMHI Series Publication #219-R)

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

R

Resources

Youth Suicide Prevention School-Based Guide ©

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Stephen Roggenbaum
Katherine J. Lazear
Justin Doan

Design & Page Layout: Bill Leader

NSU Nova Southeastern University

USF University of South Florida

Louis de la Parte Florida Mental Health Institute

Developed by...
The Louis de la Parte Florida Mental Health Institute at the University of South Florida, funded by Nova Southeastern University through a Florida Drug Free Communities Program Award.

Resources and Links continued

Florida Initiative for Suicide Prevention

FISP supports and believes in a collaborative effort to address the risk factors that contribute to the incidence of suicide

http://www.fisponline.org/

Florida Suicide Prevention Coalition (FSPC)

FSPC is a Florida grassroots coalition whose mission is to collaborate to develop and implement suicide prevention, intervention and postvention strategies and programs. Their vision statement is: A coalition of Floridians for the elimination of suicide in our communities. This is an excellent site for up to date information and resources.

http://www.floridasuicideprevention.org

Project YES.

Project YES is an educational organization working to make the world safer for all youth. Their mission is to prevent suicide and ensure the healthy development of gay, lesbian, bisexual, and transgender youth by initiating dialogue, providing education**,** and creating support systems.

http://www.projectyes.org/

Advocacy Groups/Organizations

Light for Life Foundation

Light for Life Foundation of America provides information on the Yellow Ribbon Program for preventing youth suicide. Includes brochures, fact sheets, and statistics on youth suicide.

http://www.yellowribbon.org

National Alliance for the Mentally Ill (NAMI)

NAMI is dedicated to the eradication of mental illnesses and to the improvement of the quality of life of all whose lives are affected by these diseases. Includes section on Children & Adolescents with Mental Illnesses and their Families.

http://www.nami.org/template.cfm?section=Child_and_Adolescent_Action_Center

SA\VE – Suicide Awareness \ Voices of Education

Suicide Awareness \ Voices of Education provides information on depression and suicide including a number of educational tools, from brochures, fact sheets, frequently asked questions to support materials for communities to address suicide prevention.

http://www.save.org

Suicide Prevention Action Network (SPAN)

SPAN is dedicated to the creation and implementation of effective national suicide prevention strategies. SPAN is a network of persons working to raise national awareness and advocate for a National suicide prevention policy.

http://www.spanusa.org

National Organizations

The American Academy of Child & Adolescent Psychiatry

The AACAP assists parents and families in understanding developmental, behavioral, emotional and mental disorders affecting children and adolescents.

http://www.aacap.org

Resources and Links continued

American Association of Suicidology (AAS)

The American Association of Suicidology promotes research, public awareness programs, and education and training for professionals and volunteers.

http://www.suicidology.org

The American Foundation for Suicide Prevention (AFSP)

The American Foundation for Suicide Prevention is dedicated to advancing our knowledge of suicide and our ability to prevent it.

http://www.afsp.org

American Psychiatric Association

The American Psychiatric Association is a medical specialty society recognized worldwide. Its 40,500 U.S. and international physicians specialize in the diagnosis and treatment of mental and emotional illnesses and substance abuse disorders.

http://www.psych.org

American Psychological Association (APA)

Based in Washington, DC, the APA is a scientific and professional organization that represents psychology in the United States. With more than 150,000 members, APA is the largest association of psychologists worldwide. A search of the website produced more than 330 documents.

http://www.apa.org/

Depression and Bipolar Support Alliance (DBSA)

DBSA is the nation's leading patient-directed organization focusing on the most prevalent mental illnesses — depression and bipolar disorder. The organization fosters an understanding about the impact and management of these life-threatening illnesses by providing up-to-date, scientifically-based tools and information written in language the general public can understand.

http://www.dbsalliance.org

National Mental Health Association

The National Mental Health Association is dedicated to promoting mental health, preventing mental disorders, and achieving victory over mental illness through advocacy, education, research, and service.

http://www.nmha.org

National Youth Violence Prevention Resource Center (NYVPRC)

NYVPRC was established as a central source of information on prevention programs, publications, research, and statistics on violence committed by and against children and teens. Web site serves as a user-friendly single point of access to Federal information on youth violence prevention and suicide.

http://www.safeyouth.org

Suicide Prevention Resource Center (SPRC)

SPRC is a national resource center that provides technical assistance, Training, and information in order to strengthen suicide prevention networks and advance the Nation Strategy for Suicide Prevention.

http://www.sprc.org

Government Agencies

Centers for Disease Control and Prevention (CDC)

The CDC is an agency of the U.S. Department of Health and Human Services. It provides statistics, publications, health information, and funding announcements.

http://www.cdc.gov

Resources and Links continued

National Institute on Mental Health (NIMH)

The NIMH Suicide Research Consortium is comprised primarily of NIMH scientists across the Institute who also administer research grants. The Consortium coordinates program development in suicide prevention, identifies gaps in the scientific knowledge base, stimulates and monitors research, keeps abreast of scientific developments in suicidology and public policy issues related to suicide surveillance, prevention, and treatment, and disseminates science-based information on suicidology to the public, media, and policy makers.

http://www.nimh.nih.gov

Office of the Surgeon General

The Office of the Surgeon General, Department of Health and Human Services is dedicated to protecting and improving American health. The site has The Surgeon General's Call to Action to Prevent Suicide, 1999 and the National Strategy for Suicide Prevention: Goals and Objectives for Action, 2001 available to download.

http://www.surgeongeneral.gov

National Strategy for Suicide Prevention

A collaborative effort of Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Disease Control (CDC), National Institutes on Health (NIH), Health Resources and Services Administration (HRSA), and Indian Health Services (IHS).

http://www.mentalhealth.org/suicideprevention/default.asp

Additional Resources

Children's Safety Network (CSN)

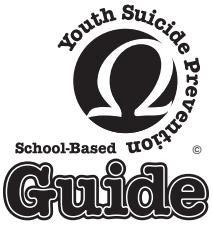
Children's Safety Network - National Injury and Violence Prevention Resource Center site contains publications and resources produced by CSN and other EDC injury prevention projects. Youth Suicide Prevention Fact Sheet Packet is available for downloading.

http://www.childrenssafetynetwork.org/

Center for Mental Health in Schools at UCLA

This Center for Mental Health in Schools at UCLA approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Its mission is to improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools. The Center is one of two national centers focusing directly on mental health in schools.

http://www.smhp.psych.ucla.edu/



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American Association of Suicidology Statistics

National Statistical Information

The following two pages of statistical informartion are provided with permission from the web site of the…

American Association of Suicidology (AAS)
4201 Connecticut Avenue, N.W. Suite 408
Washington, D.S. 20008

(202) 237-2280

http://www.suicidology.org

For other suicide data, and an archive of state data, visi the website below and click on the "Recent Suicid Statitics link:

http://mypage.iusb.edu/~jmcintos/

Suggested Citation: Doan, J., Roggenbaum, S., & Lazear, K.. (2003). *Youth suicide prevention school-based guide (c/p/r/s)*—American Association of Suicidology Statistics. Tampa, FL: Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Series Publication #219-S)

This publication is also available on-line as an Adobe Acrobat PDF file:
http://www.fmhi.usf.edu/institute/pubs/bysubject.html or
http://cfs.fmhi.usf.edu/cfsinfo/hotpubs.cfm

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AAS Statistics

Youth Suicide Prevention School-Based Guide ©

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Design & Page Layout: Bill Leader

Developed by…
The Louis de la Parte Florida Mental Health Institute at the University of South Florida, funded by the Institute for Child Health Policy at NOVA Southeastern University through a Florida Drug Free Communities Program Award.

Rate, Number, and Ranking of Suicide for Each U.S.A. State, 2002*

Rank-	State [Region] ('01 rank)	Rate	Number
1	Wyoming (04)	21.1	105
2	Alaska (06)	20.5	132
3	Montana (02)	20.2	184
4	Nevada (03)	19.5	423
5	New Mexico (01)	18.8	349
6	Arizona (10T)	16.2	886
7	Colorado (05)	16.1	727
8	West Virginia (07T)	15.3	276
9	Idaho (07T)	15.1	202
10	Vermont (26T)	14.9	92
11	Oregon (10T)	14.7	518
11	Utah (13T)	14.7	340
13	North Dakota (20T)	14.4	91
14	Oklahoma (09)	14.3	501
15	Florida (13T)	14.0	2,338
16	Arkansas (12)	13.9	377
17	Tennessee (20T)	13.4	778
17	Washington (24)	13.4	811
19	Kentucky (22)	13.2	540
20	Maine (19)	12.8	166
21	Kansas (36)	12.7	345
22	South Dakota (15)	12.4	94
23	Missouri (18)	12.2	693
24	Indiana (26T)	12.1	743
25	Mississippi (28T)	11.9	343
25	North Carolina (23)	11.9	986
27	Nebraska (35)	11.6	201
28	Alabama (28T)	11.5	514
28	Wisconsin (25)	11.5	627
30	Ohio (37)	11.3	1,287
31	Louisiana (34)	11.1	499
	United States	**11.0**	**31,655**
32	Michigan (38)	11.0	1,106
32	Virginia (31T)	11.0	799
34	Pennsylvania (39T)	10.9	1,341
35	Iowa (39T)	10.7	314
35	South Carolina (28T)	10.7	440
37	Georgia (31T)	10.6	909
37	Texas (39T)	10.6	2,311
39	New Hampshire (17)	10.4	132
40	Minnesota (42)	9.9	497
41	Hawaii (31T)	9.6	120
42	California (46T)	9.2	3,228
42	Delaware (16)	9.2	74
44	Illinois (43)	9.1	1,145
45	Maryland (44)	8.7	477
46	Rhode Island (45)	8.0	86
47	Connecticut (46T)	7.5	260
48	Massachusetts (50)	6.8	436
49	New Jersey (49)	6.4	553
49	New York (51)	6.4	1,228
51	District of Columbia (48)	5.4	31

Caution: Annual fluctuations in state levels combined with often relatively small populations can make these data highly variable. The use of several years' data is preferable to conclusions based on single years alone.

Region [Abbreviation]	Rate	Number
Mountain [M]	16.9	3,216
East South Central [ESC]	12.6	2,175
South Atlantic [SA]	11.8	6,330
West North Central [WNC]	11.5	2,235
West South Central [WSC]	11.4	3,688
Nation	**11.0**	**31,655**
East North Central [ENC]	10.7	4,908
Pacific [P]	10.3	4,809
New England [NE]	8.3	1,172
Middle Atlantic [MA]	7.8	3,122

Source: Kochanek, K.D., Murphy, S.L., Anderson, R.N., & Scott, C. (2004). Deaths: Final data for 2002. *National Vital Statistics Reports*, *53*(5). Hyattsville, MD: National Center for Health Statistics. DHHS Publication No. (PHS) 2005-1120. (p. 92, Table 29).
[data are by place of residence]
[Suicide = ICD-10 Codes X60-X84, Y87.0]

Note: All rates are per 100,000 population.

* Including the District of Columbia.

Suicide State Data Page: 2002
16 October 2004

Prepared by John L. McIntosh, Ph.D. for

American Association of Suicidology

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"to understand and prevent suicide as a means of promoting human well-being"

Visit the AAS website at:
http://www.suicidology.org

For other suicide data, and an archive of state data, visit the website below and click on the "Recent Suicide Statistics" link:
http://mypage.iusb.edu/~jmcintos/

Rate, Number, and Ranking of Suicide for Each U.S.A. State, 2001*

Rank-	State [Region] ('00 rank)	Rate	Number
01	New Mexico [M] (03)	19.8	362
02	Montana [M] (04)	19.3	175
03	Nevada [M] (02)	18.4	387
04	Wyoming [M] (05)	16.8	83
05	Colorado [M] (07T)	16.3	722
06	Alask a [P] (01)	16.1	102
07	Idaho [M] (16T)	15.9	210
07	West Virginia [SA] (11T)	15.9	286
09	Oklahoma [WSC] (09)	14.8	515
10	Arizona [M] (06)	14.5	767
10	Oregon [P] (07T)	14.5	505
12	Arkansas [WSC] (13)	14.2	382
13	Florida [SA] (11T)	14.1	2,314
13	Utah [M] (10)	14.1	321
15	South Dakota [WNC] (18T)	13.8	105
16	Delaware [SA] (32T)	13.6	108
17	New Hampshire [NE] (32T)	13.3	167
18	Missouri [WNC] (20)	12.9	725
19	Maine [NE] (23T)	12.5	161
20	North Dakota [WNC] (32T)	12.4	79
20	Tennessee [ESC] (15)	12.4	711
22	Kentucky [ESC] (16T)	12.2	495
23	North Carolina [SA] (21T)	12.1	997
24	Washington [P] (21T)	11.9	712
25	Wisconsin [ENC] (30)	11.8	639
26	Indiana [ENC] (27)	11.7	715
26	Vermont [NE] (18T)	11.7	72
28	Alabama [ESC] (14)	11.5	512
28	Mississippi [ESC] (37)	11.5	328
28	South Carolina [SA] (28T)	11.5	467
31	Georgia [SA] (35T)	11.1	935
31	Hawaii [P] (25T)	11.1	136
31	Virginia [SA] (31)	11.1	797
34	Louisiana [WSC] (35T)	11.0	493
35	Nebraska [WNC] (25T)	10.9	187
36	Kansas [WNC] (23T)	10.8	293
	U.S.A. TOTAL	**10.8**	**30,622**
37	Ohio [ENC] (41)	10.7	1,219
38	Michigan [ENC] (40)	10.5	1,051
39	Iowa [WNC] (39)	10.4	304
39	Pennsylvania [MA] (28T)	10.4	1,276
39	Texas [WSC] (38)	10.4	2,225
42	Minnesota [WNC] (43T)	9.6	480
43	Illinois [ENC] (46)	9.1	1,139
44	Maryland [SA] (43T)	8.4	454
45	Rhode Island [NE] (47)	8.3	88
46	California [P] (45)	8.2	2,831
46	Connecticut [NE] (42)	8.2	283
48	District of Columbia [SA] (51)	7.0	40
49	New Jersey [MA] (48)	6.9	588
50	Massachusetts [NE] (49T)	6.7	426
51	New York [MA] (49T)	6.6	1,253

Caution: Annual fluctuations in state levels combined with often relatively small populations can make these data highly variable. The use of several years' data is preferable to conclusions based on single years alone.

Region [Abbreviation]	Rate	Number
Mountain [M]	16.2	3,027
South Atlantic [SA]	12.1	6,398
East South Central [ESC]	11.9	2,046
West South Central [WSC]	11.3	3,615
West North Central [WNC]	11.2	2,173
Nation	**10.8**	**30,622**
East North Central [ENC]	10.5	4,763
Pacific [P]	9.3	4,286
New England [NE]	8.5	1,197
Middle Atlantic [MA]	7.8	3,117

2001

Source: Arias, E., Anderson, R.N., Kung, H.C., Murphy, S.L., & Kochanek, K.D. (2003). Deaths: Final data for 2001. *National Vital Statistics Reports, 52*(3). Hyattsville, MD: National Center for Health Statistics. [Data to be published in the CD-ROM entitled *Vital Statistics of the United States, Mortality, 2001*.] (p. 91, Table 30).
[data are by place of residence]
[Suicide = ICD-10 Codes X60-X84, Y87.0]

Note: All rates are per 100,000 population.

* Including the District of Columbia.

Suicide State Data Page: 2001
26 September 2003

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"to understand and prevent suicide as a means of promoting human well-being"

Visit the AAS website at:
http://www.suicidology.org

For other suicide data, and an archive of state data, visit the website below and click on the "Recent Suicide Statistics" link:
http://mypage.iusb.edu/~jmcintos/

U.S.A. SUICIDE: 2002 OFFICIAL FINAL DATA

	Number	Per Day	Rate	% of Deaths
Nation	31,655	86.7	11.0	1.3
Males	25,409	69.6	17.9	2.1
Females	6,246	17.1	4.3	0.5
Whites	28,731	78.7	12.2	1.4
Nonwhites	2,924	8.0	5.5	0.9
Blacks	1,939	5.3	5.1	0.7
Elderly (65+ yrs.)	5,548	15.2	15.6	0.3
Young (15-24 yrs.)	4,010	11.0	9.9	12.1

Group (Number of Sui.)	Rate
White Male (23,049)	19.9
White Female (5,682)	4.8
Nonwhite Male (2,360)	9.2
Nonwhite Female (564)	2.0
Black Male (1,633)	9.1
Black Female (306)	1.5
Hispanic (1,954)	5.0

Completions: ***suicide rate increased slightly in both 2002 and 2001 after declines for six consecutive years and a steady 2000 rate***

- Average of 1 person every 16.6 minutes killed themselves.
- Average of 1 old person every 1 hour 34.7 minutes killed themselves.
- Average of 1 young person every 2 hours 11 minutes killed themselves. (If the 264 suicides below age 15 are included, 1 young person every 2 hours 3 minutes)
- 11th ranking cause of death in U.S. | 3rd ranking cause for **young** ---------->
- 4.1 male deaths by suicide for each female death by suicide.
- Suicide ranks 11th as a cause of death; Homicide ranks 14th

Cause	Number	Rate
All Causes	33,046	81.4
1-Accidents	15,412	38.0
2-Homicide	5,219	12.9
3-Suicide	4,010	9.9

Attempts (figures are estimates; no official U.S. national data are compiled):

- 790,000 annual attempts in U.S. (using 25:1 ratio)
- 25 attempts for every death by suicide for nation. 100-200:1 for young; 4:1 for elderly.
- 5 million living Americans (estimate) have attempted to kill themselves.
- 3 female attempts for each male attempt.

Survivors (i.e., family members and friends of a loved one who died by suicide):

- *Each suicide intimately affects at least 6 other people.* (estimate- Shneidman, 1969, *On the Nature of Suicide*)
- Based on the over 745,000 suicides from 1978 through 2002, estimated that the number of survivors of suicides in the U.S. is 4.47 million(1 of every 64 Americans in 2002); number grew by nearly 190,000 in 2002.
- If there is a suicide every 16.6 minutes, then there are 6 new survivors every 16.6 minutes as well.

Suicide Methods	Number	Rate	Percent of Total		Number	Rate	Percent of Total
Firearm suicides	17,108	5.9	54.0%	All but Firearms	14,547	5.1	46.0%
Suffocation/Hanging	6,462	2.2	20.4%	Poisoning	5,486	1.9	17.3%
Falls	740	0.3	2.3%	Cut/pierce	566	0.2	1.8%
Drowning	368	0.1	1.2%	Fire/flame	150	0.1	0.5%

U.S.A. Suicide Rates 1993-2002

(Rates per 100,000 population)

Group/ Age	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
5-14	0.9	0.9	0.9	0.8	0.8	0.8	0.6	0.8	0.7	0.6
15-24	13.5	13.8	13.3	12.0	11.4	11.1	10.3	10.4	9.9	9.9
25-34	15.1	15.4	15.4	14.5	14.3	13.8	13.5	12.8	12.8	12.6
35-44	15.1	15.3	15.2	15.5	15.3	15.4	14.4	14.6	14.7	15.3
45-54	14.5	14.4	14.6	14.9	14.7	14.8	14.2	14.6	15.2	15.7
55-64	14.6	13.4	13.3	13.7	13.5	13.1	12.4	12.3	13.1	13.6
65-74	16.3	15.3	15.8	15.0	14.4	14.1	13.6	12.6	13.3	13.5
75-84	22.3	21.3	20.7	20.0	19.3	19.7	18.3	17.7	17.4	17.7
85+	22.8	23.0	21.6	20.2	20.8	21.0	19.2	19.4	17.5	18.0
65+	19.0	18.1	18.1	17.3	16.8	16.9	15.9	15.3	15.3	15.6
Total	12.1	12.0	11.9	11.6	11.4	11.3	10.7	10.7	10.8	11.0
Men	19.9	19.8	19.8	19.3	18.7	18.6	17.6	17.5	17.6	17.9
Women	4.6	4.5	4.4	4.4	4.4	4.4	4.1	4.1	4.1	4.3
White	13.1	12.9	12.9	12.7	12.4	12.4	11.7	11.7	11.9	12.2
Nonwh	7.1	7.2	6.9	6.7	6.5	6.2	6.0	5.9	5.6	5.5
Black	7.0	7.0	6.7	6.5	6.2	5.7	5.6	5.6	5.3	5.1

15 Leading Causes of Death in the U.S.A., 2002

(total of 2,443,387 deaths; 847.3 rate)

Rank & Cause of Death	Rate	Deaths
1 Diseases of heart (heart disease)	241.7	696,947
2 Malignant neoplasms (cancer)	193.2	557,271
3 Cerebrovascular diseases (stroke)	56.4	162,672
4 Chronic lower respiratory diseases	43.3	124,816
5 Accidents (unintentional injuries)	37.0	106,742
6 Diabetes mellitus (diabetes)	25.4	73,249
7 Influenza & pneumonia	22.8	65,681
8Alzheimer's disease	20.4	58,866
9 Nephritis, nephrosis (kidney disease)	14.2	40,974
10 Septicemia	11.7	33,865
11 Suicide [Intentional Self-Harm]	**11.0**	**31,655**
12 Chronic liver disease and cirrhosis	9.5	27,257
13 Essential hypertension and renal disease	7.0	20,261
14 Homicide [Assault]	6.1	17,638
15 Pneumonitis due to solids and liquids	6.1	17,593
- All other causes (Residual)	141.5	407,900

Old made up 12.3% of 2002 population but represented 17.5% of the suicides.
Young were 14.1% of 2002 population and comprised 12.7% of the suicides.

Official data source: Kochanek, K.D., Murphy, S.L., Anderson, R.N., & Scott, C. (2004). Deaths: Final data for 2002. *National Vital Statistics Reports*, *53*(5). Hyattsville, MD: National Center for Health Statistics. DHHS Publication No. (PHS) 2005-1120

Population figures source: Table I, p. 108, of the National Center for Health Statistics (Kochanek et al., 2004) publication above.

$$\text{suicide rate} = \frac{\text{number of suicides by group}}{\text{population of group}} \times 100{,}000$$

Suicide Data Page: 2002
16 October 2004
Prepared for *AAS* by John L. McIntosh, Ph.D.

U.S.A. SUICIDE: 2001 OFFICIAL FINAL DATA

	Number	Per Day	Rate	% of Deaths	Group (Number of Sui.)	Rate
Nation	30,622	83.9	10.8	1.3	White Male (22,328)	19.5
Males	24,672	67.6	17.6	2.1	White Female (5,382)	4.6
Females	5,950	16.3	4.1	0.5	Nonwhite Male (2,344)	9.3
Whites	27,710	75.9	11.9	1.3	Nonwhite Female (568)	2.1
Nonwhites	2,912	8.0	5.6	0.9	Black Male (1,627)	9.2
Blacks	1,957	5.4	5.3	0.7	Black Female (330)	1.7
Elderly (65+ yrs.)	5,393	14.8	15.3	0.3	Hispanic (1850)	5.0
Young (15-24 yrs.)	3,971	10.9	9.9	12.3		

Completions: ***suicide rate increased slightly in 2001 (from 2000) after declines for six consecutive years and a steady 2000 rate***

- Average of 1 person every 17.2 minutes killed themselves.
- Average of 1 old person every 1 hour 37.5 minutes killed themselves.
- Average of 1 young person every 2 hours 12.4 minutes killed themselves. (If the 279 suicides below age 15 are included, 1 young person every 2 hours 3.7 minutes)
- 11th ranking cause of death in U.S.— 3rd for **young**
- 4.1 male deaths by suicide for each female death by suicide.
- Suicide ranks 11th as a cause of death; Homicide ranks 13th

Cause	Number	Rate
All Causes	32,252	80.7
1-Accidents	14,411	36.1
2-Homicide	5,297	13.3
3-Suicide	3,971	9.9

Attempts (figures are estimates; no official U.S. national data are compiled):

- 765,000 annual attempts in U.S. (using 25:1 ratio)
- 25 attempts for every death by suicide for nation. 100-200:1 for young; 4:1 for elderly.
- 5 million living Americans (estimate) have attempted to kill themselves.
- 3 female attempts for each male attempt.

Survivors (i.e., family members and friends of a loved one who died by suicide):

- Each suicide intimately affects at least 6 other people. (estimate)
- Based on the over 742,000 suicides from 1977 through 2001, estimated that the number of survivors of suicides in the U.S. is 4.45 million (1 of every 64 Americans in 2001); number grew by nearly 184,000 in 2001.
- If there is a suicide every 17 minutes, then there are 6 new survivors every 17 minutes as well.

Suicide Methods	Number	Rate	Percent of Total		Number	Rate	Percent of Total
Firearm suicides	16,869	5.9	55.1%	All Other	13,753	4.8	44.9%
Suffocation/Hanging	6,198	2.2	20.2%	Poisoning	5,191	1.8	17.0%
Falls	651	0.2	2.1%	Cut/pierce	458	0.2	1.5%
Drowning	339	0.1	1.1%	Fire/flame	147	0.1	0.5%

U.S.A. Suicide Rates 1990-2001

(Rates per 100,000 population)

Group/ Age	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
5-14	0.8	0.7	0.9	0.9	0.9	0.9	0.8	0.8	0.8	0.6	0.8	0.7
15-24	13.2	13.1	13.0	13.5	13.8	13.3	12.0	11.4	11.1	10.3	10.4	9.9
25-34	15.2	15.2	14.5	15.1	15.4	15.4	14.5	14.3	13.8	13.5	12.8	12.8
35-44	15.3	14.7	15.1	15.1	15.3	15.2	15.5	15.3	15.4	14.4	14.6	14.7
45-54	14.8	15.5	14.7	14.5	14.4	14.6	14.9	14.7	14.8	14.2	14.6	15.2
55-64	16.0	15.4	14.8	14.6	13.4	13.3	13.7	13.5	13.1	12.4	12.3	13.1
65-74	17.9	16.9	16.5	16.3	15.3	15.8	15.0	14.4	14.1	13.6	12.6	13.3
75-84	24.9	23.5	22.8	22.3	21.3	20.7	20.0	19.3	19.7	18.3	17.7	17.4
85+	22.2	24.0	21.9	22.8	23.0	21.6	20.2	20.8	21.0	19.2	19.4	17.5
65+	20.5	19.7	19.1	19.0	18.1	18.1	17.3	16.8	16.9	15.9	15.3	15.3
Total	12.4	12.2	12.0	12.1	12.0	11.9	11.6	11.4	11.3	10.7	10.7	10.8
Men	20.4	20.1	19.6	19.9	19.8	19.8	19.3	18.7	18.6	17.6	17.5	17.6
Women	4.8	4.7	4.6	4.6	4.5	4.4	4.4	4.4	4.4	4.1	4.1	4.1
White	13.5	13.3	13.0	13.1	12.9	12.9	12.7	12.4	12.4	11.7	11.7	11.9
Nonwh	7.0	6.8	6.8	7.1	7.2	6.9	6.7	6.5	6.2	6.0	5.9	5.6
Black	6.9	6.7	6.8	7.0	7.0	6.7	6.5	6.2	5.7	5.6	5.6	5.3

15 Leading Causes of Death in the U.S.A., 2001

(total of 2,416,425 deaths; 848.5 rate)

Rank & Cause of Death	Rate	Deaths
1 Diseases of heart (heart disease)	245.8	700,142
2 Malignant neoplasms (cancer)	194.4	553,768
3 Cerebrovascular diseases (stroke)	57.4	163,538
4 Chronic lower respiratory diseases	43.2	123,013
5 Accidents (unintentional injuries)	35.7	101,537
6 Diabetes mellitus (diabetes)	25.1	71,372
7 Influenza & pneumonia	21.8	62,034
8Alzheimer's disease	18.9	53,852
9 Nephritis, nephrosis (kidney disease)	13.9	39,480
10 Septicemia	11.3	32,238
11 Suicide [Intentional Self-Harm]	**10.8**	**30,622**
12 Chronic liver disease and cirrhosis	9.5	27,035
13 Homicide [Assault]	7.1	20,308
14 Essential hypertension and renal disease	6.8	19,250
15 Pneumonitis due to solids and liquids	6.1	17,301
- All other causes (Residual)	140.8	400,935

Old made up 12.4% of 2001 population but represented 17.6% of the suicides.
Young were 14.0% of 2001 population and comprised 13.0% of the suicides.

Official data source: Arias, E., Anderson, R.N., Kung, H.C., Murphy, S.L., & Kochanek, K.D. (2003). Deaths: Final data for 2001. *National Vital Statistics Reports, 52*(3). Hyattsville, MD: National Center for Health Statistics. DHHS Publication No. (PHS) 2003-1120. [Data to be published in the CD-ROM annual volume entitled *Vital Statistics of the United States, Mortality, 2001*.]

Population figures source: Table I, p. 106, of the National Center for Health Statistics (Arias et al., 2003) publication above.

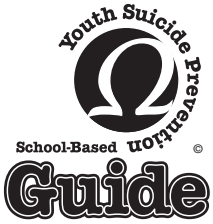
$$\text{suicide rate} = \frac{\text{number of suicides by group}}{\text{population of group}} \times 100{,}000$$

Suicide Data Page: 2001

26 September 2003

Prepared for *AAS* by John L. McIntosh, Ph.D.

Notes



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