School Interventions to Prevent Youth Suicide

I. On Suicide and its Prevention

A. About Youth Suicide/Depression/Violence

"I am sad all the time."

"I do everything wrong."

"Nothing is fun at all."

items from the
"Children's Depression Inventory"

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

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

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

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

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

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

About Violence

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

Violence in schools is a complex issue. Students assault teachers, strangers harm children, students hurt each other, and any one of the parties may come to school already damaged and violated [e.g., physically, sexually, emotionally, or negligently at home or on their way to or from school]. *The kind of violence an individual encounters varies also, ranging from mere bullying to rape or murder.*[5]

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

About Suicide and Depression

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

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

Numbers for depression vary. The National Institute of Mental Health's figure is 1.5 million children and adolescents. The American Academy of Child and Adolescent Psychiatry estimates 3.0 million.

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

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

Linked Problems

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

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

Risk Factors

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

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

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

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

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

E. 19. Constitutional Factors

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

General Guidelines for Prevention

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

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

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

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

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

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

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

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

Suicide Prevention

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

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

Enhancing Protective Factors and Building Assets

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

Community and School Protective Factors

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

Family and Peer Protective Factors

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

Individual Protective Factors

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

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

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

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

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

- a positive attitude toward life
- self-awareness -- for example, developing realistic expectations about oneself

Behavioral

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

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

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

System Change

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

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

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

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

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

What is a psychological sense of community?

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

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

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

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

Knowing What to Look For & What to Do

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

Concluding Comments

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

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

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

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

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

A Few Resource Aids

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

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

Some Websites:

National Institute of Mental Health
                http://www.nimh.nih.gov
National School Safety Center
                http://nssc1.org
Youth Suicide Prevention Program
                http://www.yspp.org/
Suicide Resources on the Internet
                http://psychcentral.com/helpme.htm

Facts at a Glance   2015

Suicide

- Suicide was the tenth leading cause of death for all ages in 2013.[1]

- There were 41,149 suicides in 2013 in the United States—a rate of 12.6 per 100,000 is equal to 113 suicides each day or one every 13 minutes.[1]

- Based on data about suicides in 16 National Violent Death Reporting System states in 2010, 33.4% of suicide decedents tested positive for alcohol, 23.8% for antidepressants, and 20.0% for opiates, including heroin and prescription pain killers.[2]

- Suicide results in an estimated $51 billion in combined medical and work loss costs.[1]

Nonfatal Suicidal Thoughts and Behavior

- Among adults aged ≥18 years in the United States during 2013:[3]

  - An estimated 9.3 million adults (3.9% of the adult U.S. population) reported having suicidal thoughts in the past year.

  - The percentage of adults having serious thoughts about suicide was highest among adults aged 18 to 25 (7.4%), followed by adults aged 26 to 49 (4.0%), then by adults aged 50 or older (2.7%).

  - An estimated 2.7 million people (1.1%) made a plan about how they would attempt suicide in the past year.

  - The percentage of adults who made a suicide plan in the past year was higher among adults aged 18 to 25 (2.5%) than among adults aged 26 to 49 (1.35%) and those aged 50 or older (0.6%).

  - An estimated 1.3 million adults aged 18 or older (0.6%) attempted suicide in the past year. Among these adults who attempted suicide, 1.1 million also reported making suicide plans (0.2 million did not make suicide plans).

- Among students in grades 9-12 in the U.S. during 2013:[4]

  - 17.0% of students seriously considered attempting suicide in the previous 12 months (22.4% of females and 11.6% of males).

  - 13.6% of students made a plan about how they would attempt suicide in the previous 12 months (16.9% of females and 10.3% of males).

  - 8.0% of students attempted suicide one or more times in the previous 12 months (10.6% of females and 5.4% of males).

  - 2.7% of students made a suicide attempt that resulted in an injury, poisoning, or an overdose that required medical attention (3.6% of females and 1.8% of males).

Gender Disparities

- Males take their own lives at nearly four times the rate of females and represent 77.9% of all suicides.[1]

- Females are more likely than males to have suicidal thoughts.[3]

- Suicide is the seventh leading cause of death for males and the fourteenth leading cause for females.[1]

- Firearms are the most commonly used method of suicide among males (56.9%).[1]

- Poisoning is the most common method of suicide for females (34.8%).[1]

Suicide Facts at a Glance 2015

Racial and Ethnic Disparities

• Suicide is the eighth leading cause of death among American Indians/Alaska Natives across all ages.[1]

• Among American Indians/Alaska Natives aged 10 to 34 years, suicide is the second leading cause of death.[1]

• The suicide rate among American Indian/Alaska Native adolescents and young adults ages 15 to 34 (19.5 per 100,000) is 1.5 times higher than the national average for that age group (12.9 per 100,000).[1]

• The percentages of adults aged 18 or older having suicidal thoughts in the previous 12 months were 2.9% among blacks, 3.3% among Asians, 3.6% among Hispanics, 4.1% among whites, 4.6% among Native Hawaiians /Other Pacific Islanders, 4.8% among American Indians/Alaska Natives, and 7.9% among adults reporting two or more races.[3]

• Among Hispanic students in grades 9-12, the prevalence of having seriously considered attempting suicide (18.9%), having made a plan about how they would attempt suicide (15.7%), having attempted suicide (11.3%), and having made a suicide attempt that resulted in an injury, poisoning, or overdose that required medical attention (4.1%) was consistently higher than white and black students.[4]

Age Group Differences

• Suicide is the third leading cause of death among persons aged 10-14, the second among persons aged 15-34 years, the fourth among persons aged 35-44 years, the fifth among persons aged 45-54 years, the eighth among person 55-64 years, and the seventeenth among persons 65 years and older.[1]

• In 2011, middle-aged adults accounted for the largest proportion of suicides (56%)[1], and from 1999-2010, the suicide rate among this group increased by nearly 30%.[5]

• Among adults aged 18-22 years, similar percentages of full-time college students and other adults in this age group had suicidal thoughts (8.0 and 8.7%, respectively) or made suicide plans (2.4 and 3.1%).[3]

• Full-time college students aged 18-22 years were less likely to attempt suicide (0.9 vs. 1.9 percent) or receive medical attention as a result of a suicide attempt in the previous 12 months (0.3 vs. 0.7%).[3]

Nonfatal, Self-Inflicted Injuries*

• In 2013, 494,169 people were treated in emergency departments for self-inflicted injuries.[1]

• Nonfatal, self-inflicted injuries (including hospitalized and emergency department treated and released) resulted in an estimated $10.4 billion in combined medical and work loss costs.[1]

References

1. Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2013, 2011) National Center for Injury Prevention and Control, CDC (producer). Available from http://www.cdc.gov/injury/wisqars/index.html.

2. Parks SE, Johnson LL, McDaniel DD, Gladden M. Surveillance for Violent Deaths– National Violent Death Reporting System, 16 states, 2010. MMWR 2014; 63(ss01): 1-33. Available from http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm.

3. Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD: Substance Abuse and Mental Health Services, 2014. Available at http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf.

4. Kann L, Kinchen S, Shanklin SL, et al. Youth Risk Behavior Surveillance — United States, 2013. MMWR 2014; 63(ss04): 1-168. Available from http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6304a1.htm.

5. Sullivan EM, Annest JL, Luo F, Simon TR, Dahlberg LL. Suicide Among Adults Aged 35-36 Years – United States, 1999-2010. MMWR 2013; 62(17): 321-325. Available from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6217a1.htm.

*The term "self-inflicted injuries" refers to suicidal and non-suicidal behaviors such as self-mutilation.

Trends in the Prevalence of Suicide–Related Behavior
National YRBS: 1991—2015

The national Youth Risk Behavior Survey (YRBS) monitors priority health risk behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults in the United States. The national YRBS is conducted every two years during the spring semester and provides data representative of 9th through 12th grade students in public and private schools throughout the United States.

Percentages													Change from 1991–2015[1]	Change from 2013–2015[2]
1991	1993	1995	1997	1999	2001	2003	2005	2007	2009	2011	2013	2015		
Seriously considered attempting suicide (during the 12 months before the survey)														
29.0	24.1	24.1	20.5	19.3	19.0	16.9	16.9	14.5	13.8	15.8	17.0	17.7	Decreased 1991—2015 Decreased 1991—2009 Increased 2009—2015	No change
Made a plan about how they would attempt suicide (during the 12 months before the survey)														
18.6	19.0	17.7	15.7	14.5	14.8	16.5	13.0	11.3	10.9	12.8	13.6	14.6	Decreased 1991—2015 Decreased 1991—2009 Increased 2009—2015	No change
Attempted suicide (one or more times during the 12 months before the survey)														
7.3	8.6	8.7	7.7	8.3	8.8	8.5	8.4	6.9	6.3	7.8	8.0	8.6	Decreased 1991—2015 No change 1991— 2015	No change
Attempted suicide that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (during the 12 months before the survey)														
1.7	2.7	2.8	2.6	2.6	2.6	2.9	2.3	2.0	1.9	2.4	2.7	2.8	No change 1991—2015	No change

[1] Based on linear and quadratic trend analyses using logistic regression models controlling for sex, race/ethnicity, and grade, $p < 0.05$. Significant linear trends (if present) across all available years are described first followed by linear changes in each segment of significant quadratic trends (if present).
[2] Based on t-test analysis, $p < 0.05$.

C. Common Myths

THE MYTHS & FACTS OF YOUTH SUICIDE

http://suicideprevention.nv.gov/Youth/Myths/

Office of Suicide Prevention

If you or someone you know is in crisis, please call:

SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

isit the National Suicide Prevention Lifeline website

Notice: This informational website is not intended as a crisis response or hotline. Local crisis hotline numbers can be found in the front of your local phone book or call 911.

COMMONLY-HELD INCORRECT BELIEFS ABOUT SUICIDE

These myths of suicide stand in the way of providing assistance for those who are in danger. By removing the myths, those responsible for the care and education of young people will be more able to recognize those who are at risk and provide the help that is needed.

MYTH: Talking about suicide or asking someone if they feel suicidal will encourage suicide attempts.

FACT: Talking about suicide provides the opportunity for communication. Fears that are shared are more likely to diminish. The first step in encouraging a suicidal person to live comes from talking about those feelings That first step can be the simple inquiry about whether or not the person is intending to end their life. However, talking about suicide should be carefully managed.

MYTH: Young people who talk about suicide never attempt or complete suicide.

FACT: Talking about suicide can be a plea for help and it can be a late sign in the progression towards a suicide attempt. Those who are most at risk will show other signs apart from talking about suicide. If you have concerns about a young person who talks about suicide:

- Encourage him/her to talk further and help them to find appropriate counseling assistance.
- Ask if the person are thinking about making a suicide attempt.
- Ask if the person has a plan.
- Think about the completeness of the plan and how dangerous it is. Do not trivialise plans that seem less complete or less dangerous. All suicidal intentions are serious and must be acknowledged as such.
- Encourage the young person to develop a personal safety plan. This can include time spent with others, check-in points with significant adults/ plans for the future.

MYTH: A promise to keep a note unopened and unread should always be kept.

FACT: Where the potential for harm, or actual harm, is disclosed then confidentiality cannot be maintained. A sealed note with the request for the note not to be opened is a very strong indicator that something is seriously amiss. A sealed note is a late sign in the progression towards suicide.

MYTH: Attempted or completed suicides happen without warning.

FACT: The survivors of a suicide often say that the intention was hidden from them. It is more likely that the intention was just not recognized. These warning signs include:

- The recent suicide, or death by other means, of a friend or relative.
- Previous suicide attempts.
- Preoccupation with themes of death or expressing suicidal thoughts.
- Depression, conduct disorder and problems with adjustment such as substance abuse, particularly when two or more of these are present.
- Giving away prized possessions/ making a will or other final arrangements.
- Major changes in sleep patterns - too much or too little.
- Sudden and extreme changes in eating habits/ losing or gaining weight.
- Withdrawal from friends/ family or other major behavioral changes.

- Dropping out of group activities.
- Personality changes such as nervousness, outbursts of anger, impulsive or reckless behavior, or apathy about appearance or health.
- Frequent irritability or unexplained crying.
- Lingering expressions of unworthiness or failure.
- Lack of interest in the future.
- A sudden lifting of spirits, when there have been other indicators, may point to a decision to end the pain of life through suicide.

MYTH: If a person attempts suicide and survives, they will never make a further attempt.

FACT: A suicide attempt is regarded as an indicator of further attempts. It is likely that the level of danger will increase with each further suicide attempt.

MYTH: Once a person is intent on suicide, there is no way of stopping them.

FACT: Suicides can be prevented. People can be helped. Suicidal crises can be relatively short-lived. Suicide is a permanent solution to what is usually a temporary problem. Immediate practical help such as staying with the person, encouraging them to talk and helping them build plans for the future, can avert the intention to attempt or complete suicide. Such immediate help is valuable at a time of crisis, but appropriate counselling will then be required.

MYTH: People who threaten suicide are just seeking attention.

FACT: All suicide attempts must be treated as though the person has the intent to die. Do not dismiss a suicide attempt as simply being an attention-gaining device. It is likely that the young person has tried to gain attention and, therefore, this attention is needed. The attention that they get may well save their lives.

MYTH: Suicide is hereditary.

FACT: Although suicide can be over-represented in families, it is attempts not genetically inherited. Members of families share the same emotional environment, and the completed suicide of one family member may well raise the awareness of suicide as an option for other family members.

MYTH: Only certain types of people become suicidal.

FACT: Everyone has the potential for suicide. The evidence is that predisposing conditions may lead to either attempted or completed suicides. It is unlikely that those who do not have the predisposing conditions (for example, depression, conduct disorder, substance abuse, feeling of rejection, rage, emotional pain and anger) will complete suicide.

MYTH: Suicide is painless.

FACT: Many suicide methods are very painful. Fictional portrayals of suicide do not usually include the reality of the pain.

MYTH: Depression and self-destructive behavior are rare in young people.

FACT: Both forms of behavior are common in adolescents. Depression may manifest itself in ways which are different from its manifestation in adults but it is prevalent in children and adolescents. Self-destructive behavior is most likely to be shown for the first time in adolescence and its incidence is on the rise.

MYTH: All suicidal young people are depressed.

FACT: While depression is a contributory factor in most suicides, it need not be present for suicide to be attempted or completed .

MYTH: Marked and sudden improvement in the mental state of an attempter following a suicidal crisis or depressive period signifies that the suicide risk is over.

FACT: The opposite may be true. In the three months following an attempt, a young person is at most risk of completing suicide. The apparent lifting of the problems could mean the person has made a firm decision to commit suicide and feels better because of this decision.

MYTH: Once a young person is suicidal, they will be suicidal forever.

FACT: Most young people who are considering suicide will only be that way for a limited period of their lives. Given proper assistance and support, they will probably recover and continue to lead meaningful and happy lives unhindered by suicidal concerns.

MYTH: Suicidal young people cannot help themselves.

FACT: While contemplating suicide, young people may have a distorted perception of their actual life situation and what solutions are appropriate for them to take. However, with support and constructive assistance from caring and informed people around them, young people can gain full self-direction and self-management in their lives.

MYTH: The only effective intervention for suicide comes from professional psychotherapists with extensive experience in the area.
FACT: All people who interact with suicidal adolescents can help them by way of emotional support and encouragement. Psychotherapeutic interventions also rely heavily on family, and friends providing a network of support.

MYTH: Most suicidal young people never seek or ask for help with their problems.
FACT: Evidence shows that they often tell their school peers of their thoughts and plans. Most suicidal adults visit a medical doctor during the three months prior to killing themselves. Adolescents are more likely to 'ask' for help through non-verbal gestures than to express their situation verbally to others.

MYTH: Suicidal young people are always angry when someone intervenes and they will resent that person afterwards.
FACT: While it is common for young people to be defensive and resist help at first, these behaviours are often barriers imposed to test how much people care and are prepared to help. For most adolescents considering suicide, it is a relief to have someone genuinely care about them and to be able to share the emotional burden of their plight with another person. When questioned some time later, the vast majority express gratitude for the intervention.

MYTH: Break-ups in relationships happen so frequently, they do not cause suicide.
FACT: Suicide can be precipitated by the loss of a relationship.

MYTH: Suicidal young people are insane or mentally ill.
FACT: Although suicidal adolescents are likely to be extremely unhappy and may be classified as having a mood disorder, such as depression, most are not legally insane. However, there are small numbers of individuals whose mental state meets psychiatric criteria for mental illness and who need Psychiatric help.

MYTH: Most suicides occur in winter months when the weather is poor.
FACT: Seasonal variation data are essentially based on adult suicides, with limited adolescent data available. However, it seems adolescent suicidal behavior is most common during the spring and early summer months.

MYTH: Suicide is much more common in young people from higher (or lower) socioeconomic status (SES) areas.
FACT: The causes of suicidal behavior cut across SES boundaries. While the literature in the area is incomplete, there is no definitive link between SES and suicide. This does not preclude localized tendencies nor trends in a population during a certain period of time.

MYTH: Some people are always suicidal.
FACT: Nobody is suicidal at all times. The risk of suicide for any individual varies across time, as circumstances change. This is why it is important for regular assessments of the level of risk in individuals who are 'at risk'.

MYTH: Every death is preventable.
FACT: No matter how well intentioned, alert and diligent people's efforts may be, there is no way of preventing all suicides from occurring.

MYTH: The main problem with preventive efforts is trying to implement strategies in an extremely grey area.
FACT: The problem is that we lack a complete understanding of youth suicide and know more about what is not known than what is fact.

REFERENCES
- National Mental Health Association
- Youth Suicide Prevention Education Program
- The Trevor Project

D. Risk and Protective Factors

Suicide: Risk and Protective Factors

Risk Factors for Suicide

A combination of individual, relational, community, and societal factors contribute to the risk of suicide. Risk factors are those characteristics associated with suicide—they might not be direct causes.
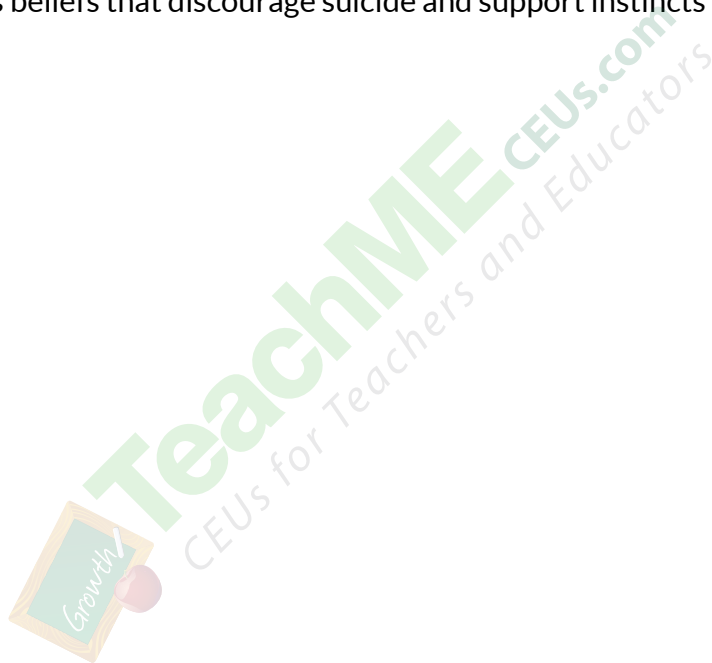
Risk Factors

- Family history of suicide
- Family history of child maltreatment
- Previous suicide attempt(s)
- History of mental disorders, particularly clinical depression
- History of alcohol and substance abuse
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma)
- Local epidemics of suicide
- Isolation, a feeling of being cut off from other people
- Barriers to accessing mental health treatment
- Loss (relational, social, work, or financial)
- Physical illness
- Easy access to lethal methods
- Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts

Protective Factors for Suicide

Protective factors buffer individuals from suicidal thoughts and behavior. To date, protective factors have not been studied as extensively or rigorously as risk factors. Identifying and understanding protective factors are, however, equally as important as researching risk factors.

Protective Factors

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Family and community support (connectedness)
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes
- Cultural and religious beliefs that discourage suicide and support instincts for self-preservation

D. Risk and Protective Factors (cont.)

Developmental Trajectories of Suicidal Thoughts and Behaviors From Adolescence Through Adulthood. D.B. Goldston, A. Erkanli, S. S. Daniel, N. Heilbron, B.E. Weller, & O. Doyle (2016). *Journal of the American Academy of Child Adolescent Psychiatry, 55*, 400–407.

Objective: Little is known about the patterns among individuals in the long-term course of suicidal thoughts and behaviors (STBs). The objective of this study was to identify developmental trajectories of STBs from adolescence through young adulthood, as well as risk and protective covariates, and nonsuicidal outcomes associated with these trajectories.

Method: A total of 180 adolescents (ages 12–18 years at recruitment) were repeatedly assessed over an average of 13.6 years (2,273 assessments) since their psychiatric hospitalization. Trajectories were based on ratings of STBs at each assessment. Covariates included psychiatric risk factors (proportion of time in episodes of psychiatric disorders, hopelessness, trait anxiety, impulsivity, and aggression in adulthood, sexual and physical abuse, parental history of suicidal behavior), protective factors (survival and coping beliefs, social support in adulthood, parenthood), and nonsuicidal outcomes (social adjustment and functional impairment in adulthood, school drop-out, incarcerations).

Results: Using a Bayesian group-based trajectory model, 4 trajectories of STBs were identified: an increasing risk class (11%); a highest overall risk class (12%); a decreasing risk class (33%); and a low risk class (44%). The 4 classes were associated with distinct patterns of correlates in risk and protective factors and nonsuicidal outcomes.

Conclusion: Adolescents and young adults have heterogeneous developmental trajectories of STBs. These trajectories and their covariates may inform strategies for predicting STBs and targeting interventions for individuals at risk for suicidal behavior.

E. About Prevention

(1) About Strategies

Suicide: Prevention Strategies

http://www.cdc.gov/ViolencePrevention/suicide/prevention.html

Suicide is a serious but preventable public health problem that can have lasting harmful effects on individuals, families, and communities. While its causes are complex, the goals of suicide prevention is simple—reduce factors that increase risk and increase factors that promote resilience or coping. With a public health approach, prevention occurs at all levels of society—from the individual, family, and community levels to the broader social environment. Effective prevention strategies are needed to promote awareness of suicide while also promoting prevention, resilience, and a commitment to social change.

A public health approach to suicide prevention may be undertaken using the following resources:

Strategizing for Suicide Prevention

- National Strategy for Suicide Prevention (Department of Health and Human Services) (http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/) This revised national strategy emphasizes the role every American can play in protecting their friends, family members, and colleagues from suicide. It also provides guidance for schools, businesses, health systems, clinicians and many other sectors that takes into account nearly a decade of research and other advancements in the field since the last strategy was published.

- Strategic Direction for the Prevention of Suicidal Behavior: Promoting Individual, Family, and Community Connectedness to Prevent Suicidal Behavior   [PDF 507KB] This document describes a five-year vision for the CDC's work to prevent fatal and nonfatal suicidal behavior. Our key strategy is promoting individual, family, and community connectedness.

- State Suicide Prevention Planning: A CDC Research Brief   [PDF 4MB] This document summarizes the results of a CDC research study conducted to describe the key ingredients of successful state-based suicide prevention planning.

Effective and Promising Programs

- Best Practices Registry: Suicide Prevention Resource Center (http://www.sprc.org/bpr)
  The Suicide Prevention Resource Center (SPRC), in collaboration with the American Foundation for Suicide Prevention, maintains the *Best Practices Registry* (BPR). This registry, funded by the Substance Abuse and Mental Health Services Administration, identifies, reviews, and disseminates information about best practices that address specific objectives of the *National Strategy for Suicide Prevention*.
- SAMHSA's National Registry of Evidence-Based Programs and Practices (http://www.nrepp.samhsa.gov)
  The National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers.

Reviews of Preventive Interventions

- Beautrais A, Fergusson D, Coggan C, Collings C, Doughty C, Ellis P, Hatcher S, Horwood J, Merry S, Mulder R, Poulton R, Surgenor L. Effective strategies for suicide prevention in New Zealand: a review of the evidence. N Z Med. 2007; 120(1251), U2459.
- Brown GK, Green KL. A review of evidence-based follow-up care for suicide prevention. *American Journal of Preventive Medicine*, 2014; 47(3S2):S209–S215.
- Gould MS, Greenberg T, Velting DM & Shaffer D. Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry,* 2003; 42:386-405.
- Krug, EG, Dahlberg, LL, Mercy, JA, Zwi, AB, and Lozano. R. (2002). Chapter 7. Self-Directed Violence. In the World Report on Violence and Health Geneva, World Health Organization [PDF 239KB] (http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap7.pdf) .
- Mann JJ, Apter A, Bertolote J, et al. Suicide prevention strategies: a systematic review. *Journal of the American Medical Association* 2005; 294:2064-74.
- National Research Council. *Reducing Suicide: A National Imperative* (http://www.nap.edu/books/0309083214/html) . Washington, DC: The National Academies Press, 2002.
- O'Neil ME, Peterson K, Low A, Carson S, Denneson LM, Haney E, Shiroma P and Kansagara D. Suicide Prevention Interventions and Referral/Follow-up Services: A Systematic Review. VA-ESP Project #05-225; 2012.

Other Resources

- Preventing Suicide: Program Activities Guide
  Describes CDC's public health activities and research to prevent suicide and suicidal behavior.

(2) 2012 NATIONAL STRATEGY FOR SUICIDE PREVENTION

A Comprehensive Approach to Suicide Prevention

This description highlights some of the many clinical and community services and supports that should be available to a person who struggles with depression and thoughts of suicide.

In the community, when the person interacts with family members, friends, physicians, and others:

- Reduced prejudice about mental disorders and suicide makes it more likely that the person will let others know about symptoms and seek help;

- Responsible media reporting of mental illness and suicide reduces prejudice and prevents contagion;

- A well-implemented public awareness campaign raises cognizance of the signs and symptoms of mental disorders and risks for suicide and of where help is available locally;

- Training of community service providers makes it easier to identify the person at risk and increases appropriate referrals;

- Systems are in place to ensure that the person is referred to and safely transported to the appropriate facility for evaluation; and

- Reducing access to lethal means makes it less likely that the person will engage in suicidal behaviors.

At the primary care provider or emergency department:

- Screening improves the likelihood that the person will receive appropriate evaluation and treatment;

- Training on recognition of risk and quality of care increases the likelihood of a good outcome;

- The care provider accurately diagnoses and records the problems and ensures that the appropriate public health surveillance systems are notified or made aware of the diagnoses;

- The implementation of trauma-informed policies and practices ensures that the person is treated with respect and in a way that promotes healing and recovery;

- Easy access to mental health care referrals for individuals with suicide risk increases the likelihood of a better outcome;

- Education efforts by health care providers increase knowledge of the warning signs of suicide risk among the individual and his or her family and/or support network; and

- Continuous care and improved aftercare leads to better monitoring and followup of the at-risk individual over time.

In the community, while receiving care:

- Reduced prejudice regarding mental health issues and suicide leads to greater acceptance by family members and friends;

- The availability of high-quality mental health services that are linguistically and culturally appropriate makes it less likely that depression or related problems will recur;

- Sharing information, with the person's permission, among care providers allows treatment to be better coordinated and collaborative; and

- Resources are available to offer social support, resiliency training, problem-solving skills, and other protective factors to the person and his or her family members and/or support network.

(3) Should schools get involved?

SUICIDE PREVENTION: FACTS FOR SCHOOLS

"What happened in our district could happen anywhere."

"Every school in our district had a crisis plan if a staff member died of cancer or a student got in a car accident. But suicide . . . it wasn't on my agenda," said a superintendent. "We just did not think it was going to happen here. Unfortunately we learned the hard way. It was only after we had a [death in our school community by] suicide that we realized we needed to take a comprehensive approach to preventing a tragedy like this. And we realized we needed to involve everybody—the school staff, students, parents, and the community."

—Superintendent in a New England School District

Many high school students reported that they had seriously considered suicide in the past year (CDC, 2010a).

- Suicide is the third leading cause of death among teenagers (CDC, 2009a).

- One out of every 53 high school students (1.9 percent) reported having made a suicide attempt that was serious enough to be treated by a doctor or a nurse (CDC, 2010a).

- For each suicide death among young people, there may be as many as 100–200 suicide attempts (McIntosh, 2010).

- Approximately 1 out of every 15 high school students attempts suicide each year (CDC, 2010a).

- The toll among some groups is even higher. For example, the suicide death rate among 15–19-year-old American Indian/Alaska Native males is 2½ times higher than the overall rate for males in that age group (Heron, 2007).

FOUR REASONS WHY SCHOOLS SHOULD ADDRESS SUICIDE

While everyone who cares for and about young people should be concerned with youth suicide, schools have special reasons for taking action to prevent these tragedies:

1. **Maintaining a safe school environment is part of a school's overall mission.** There is an implicit contract that schools have with parents to protect the safety of their children while they are in the school's care. Fortunately, suicide prevention is consistent with many other efforts to protect student safety.

   - Many activities designed to prevent violence, bullying, and the abuse of alcohol and other drugs may also reduce suicide risk among students (Epstein & Spirito, 2009).

- Programs that improve school climate and promote connectedness help reduce risk of suicide, violence, bullying, and substance abuse (Resnick et al., 1997; Blum, McNeely, & Rinehart, 2002).

- Efforts to promote safe schools and adult caring also help protect against suicidal ideation and attempts among LGB youth (Eisenberg & Resnick, 2006).

- Some activities designed to prevent suicide and promote student mental health can reinforce the benefits of other student wellness programs.

2. **Students' mental health can affect their academic performance.** Depression and other mental health issues can interfere with the ability to learn and can affect academic performance. According to the 2009 Youth Risk Behavior Survey (CDC, 2010b):

- Approximately 1 of 2 high school students receiving grades of mostly Ds and Fs felt sad or hopeless. But only 1 of 5 students receiving mostly grades of A felt sad or hopeless.

- 1 out of 5 high school students receiving grades of mostly Ds and Fs attempted suicide. Comparatively, 1 out of 25 who receive mostly A grades attempted suicide.

3. **A student suicide can significantly impact other students and the entire school community.** Knowing what to do following a suicide is critical to helping students cope with the loss and prevent additional tragedies that may occur. Adolescents can be susceptible to suicide contagion (sometimes called the "copycat effect"). This may result in the relatively rare phenomenon of "suicide clusters" (unusually high numbers of suicides occurring in a small area and brief time period) (Gould, Wallenstein, Kleinman, O'Carroll, & Mercy, 1990).

4. **Schools have been sued for negligence for the following reasons** (Doan, Roggenbaum, & Lazear, 2003; Juhnke, Granello, & Granello, 2011; Lieberman, 2008–2009; Lieberman, Poland, & Cowan, 2006):

- Failure to notify parents if their child appears to be suicidal

- Failure to get assistance for a student at risk of suicide

- Failure to adequately supervise a student at risk of suicide

E. About Prevention (cont.)

(3) Should schools get involved? (cont.).

Primary prevention of suicide and suicidal behaviour for adolescents in School Setting

Background

Description of the condition

Worldwide, suicide is amongst the top three causes of death for adolescents, accounting for an estimated 9.1% of all youth deaths (Patton 2009; Wasserman 2005). Best estimates suggest that out of every 100,000 adolescents, 7.4 die due to suicide (Wasserman 2005), and a further 13,000 engage in non-fatal intentional self harm behaviour (Silverman 2007b; WHO 2010), which increases the risk of eventual suicide (Garland 1993; Hawton 1998; Wasserman 2005). Between 1965 and 1999, suicide rates for male adolescents in particular increased dramatically, and these rates have generally only slightly declined since 1999 (Fleming 2007; Patton 2009; Wasserman 2005, but see Windfuhr 2013). Although male adolescents are more likely to die by suicide, female adolescents are most likely to engage in non-fatal suicidal behaviours (Fleming 2007; Patton 2009; Wasserman 2005).

Both adolescent suicide and suicidal behaviour (fatal or non-fatal intentional self harm behaviour, e.g., suicide or suicide attempts; Silverman 2007b) are associated with a consistent but wide-ranging series of risk factors (Beautrais 2000; Bridge 2006; Borowsky 2001; Evans 2004; Gould 2003; Haw 2013; Hawton 2012). Sociodemographic risk factors include social disadvantage (including current financial stressors), gender (males are more at risk for suicide, females for suicidal behaviour), and minority sexual orientation. There is also evidence for genetic and biological vulnerabilities to suicide. Psychological risk factors include prior suicidal behaviour, suicidal ideation, the presence of any psychiatric disorder (but particularly disorders of mood, substance misuse, disruptive/antisocial behaviour, and eating disorders), and aggressive-impulsive behaviour (e.g., in association with personality disorders). Psychosocial risk factors include disconnection to school or work, problems with health, life stressors involving legal or relationships (e.g., relationship losses, family discord, bullying), experiences of physical and/or sexual abuse, and exposure to suicidal behaviour (e.g., familial, peer, media). Access to means also increases vulnerability to suicide. Compared with adults, adolescents represent the most at-risk group for contagion suicides (when individuals become aware of, and imitate, real or fictional suicidal behaviour (Gould 2003b)), or suicide clusters (a group of suicides and/or suicidal behaviour occurring at a similar time, in a similar location CDC 1994), and school settings in particular represent an environmental risk factor for contagion suicides (Larkin 2012). Emotional well-being and family connectedness protect against suicidal behaviour. Specific risk factors vary by sex, ethnicity, and age (Andrews 1992; Borowsky 2001; Fennig 2005; La Vecchia

Description of the intervention

Given that the majority of adolescents (up to the age of 18 years) receive, or are entitled to, formal education, many suicide prevention programmes have been implemented in secondary schools, to target this convenience sample. In general, suicide prevention programmes can occur at one of three levels: universal programmes target all adolescents within a population; selective programmes target subgroups who possess one or more risk factors for suicidal behaviours; and indicated programmes target specific individuals who are known to be at-risk for suicidal behaviour (Institute of Medicine 1994; Kalafat 2003).

In general, school-based prevention programmes are usually either universal or selective. Common universal suicide prevention programmes include gatekeeper training programmes (brief training in a one or two workshop format, designed to teach adults who work with adolescents, such as teachers and counsellors, to recognise students who are at-risk, and provide, or refer them for, support), peer support programmes (brief training designed to place students in leadership roles, and then teach them to recognise, support, and refer at-risk peers), suicide awareness education programmes (short-term classroom-based teaching, designed to provide information to students about suicide, how to identify risk in oneself or peers, and how

to seek help), and skills development programmes (classroom-based teaching over a medium-term period (i.e., less than a term), designed to teach students specific skills as protective factors, such as coping skills, problem solving, and cognitive skills) (Gould 2003; Katz 2013; Lake 2011). Universal programmes are either administered by qualified external personnel, or by teachers who are known to the students and who are trained as administrators.

The most common selective suicide prevention programmes are screening programmes, in which trained school staff or external personnel administer self report questionnaires or interviews to identify at-risk students (e.g., students displaying suicidal ideation, substance use problems, or depression), and then these students are referred for mental health treatment, or to take part in a prevention programme (e.g., skills development) (Bursztein 2011; Eckert 2009; Eggert 1995; Guo 2002; Silbert 1991; Thompson 2000; Thompson 2001).

Indicated suicide prevention programmes would target students who had engaged in suicidal behaviour, or had indicated suicidal behavioural intent (e.g., cognitive behavioural therapy for individuals who were known to have experienced suicidal ideation, or suicidal behaviour, e.g., Spirito 2011; Tarrier 2008, or dialectical behavioural therapy for individuals with a history of suicidal behaviour, Rathus 2002). Given that the aim of prevention programmes is usually to intervene prior to suicidal behaviour, across either an at-risk (selected) or population level group (universal), individual, indicated programmes are less likely to be the focus of suicidal prevention efforts.

E. About Prevention (cont.)

(4) Issues About School Involvement

Does Suicide Education Stigmatize Some Students &

Increase the Risk of Suicide Ideation?

Educational programs to prevent student suicide are designed to increase student and faculty knowledge of the phenomena. They typically focus on informing students about warning signs and where to get help in times of crisis.

Concerns have been raised that increased knowledge may have some negative consequences. For one, it has been suggested that such programs may inadvertently add to the tendency to stigmatize those in are identified as needing help. In turn, the stigmatization may cause suffering students to be less willing to get help and exacerbate their negative feelings about self and others. There is also concern that increased knowledge may contribute to the type of "suicide contagion" among students that has been reported following a peer's suicide.

Examples of what one hears:

Universal suicide education programs in schools are essential because they teach "at-risk" students where to find help, and they give others the ability to recognize when their peers are at risk.

Students "at-risk" for suicide already feel socially isolated; putting a spotlight on them will make them feel worse.

Suicide education programs can promote mental health in schools, and they are easy to implement.

Suicide education teaches students how to commit suicide if they didn't know how ro already.

Formal Positions:

- *Pro* – Those in favor of universal suicide education in schools see the programs as an efficient (easy to implement) and effective suicide prevention strategy. They argue knowledge is power – "at-risk" individuals benefit from info on how to receive help and their peers learn warning signs so they can play a role in ensuring those "at risk" are guided to help. Moreover, they suggest that the programs can have additional mental health benefits.

- *Con* – Those who argue against suicide education in schools stress that such programs can prompt suicidal thinking, teach suicide as an acceptable option in responding to problems (and even glorify suicide), teach students how to do it, and contribute to a contagion effect.
  Additionally, they warn that promoting awareness and vigilance for suicide warning signs may increase the stigma surrounding mental health concerns and exacerbate hesitation in seeking help.

- *Pro with reservations* – This position stresses that, unless the programs are well designed and implemented by highly qualified professionals, there is a significant danger of producing some of the negative effects that are raised by those who argue against suicide education in schools. In such cases, these programs could end up doing more harm than good.

Examples of Documents Related to the Issue:

(a) Related to Both Sides

>>*Media Contagion and Suicide Among the Young* by M. Gould, P. Jameson, & D. Romer –
http://www.columbia.edu/itc/hs/medical/bioethics/nyspi/material/MediaContagionAndSuicide.pdf

>>*Stigma and Suicide* by Prevent Suicide Now.com –
http://www.preventsuicidenow.com/stigma-and-suicide.html

>>*Stigma: Building Awareness And Understanding About Mental Illness* by the National Mental
Health Association – http://www.nmha.org/infoctr/factsheets/14.cfm

>>*Suicide Contagion and the Reporting of Suicide: Recommendations from a National
Workshop* by the Center for Disease Control –
http://wonder.cdc.gov/wonder/prevguid/m0031539/m0031539.asp

>> *Summary of National Strategy for Suicide Prevention: Goals and Objectives for Action*
by the U.S. Department of Health and Human Services –
http://www.mentalhealth.org/publications/allpubs/SMA01-3518/default.asp#goal1

>>*Surgeon General's Call to Action to Prevent Suicide*
by the Department of Health and Human Services
http://www.surgeongeneral.gov/library/calltoaction/calltoaction.pdf

>>*The Prevention, Recognition, and Management of Young People at Risk of Suicide:
Development of Guidelines for Schools* by The Ministry of Education (New Zealand)
http://www.nzgg.org.nz/guidelines/0028/Development_of_guidelines__.pdf

(b) On the Pro Side

>>*Common Misconceptions About Suicide*
by Suicide Awareness Voices of Education
http://www.save.org/prevention/misconceptions.html

>>*Youth Suicide Prevention Programs: A Resource. Chapter 4: General Suicide Education*
by The Center for Disease Control
http://www.cdc.gov/ncipc/dvp/Chapter%204.PDF

(c) On the Con Side

>>*Societal Stigma Closes the Caskets from Suicide*
by Alvin B. Janski
http://www.namistl.org/images/pdf/articles/social_stigma.pdf

>>*Youth Suicide Fact Sheet*
by SafeYouth.org
http://www.safeyouth.org/scripts/facts/suicide.asp

>>Vieland , V., Whittle, B., Garland, A., Hicks, R, et al. (1991). The impact of curriculum-
based suicide prevention programs for teenagers: An eighteen-month follow-up. *Journal of
the American Academy of Child Adolescent Psychiatry*, 37, 484-487.
  This study examined the efficacy of curriculum based suicide prevention programs. More
  specifically, the authors examined actual help-seeking behaviors and suicide morbidity in
  relation to exposure to such programs. They suggest that there is no "convincing evidence of any
  program effect" and that when programs were conducted indiscriminately, these programs often
  displayed negative effects.

Summary of Key Issues

Pro Arguments for Suicide Education Prevention Programs in Schools

- Gives "at-risk" students options for help that they might not know about

- Gives students and staff the knowledge they need to recognize warning signs so that they can help guide those in need to resources

- Efficient and easy to implement

- Can have additional mental health benefits

Con Arguments for Suicide Education Prevention Programs in Schools

- May exacerbate a student's problems by increasing stigma and may enhance reluctance to seek help

- May increase suicide ideation, sanction suicide, "teach" students how to do it, and contribute to suicide contagion effects

- Some evidence suggests the programs are not effective

- If not implemented correctly and carefully, they may do more harm than good

E. About Prevention (cont.)

(5) Best Practices

Using the Best Practices Registry (BPR)   http://www.sprc.org/bpr/using-bpr

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What does the term "evidence-based" mean? Is it the same as "effective prevention?"

Simply put, *evidence-based* means "based on scientific research." A common use of this term is in the phrase *evidence-based programs*, which are interventions that have been rigorously evaluated and demonstrated positive outcomes. For suicide prevention, positive outcomes are reductions in suicidal behaviors or changes in suicide-related risk and protective factors. It is accurate to say that evidence-based programs are "effective" for the populations and settings in which they were tested.

In addition to evidence-based *programs*, the research literature also offers broad *principles and processes* for creating and implementing prevention efforts that are more likely to be effective (sometimes also referred to as *science-based* as well as *effective* prevention.) Examples include using a data-driven planning process; addressing identified risk and protective factors; setting clear goals and objectives; tailoring programs to the geography, culture, and language of the target audience; and combining multiple strategies into an integrated comprehensive program.

Effective prevention practice includes both choosing evidence-based *programs* and adhering to *principles and processes* based on research.

How does the BPR incorporate the best available research evidence?

1. **By listing evidence-based suicide interventions in Section I.** The source for these interventions is SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP). At minimum, all Section I programs must demonstrate one or more positive outcomes relevant to suicide prevention to qualify for NREPP review. For more information, see Section I.

2. **By basing Section II and III review criteria on current research and expertise.** The design of the BPR recognizes that the suicide prevention field can benefit from dissemination of other information in addition to evaluated programs. These include (1) guidance and recommendations created by experts or consensus processes (Section II listings); and (2) programs, practices, and policies that have undergone review to assess whether the content is accurate, safe, likely to meet specified objectives, and consistent with standards of program design (Section III listings.) While the practices listed in Sections II and III are *not* evidence-based programs, the criteria used to review these programs are based on the best available research and expertise. For example, the statements in Section II are based on literature reviews and expert consensus. Similarly, the content of materials in Section III has been reviewed for adherence to standards that are based on research and expert consensus.

   While the BPR is a useful resource for identifying programs and materials, **selecting programs from the BPR is not a substitute for engaging in effective planning *processes and adhering to principles of effective prevention*.** In other words, planners should not simply "pick from the list," but rather should engage in a systematic planning effort and use the BPR to help identify programs or materials that address local needs and circumstances. The next section provides recommendations for using the BPR within the context of an effective planning process.

How can I use the BPR as a resource for developing effective suicide prevention programs?

(1) **Engage in a systematic planning process.** Program planners are encouraged to use the BPR in the context of a systematic strategic planning process (this example is broadly applicable to community planning, although the surrounding text describes its use in a campus context). In this type of planning process, multiple stakeholders typically work together to assess local needs, assets, and readiness, set goals, choose or create interventions that match local problems and circumstances, and evaluate efforts and use the results for improvement.

BPR listings can be used in several ways during this planning process. For example, planners can search Section I for evidence-based suicide prevention programs that match their identified needs, resources, and audiences. Since the BPR is not a comprehensive list of all evaluated programs, planners are encouraged to conduct a literature search as well. If no evidence-based programs exist that match local needs, planners may consider adapting one of the programs listed in Section I or found in the literature, making revisions based on theory, local assessment, and an understanding of the audience, while retaining key intervention ingredients. Resources about "program fidelity and adaptation" can be helpful in guiding these types of program revisions. A detailed synthesis of the literature on factors that influence program implementation can also inform decisions about local implementation of evidence-based programs.

Whether creating a new program or using an existing one, 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 resource materials, trainings, protocols and policies for suicide prevention that include accurate information, are likely to meet program objectives, follow safe messaging guidelines, and adhere to recommendations for suicide prevention program design. While the programs and materials in Section III have not been reviewed for effectiveness, they are examples of program content that meet specified standards and may be suitable for addressing identified program needs. Finally, by applying the Section III content standards to programs they create or implement, prevention professionals can increase the likelihood that their programs and practices will be effective.

(2) **Follow principles of effective prevention practice.** Suicide prevention practitioners can benefit from the large body of research about what works in the prevention of other health and safety problems such as injury and substance abuse. For example,

- One review of prevention efforts across four areas (substance abuse, risky sexual behavior, school failure, and juvenile delinquency and violence) identified nine characteristics that were consistently associated with effective prevention programs: Programs were comprehensive, included varied teaching methods, provided sufficient dosage, were theory driven, provided opportunities for positive relationships, were appropriately timed, were socioculturally relevant, included outcome evaluation, and involved well-trained staff.
- Recognizing that best practice principles exist for specific kinds of efforts, this summary provides principles of effective substance abuse prevention divided into six domains: Individual, Family, Peer, School, Community, and Society/Environmental.
- The broader public health literature also emphasizes the need to undertake environmental and systems change efforts that complement and work in sync with individually-focused interventions. Injury prevention expresses this concept through the Three Es of Prevention: Education, Enforcement, and Environment.

Once interventions are selected to meet local needs, planners are encouraged to visit Section II of the BPR and to conduct a targeted search of the broader literature to determine whether there are science-based or best practice principles documented for that type of program, policy, or service (e.g., gatekeeper training, media campaigns, professional training programs, policy development.)

(3) **Conduct program evaluation and disseminate the findings.** Planners are encouraged to build evaluation into their efforts to assess the effectiveness of their programs and build the knowledge base in the field.

For more information about effective planning and evaluation, see

- About Suicide Prevention
- A Strategic Planning Approach to Suicide Prevention (free online workshop)
- Locating and Understanding Data for Suicide Prevention (free online workshop)
- Colleges & Universities: Developing a Campus Program
- American Indian / Alaska Native Suicide Prevention: Basics of Getting Started
- Evaluation Resources in the SPRC Library
- Planning Resources in the SPRC Library

Section I: Evidence-Based Programs http://www.sprc.org/bpr/section-i-evidence-based-programs

Section I of the Best Practices Registry (BPR) lists evidence-based programs, that is, interventions that have undergone rigorous evaluation and demonstrated positive **outcomes** (as opposed to Section III programs, whose **content** is reviewed). It is accurate to say Section I programs are effective, although their effectiveness may not hold true for all audiences or settings. Also see "NREPP Description" and "Guidance for NREPP Users" (links at right) for more details.

Section I: Evidence-Based Programs combines programs from two sources:

- **National Registry of Evidence-Based Programs and Practices (NREPP)**
  NREPP is SAMHSA's online registry of interventions that have demonstrated effectiveness in the prevention or treatment of mental health and substance use disorders, including some interventions that address suicide. While NREPP is independent of the BPR, all suicide-related interventions listed in NREPP are also included in Section I of the BPR.

- **SPRC/AFSP Evidence-Based Practices Project (EBPP)**

  The EBPP was a previous effort to identify evidence-based suicide prevention practices. Interviews for the EBPP were stopped in 2005 when SAMSHA began reviewing suicide-related interventions for NREPP. Based on expert review, the EBPP included 12 evidence-based programs that were classified as either effective or promising. These 12 programs continue to be included in Section I of the BPR (most are now also listed in NREPP.) For more information about the EBPP, see EBPP Project Description (PDF) and List of Programs Identified by the EBPP (PDF).

Because NREPP is the primary source for BPR Section I programs, the remainder of this page focuses on NREPP.

Section I Listings: Evidence-Based Programs

The list below includes suicide-related interventions currently listed in NREPP and those previously identified by the EBPP. (Several programs are listed in both registries.) NREPP-listed programs are linked to the program description on the NREPP website. EBPP program information is provided in a program fact sheet (PDF format).

Title	Type of Program	Organization	Factsheet
American Indian Life Skills Development/Zuni Life Skills Development	Education & Training	University of Washington Press	
Applied Suicide Intervention Skills Training (ASIST)	Education & Training	LivingWorks	
Assisted Outpatient Treatment (AOT)	Treatment	Treatment Advocacy Center	
Attachment-Based Family Therapy (ABFT)	Treatment	Drexel University	
Brief Psychological Intervention after Deliberate Self-Poisoning	Treatment	University of Manchester	
CAST (Coping and Support Training)	Education & Training	Reconnecting Youth, Inc.	
Dialectical Behavior Therapy	Treatment	Behavioral Tech LLC	
Dynamic Deconstructive Psychotherapy (DDP)	Treatment	Upstate Medical University, NY	
Emergency Department Means Restriction Education	Education & Training	Markus J. Kruesi M.D.	
Emergency Room Intervention for Adolescent Females	Treatment	Mary Jane Rotheram-Borus, Ph.D.	
Kognito At-Risk for College Students	Education & Training	Kognito Interactive	
Kognito At-Risk for High School Educators	Education & Training	Kognito Interactive	
Kognito Family of Heroes	Education & Training	Kognito Interactive	
LEADS: For Youth (Linking Education and Awareness of Depression and Suicide)	Education & Training	Suicide Awareness Voices of Education (SAVE)	
Lifelines Curriculum	Education & Training	Hazelden	
Model Adolescent Suicide Prevention Program (MASPP)	Education & Training	North Central Community-Based Services	
Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric)	Treatment	MST Institute	
PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial)	Treatment	Patrick J. Raue, Ph.D.	
QPR Gatekeeper Training for Suicide Prevention	Education & Training	QPR Institute	
Reconnecting Youth	Education & Training	Reconnecting Youth Inc.	
Reduced Analgesic Packaging	Guidelines & Protocols	Keith Hawton	
SOS Signs of Suicide	Education & Training	Screening for Mental Health	
Sources of Strength	Education & Training	Sources of Strength, Inc.	
United States Air Force Suicide Prevention Program	Education & Training	United States Air Force	

E. About Prevention (cont.)

(6) Guides

Working with suicidal individuals can be a challenging and anxiety-provoking experience for practitioners. Working with children and young people who have suicidal thoughts or intentions can present an even greater challenge. It is important in such circumstances for the practitioner to have the insight, knowledge, ability and confidence to respond appropriately.

This book is part of the 'School-Based Practice in Action' series and provides information and resources to aid those working in a school context including administrators, teachers and school mental health professionals. Those working outside of school in youth and community settings would possibly also find aspects of the book helpful.

The authors – Terri Erbacher, Jonathan Singer and Scott Poland – demonstrate a comprehensive understanding of relevant theory and empirical research, and draw from their own extensive clinical expertise. Based in Pennsylvania (Erbacher and Singer) and Florida (Poland), each of them is a faculty member at a US university and an active practitioner and advocate in the field of suicide prevention. Erbacher, for example, is both a clinical assistant professor as well as an award-winning school psychologist who has held key positions in suicide prevention programmes/organisations.

A key argument communicated throughout the book is the imperative that all practitioners working with children and young people have a part to play in the prevention of suicide, and that a community approach should be adopted. The book contains 12 chapters of useful material and resources including links to eResources. The initial chapter provides case studies and poses important questions to prompt the reader to consider what their own responses would be to a series of school-based suicidal dilemmas. This is followed in the subsequent chapters by an overview of gatekeeper training, school crisis response planning, and school liability issues and best practices. The middle section of the book focuses on suicide risk assessment and suicide prevention, intervention and postvention. The final chapters cover topics such as bereavement and also how to provide care for the caregiver.

While the facts and statistics in the early part of the book may not be new for those who are counsellors or mental health practitioners, the information clearly outlines the issues around suicide. For those professionals who do not have a clinical or mental health background, the overview of key definitions and areas such as risk factors would be particularly useful. Although suicide is a complex subject, the authors provide comprehensive and practical information to explain what changes to look out for in the young person. They also highlight factors the practitioner needs to be aware of in the young person that may decrease or increase their suicidal risk.

As already mentioned, the authors promote the importance of the school community working together in order to support children and young people who may be vulnerable to suicide. At first sight it may seem that the authors want everyone to act as counsellors. However, I believe what the authors want to communicate is the need to work in partnership. For example, the concerns of a teacher who on reading a child's essay thinks that the child may be experiencing suicidal ideas or that of a lunchtime supervisor who notices that a child seems to be more withdrawn than usual should be investigated further. By being aware of possible concerns, the practitioner can either have a courageous conversation with the child or inform an appropriate member of staff. Adopting this collaborative approach increases the chances of preventing suicide.

For counsellors and school mental health practitioners there is a very helpful chapter covering risk assessments which clearly outline the varying levels of risk that may be experienced by a child or young person. Even for an experienced professional, carrying out a suicide risk assessment can be a challenge with a child. The authors provide helpful vignettes on how to approach difficult conversations with the child or young person in order to assess the level of risk and the action that needs to be taken to offer the right support.

While most of this book attends to suicidal prevention, there is a section on how to deal with the aftermath of a school suicide. This is an area which I have rarely found documented and I believe any school professional dealing with a tragic event such as suicide would find this section invaluable. The chapter provides step-by-step suggestions on a whole range of issues such as supporting the students, coordinating community meetings and using social media networks. The need for a thorough review following a crisis is also highlighted to ensure lessons are learnt from what worked well and areas identified which may require improvement.

Working within a school context can be extremely rewarding but there are times when the work can be stressful and challenging. A particularly informative chapter explores care for the caregiver. In this section the signs of burnout, compassion fatigue and vicarious trauma are outlined along with examples of cases. There is helpful insight into the demands placed upon school practitioners and how easy it can be to support others while neglecting oneself. The importance of maintaining a good work–life balance (having clear boundaries between home and work), eating and sleeping well, and liaising with colleagues are all emphasised.

A possible limitation with this book is that much of the content relates directly to the United States. So, for example, Chapter 4 highlights legal issues faced by schools in the United States who have been involved in litigation following student suicide. However, other countries may have completely different legal systems and so may not face the same issues as the authors present. They do mention how different countries have attempted to address the issue of restricting access to means. While a significant proportion of the book is contextualised for those in the United States I do believe there is enough content to remain applicable to a wider demographic.

Reference is made on a number of occasions to the necessity of being mindful of cultural diversity. The authors suggest the need to work closely with community and faith groups following student suicide but this is dependent on those links being forged well in advance of such tragic circumstances. Unfortunately, within some communities certain people groups may be marginalised from the mainstream or may choose to be on the margins due to perceived mistrust. Similarly, the authors mention differences in religious practices and how funerals may vary greatly from one religious group to another. Significant wisdom and sensitivity is required at such times to respect the families' values and beliefs as each family is unique and their needs for support will have to be responded to accordingly.

School mental health practitioners will benefit most from reading this book as it provides a comprehensive overview in a well-organised format of the aspects which need to be considered when working with children and young people who are struggling with suicide.

Ten Recommendations for Effective School-Based, Adolescent, Suicide Prevention Programs. P.W.G. Surgenor, P. Quinn, & C. Hughes (2016). *School Mental Health* (online). http://link.springer.com/article/10.1007/s12310-016-9189-9

Abstract: School-based suicide prevention programs are one of the key strategies to address suicide in adolescence. The number of programs increased rapidly during the 1980s and was largely designed for high school- or middle school-aged students (11–18 years old), due to the vulnerable time and predictive risk of future suicidal ideation or health problems in later life. However, key recommendations from these studies are often obscured by the volume of such programs, resulting in significant challenges for program designers. This study aimed to undertake a review of the numerous suicide prevention programs implemented globally in recent years to provide informed recommendations for the development of effective school-based programs for adolescents. The study employed a scoping review process to enable the deconstruction of large or complex issues to promote comprehension and ease of interpretation. A search of online international databases using combinations of key words (variations in 'suicide,' 'school,' 'program,' and 'prevention') within a specified time frame (January 2010 to June 2015) identified 397 articles. Preferred reporting items for systematic reviews and meta-analyses were used to identify relevant articles at each stage of the review process, resulting in a total of 20 studies addressing 13 different school programs. Results were presented using established program categories (as education/awareness, gatekeeper, peer leadership, skills, screening/assessment) and informed ten recommendations that address the design, content, delivery, and review of school-based suicide prevention programs for adolescents.

The Youth Suicide Prevention School-Based Guide is designed to provide accurate, user-friendly information. The Guide is not a program but a tool that provides a framework for schools to assess their existing or proposed suicide prevention efforts (through a series of checklists) and provides resources and information that school administrators can use to enhance or add to their existing program. 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 provides information to schools to assist them in the development of a framework to work in partnership with community resources and families.

Download the entire Guide

Download Individual Parts — Overview and Issue Briefs

Overview	The Guide Overview
Issue Brief 1	Information Dissemination in Schools
Issue Brief 2	School Climate
Issue Brief 3a	Risk Factors: Risk and Protective Factors, and Warning Signs
Issue Brief 3b	Risk Factors: How Can a School Identify a Student At-Risk for Suicide?
Issue Brief 4	Administrative Issues
Issue Brief 5	Suicide Prevention Guidelines
Issue Brief 6a	Intervention Strategies: Establishing a Community Response
Issue Brief 6b	Intervention Strategies: Crisis Intervention & Crisis Response Teams
Issue Brief 6c	Intervention Strategies: Responding to a Student Crisis
Issue Brief 7a	Preparing for and Responding to a Death by Suicide: Steps for Responding to a Suicidal Crisis
Issue Brief 7b	Preparing for and Responding to a Death by Suicide: Responding to and Working with the Media
Issue Brief 8	Family Partnerships
Issue Brief 9	Culturally and Linguistically Diverse Populations

Download individual Checklists

Now included in the Best Practices Registry (BPR) for Suicide Prevention, a collaboration between the Suicide Prevention Resource Center (SPRC) and the American Foundation for Suicide Prevention (AFSP).

Checklist 1	Information Dissemination in Schools
True/False 1t	Information Dissemination in Schools: The Facts about Adolescent Suicide
Checklist 2	School Climate
Checklist 4	Administrative Issues
Checklist 5	Suicide Prevention Guidelines
Checklist 6	Intervention Strategies
Checklist 7a	Preparing for and Responding to a Death by Suicide: Steps for Responding to a Suicidal Crisis
Checklist 7b	Preparing for and Responding to a Death by Suicide: Responding to and Working with the Media—Sample Forms for Schools
Checklist 9	Culturally and Linguistically Diverse Populations
Programs	Suicide Prevention Programs
Resources	Resources & Links
Statistics	National Suicide-Related Statistics

Annotated Bibliography I and II

Annotated Bibliography I includes summaries from a subset of research articles related to school-based and youth suicide prevention that were included in the development of The Guide. Annotated Bibliography II includes summaries from a subset of research articles related to school-based and youth suicide prevention that were published after the development of The Guide or some that were related to a more intense investigation of cultural issues.

Literature Review

The Literature Review for the Guide's development is included.

Annotated Bibliography I & II and Literature Review [5mb pdf]

Customize the Guide for your community

The Guide can be customized for your community. The University of South Florida, original authors of The Guide, collaborated with New York's Orange County Department of Mental Health and Orange-Ulster BOCES by request to create a tailored edition for their community. For more information, **click here**.

Affiliation

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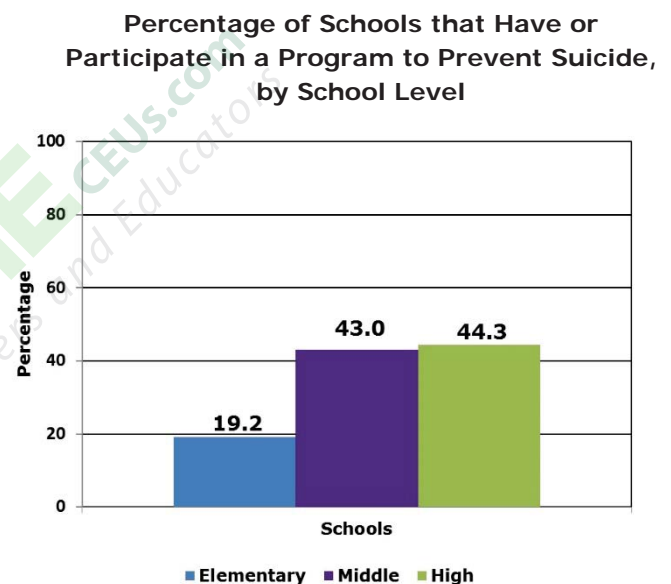
Suicide Prevention

About SHPPS: SHPPS is a national survey periodically conducted to assess school health policies and practices at the state, district, school, and classroom levels. This fact sheet reports data from the 2014 study, which collected data at the school and classroom levels.

Healthy and Safe School Environment

Percentage of Elementary Schools, Middle Schools and High Schools that Have a Plan for Actions to be Taken When a Student at Risk for Suicide is Identified, and Among Schools with Such a Plan, the Specific Plan Requirements			
	Elementary	**Middle**	**High**
Has a plan for the actions to be taken when a student at risk for suicide is identified	88.1	92.0	99.6
Plan requires that*			
The student's family be informed	98.8	97.8	96.0
The student be referred to a mental health provider	72.3	80.0	78.2
A visit with a mental health provider be documented before the student returns to school	45.6	60.4	60.3
*Among schools that had a plan for actions to be taken when a student at risk for suicide is identified.			

Percentage of Schools that Have or Participate in a Program to Prevent Suicide, by School Level

Health Services and Counseling, Psychological, and Social Services

- The percentage of schools that provided suicide prevention services increased from 34.2% in 2000 to 44.9% in 2014.*

- During the two years before the study:
  - 53.2% of school health services coordinators who served as study respondents received professional development on suicide prevention.

  - 75.9% of school mental health and social services coordinators who served as study respondents received professional development on suicide prevention.

* Regression analyses were performed that took all available years of data into account, but not all significant trends are reported. To account for multiple comparisons, selected trends are included only if the p-value from the regression analysis was < .01, and either the difference between the two endpoints (2000 or 2006 and 2014) was >10 percentage points or the 2014 estimate increased by at least a factor of two or decreased by at least half as compared to the 2000 or 2006 estimate.

Percentage of Schools that Provided Suicide Prevention Services in One-on-One or Small-Group Settings, by School Level			
Location	Elementary	Middle	High
At school by health services or counseling, psychological, or social services staff	41.4	36.7	64.5
Through arrangements with providers not on school property	32.6	48.1	34.4

Health Education

Percentage of Schools in Which Students are Required to Receive Instruction on Suicide Prevention, by School Level
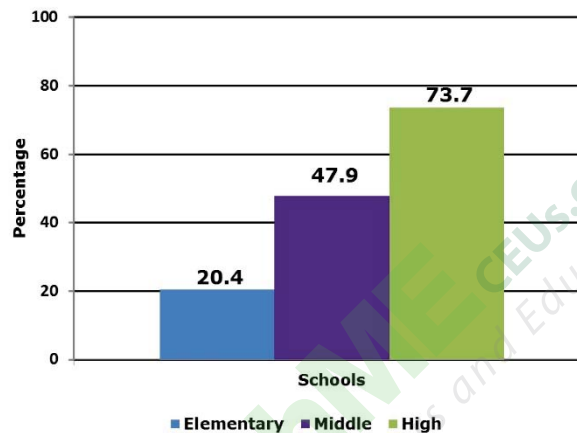
Percentage of Schools in Which Teachers Taught* Specific Suicide Prevention Topics as Part of Required Instruction, by School Level			
Topic	Elementary	Middle	High
How students can influence, support, or advocate for others to prevent suicidal behaviors	14.5	52.2	70.4
How to find valid information or services to prevent suicidal behaviors	11.8	42.1	69.8
Recognizing signs and symptoms of people who are in danger of hurting themselves	10.7	53.2	73.4
Resisting peer pressure that would increase risk of suicidal behaviors	13.1	45.2	62.1
Social or cultural influences on suicidal behaviors	8.2	40.1	63.6
The influence of families on suicidal behaviors	6.5	38.5	60.1
The influence of peers on suicidal behaviors	15.4	48.9	73.0
The influence of the media on suicidal behaviors	7.3	36.7	62.6
The relationship between alcohol or other drug use and suicidal behaviors	10.9	47.1	70.9
The relationship between suicide and emotional and mental health	9.7	50.8	73.6
The relationship between suicide and other types of violence	6.8	40.8	64.7
What to do if someone is thinking about hurting himself or herself	21.5	57.1	75.3
When to seek help for suicidal thoughts	14.5	52.7	73.4
* In at least one elementary school class or in at least one required health education course in middle schools or high schools.			

- 28.4% of required health education classes and courses had a teacher who received professional development on suicide prevention during the two years before the study.

F. A Public Health Concern

Enhanced Evaluation and Actionable Knowledge for Suicide Prevention Series

Suicide Prevention: A Public Health Issue

The Enhanced Evaluation and Actionable Knowledge project is part of an intra-agency agreement between CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of this project was to engage three <u>Garrett Lee Smith Memorial Act</u> grantees* in a process to create products that apply evaluation findings to strengthen suicide prevention practice.

The economic and human cost of suicidal behavior to individuals, families, communities and society makes suicide a serious public health problem around the world. In the US, suicide is one of the leading causes of death among young people. It is the third leading cause of death among 15-24 year olds and the second leading cause of death among 25-34 year olds. What's more, in 2009, almost 1 in 7 high school students (grades 9-12) reported that they had seriously considered suicide in the past year (CDC, 2010). That is equal to three students in a typical classroom of 20 (U.S. Dept. of Education, 2009).

Suicidal Behavior

Suicidal behavior includes:

- Suicidal ideation (thinking about ending one's life)

- Suicide attempt (non-fatal suicidal behavior)

- Suicide (ending one's life)

In the past, suicide was addressed by providing mental health services to people who were already experiencing or showing signs of suicidal thoughts or behavior. While services such as therapy and hospitalization are critical for those who may be thinking about or who have made a suicide attempt, they do not prevent suicidal thoughts or behaviors from happening in the <u>first place</u>. There are also other factors besides mental health, which place people at risk for suicide. A public health approach to suicide prevention can address these factors in many ways.

First, public health uses a population approach to improve health on a large scale. A population approach means focusing on prevention approaches that impact groups or populations of people, versus treatment of individuals. Second, public health focuses on preventing suicidal behavior before it ever occurs (primary prevention), and addresses a broad range of risk and protective factors. Third, public health holds a strong commitment to increasing our understanding of suicide prevention through science, so that we can develop new and better solutions. Finally, public health values multi-disciplinary collaboration, which brings together many different perspectives and experience to enrich and strengthen the solutions for the many diverse communities.

* The three Enhanced Evaluation Actionable Knowledge grantees were 1) Tennessee Lives Count 2) Maine Youth Suicide Prevention Program and 3) the Native American Rehabilitation Association of the Northwest (NARA-NW).

Population Approach

Part of public health's broad view is an emphasis on population health—not just the health of individuals. While suicide is often thought of as an individual problem, it actually impacts families, communities, and society in general. The long-term goal of public health is to reduce people's <u>risk</u> for suicidal behavior by addressing factors at the individual (e.g., substance abuse), family (e.g., poor quality parent-child relationships), community (e.g., lack of connectedness to people or institutions), and societal levels (e.g., social norms that support suicide as an acceptable solution to problems; inequalities in access to opportunities and services) of the social ecology.

What does this look like?
The Native American Rehabilitative Association of the Northwest (NARA) has developed the Life is Sacred Starter Kit, with resources for youth service providers. These resources focus on the core message of "culture as prevention" and provide concrete actions parents and family members can take to promote resilience in American Indian/Alaska Native youth.

Primary Prevention

Public health emphasizes efforts to prevent violence (in this case, toward oneself) before it happens. This approach requires addressing factors that put people at <u>risk</u> for, or <u>protect</u> them from, engaging in suicidal behavior.

What does this look like?
The Tennessee Lives Count initiative conducted Gatekeeper Training - training of service providers who typically interact with youth (e.g., teachers, social workers, juvenile justice staff) on identifying and referring youth at risk for suicide before suicide occurs. As opposed to traditional mental health approaches where youth are typically identified and treated after suicidal behavior has happened, this model empowers adults who come into contact with youth on a daily basis to identify the very early warning signs of suicide and get help for youth before suicidal behavior has occurred.

Commitment to Science

Public health is responsible for tracking suicide trends and identifying risk and protective factors for suicidal behavior. From this information, suicide prevention strategies are developed and evaluated to identify the most effective interventions. Finally, public health is responsible for learning how to put in place these effective interventions on a wide scale. All of these scientific activities increase our understanding of suicidal behavior and the most effective ways to prevent it.

What does this look like?
Three Garrett Lee Smith Memorial Act grantees conducted enhanced evaluations of youth suicide prevention programs and strategies. Survey data collected through these evaluations revealed: 1) trends in suicidal behavior and culturally-specific risk and protective factors among a sample of 233 American Indian/Alaska Native youth, 2) information on how to put in place early identification and referral data systems for school-based gatekeeper training programs, and 3) key factors important for successful implementation of gatekeeper training across different settings/populations.

Multi-disciplinary Perspective

Public health includes many disciplines (e.g. psychology, epidemiology, sociology) across multiple sectors (e.g. health, media, business, criminal justice, education). Public health often serves as a convener of these diverse perspectives in order to best address complex problems like suicide. Suicide is related to other forms of violence (for example: exposure to violence as a child is associated with suicidal behavior as an adult; Dube et al., 2001), as well as other health problems, which makes this multi-disciplinary approach critical.

What does this look like?
The Maine Youth Suicide Prevention Program uses a multi-disciplinary referral network as an essential component of a comprehensive school-based suicide prevention program. The network includes the school, the local crisis response agency, community mental health providers, substance abuse treatment providers, and hospitals. The collaboration of organizations across these different sectors has been important for addressing challenges by coordinating services, resources, and solutions necessary for the success of the suicide prevention program.

What can you do to promote a public health approach to suicide prevention in your community or organization? The table below may be a helpful as a conversation starter with others who share an interest in addressing this issue. Think about what your community or organization is already doing that is in line with a population approach and focus on primary prevention. Then brainstorm ideas for what can be added to existing programs or activities in schools, faith organizations, youth serving organizations, or other organizations in your community.

Population Approach. Part of public health's broad view is an emphasis on population health—not just the health of individuals. Suicide has been typically treated as an individual experience (e.g. hospitalization, individual therapy); however, its consequences and potential solutions also affect society in general (e.g. economic impact of loss to labor force).	***What does a population approach look like?*** It goes beyond a focus on the individual to include peers, family, community, and society as a whole. (Example: District-wide training on suicide awareness/prevention for all teachers, administrators and other school personnel.)
	What can my community or organization do?
Primary Prevention. Public health emphasizes efforts to prevent suicide before it occurs. This approach requires not only reducing the factors that put people at risk, but also increasing the factors that protect people from engaging in suicidal behavior.	***What does primary prevention look like?*** It occurs before harm is done. (Example: Prevention program for parents and youth that focuses on building positive relationships and the protective benefits of family and community support (connectedness).)
	What can my community or organization do?
Commitment to Science. Public health monitors and tracks suicide trends, researches risk and protective factors, evaluates interventions, and determines how best to implement effective interventions, moving science to action and vice versa.	***What does commitment to science look like?*** Knowing where to look for community data and research information about risk and protective factors for suicidal behavior. Examples: • State and National Data: www.cdc.gov/injury/wisqars/index.html • Risk and Protective Factors: www.cdc.gov/ViolencePrevention/suicide/riskprotectivefactors.html • Registry of Evaluated Programs: www.nrepp.samhsa.gov/
	Where are your sources for local data? (youth risk behavior surveys, hospital/emergency room records, etc.)
Multi-disciplinary Perspective. Public health includes many disci¬plines and perspectives, which helps when addressing complex problems like suicide. Public health often serves a convening role in bringing together representatives from sectors such as health, media, business, criminal justice, behavioral science, epidemiology, social science, advocacy, and education, which all have important roles to play in suicide prevention.	***What does a multi-disciplinary perspective look like?*** Strategies addressing suicide prevention include many types of organizations. (Example: A small school district convenes a suicide prevention advisory council that includes the local public health department, hospitals, law enforcement, 211 crisis line, mental health providers, the local chamber of commerce, faith-based community, youth serving organizations and substance abuse treatment providers.)
	Which organizations are or should be included in suicide prevention planning activities in my community?

References

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II. The Role of Schools

A. The Role of High School Mental Health Providers in Preventing Suicide

Ellen's English teacher told the school counselor, Ms. Thompson, that several of Ellen's class writing assignments indicated that she was under a lot of stress and might want to kill herself. Ms. Thompson asked Ellen to come in for a visit with her.

Ms. Thompson looked at a few of Ellen's writings and talked with her about how she was feeling. Next, Ms. Thompson conducted an assessment to determine Ellen's risk for suicide. After reviewing the results, she notified Ellen's parents that Ellen was clearly at risk. Then she took the following steps:

- Referred Ellen to a school support group for students dealing with a lot of stress
- Suggested she join an afterschool math tutoring program to get extra help
- Helped her make an appointment with a psychologist at a local community mental health center

Over the next weeks, Ms. Thompson stayed in contact with Ellen to ensure that she was following through on the interventions and to assist her as needed. She also encouraged Ellen to contact her at any time if she wanted to talk.

(Based on the experiences of a school psychologist)

Key Steps to Reduce Suicide Risk among Students:

Understand why suicide prevention fits with your role as a high school mental health provider

Identify students who may be at risk for suicide

Respond to students who may be at risk for suicide

Be prepared to respond to a suicide death

Consider becoming involved in schoolwide suicide prevention

This information sheet is for mental health staff that the school has designated as being responsible for handling student mental health crises. For some schools, the mental health contact may need to be a service provider in the community. It is important that all school staff know who the main mental health contact person is.

Understand Why Suicide Prevention Fits with Your Role as a High School Mental Health Provider

As a school mental health provider, you have an important role to play. You are in a key position to:

- Observe students' behavior and act when you suspect that a student may be at risk of self-harm

- Provide needed expertise, support, and information to teachers, other school staff, students, and parents who may notice that one of their students, peers, or children is having difficulties but may not know what to do about it
- Determine the next steps to take regarding a student's safety and treatment

Know the facts

Suicide touches everyone—all ages and incomes; all racial, ethnic, and religious groups; and in all parts of the country. The emotional toll on those left behind remains long after the event.

- About 4,700 young people ages 14–24 die by suicide (CDC, 2010).

- Approximately 1 out of 6 high school students seriously consider attempting suicide (CDC, 2012).

- 1 out of 13 high school students attempt suicide one or more times (CDC, 2012).

However, there is help and hope when individuals, schools, and communities join forces to address suicide as a preventable public health problem.

Identify Students Who May Be at Risk for Suicide

Be alert to problems that increase suicide risk

You may notice problems facing your students that may put them at risk for suicide. There are a large number of risk factors for suicide. Some of the most significant ones are:

- Prior suicide attempt(s)
- Alcohol and drug abuse
- Mood and anxiety disorders, e.g., depression, posttraumatic stress disorder (PTSD)
- Access to a means to kill oneself, i.e., lethal means

Suicide risk is usually greater among people with more than one risk factor. For individuals who are already at risk, a "triggering" event causing shame or despair may make them more likely to attempt suicide. These events may include problems in school (academic and/or discipline), family problems or abuse, relationship problems or break-ups, bullying, and legal difficulties. Even though most people with risk factors will not attempt suicide, they should be evaluated by a professional.

(Adapted from Rodgers, 2011 and SPRC, 2008)

Look for signs of immediate risk for suicide

There are some behaviors that may mean a person is at immediate risk for suicide. These three should prompt you to take action right away:

- **Talking about wanting to die or to kill oneself**
- **Looking for a way to kill oneself, such as searching online or obtaining a gun**
- **Talking about feeling hopeless or having no reason to live**

Other behaviors may also indicate a serious risk—especially if the behavior is new; has increased; and/or seems related to a painful event, loss, or change:

- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

(Adapted from National Suicide Prevention Lifeline, [n.d.])

Respond to a Student Who May Be at Risk for Suicide

Take action if you encounter a student who is at immediate risk

If someone is:

- **Talking about wanting to die or to kill oneself**
- **Looking for a way to kill oneself, such as searching online or obtaining a gun**
- **Talking about feeling hopeless or having no reason to live**

Take the following steps right away:

1. Talk with the student. Listen without judging and show you care.
2. Assess the student for risk of suicide and other forms of self-injury.
3. Take away any potential method of harm, such as a knife or pills.
4. Do not leave the student alone (not even in a restroom).
5. Collaborate with the school administration and any other available behavioral health staff in making decisions about next steps.
6. Notify and involve the parents/legal guardians. They must always be notified when there appears to be any risk that a student may harm himself or herself, unless doing so would place the child in a dangerous situation. It is important to be sensitive to the family's culture, including attitudes towards suicide, mental health, privacy, and help-seeking.

> ### *National Suicide Prevention Lifeline*
>
> **The Lifeline is a 24-hour toll-free phone line for people in suicidal crisis or emotional distress. The phone number is 1-800-273-TALK (8255). For a Lifeline wallet-sized card listing the warning signs of suicide and the toll-free number, go to http://www.suicidepreventionlifeline.org/getinvolved/materials.aspx**

7. Provide parents with any needed referrals to mental health resources.

8. Document all actions to ensure communication among school staff, parents, and service providers and to make sure the student gets needed services.

9. Follow up with the parents to determine how best to provide the student with support after the crisis.

(Adapted from Los Angeles Unified School District, 2010, and SAMHSA, 2012)

Reach out to a student who may be at risk

The steps above are an appropriate response to a student showing immediate warning signs of suicide. To help the many other students who may be at risk for suicide, take the steps below:

- Talk with the student. Listen without judging and show you care.
- Assess the student for risk of suicide and other forms of self-injury.
- If the student needs further help, contact his or her parents and take the steps listed in the section above as they are appropriate to the situation.

For more detailed steps and tools for responding to a student at risk of suicide, see chapter 2 in *Preventing Suicide: A Toolkit for High Schools*, which is listed in the Resources section of this sheet. For trainings for mental health providers, see *Assessing and Managing Suicide Risk* and *Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians* in the Resources section.

Be Prepared to Respond to a Suicide Death

The suicide, or violent or unexpected death, of a student, teacher, well-known community member, or even a celebrity can result in an increased risk of suicide for vulnerable young people. Therefore, an essential part of any crisis or suicide prevention plan is responding appropriately to a tragedy that may put students at risk for suicide. This response is often called *postvention*. In a school setting, recommended measures include:

- Grief counseling for students and staff, and support for yourself
- Identification of students who may be put at risk by a traumatic incident
- Support for students at risk
- Support for families
- Communication with the media to reduce the possibility of unsafe news coverage that could lead to additional suicides or emotional trauma
- Check-ins with students at risk at later times after the death, e.g., within a month or on the anniversary of the death

For more information about postvention, see *After a Suicide: A Toolkit for Schools*, which is listed in the Resources section.

Address Cultural Differences

Differences in cultural background can affect how students respond to problems, the way they talk about death and dying, and their attitudes toward suicide, as well as how they feel about sharing personal information, speaking with adults, and seeking help. It is important to be aware of possible differences and tailor your responses to students accordingly. For example, individuals from some cultures may not be open to seeing a mental health provider, but they may be willing to talk with a faith community leader or traditional healer.

Helping Your Colleagues

Suicide can occur among your colleagues as well as among students. If you notice signs of risk for suicide in your colleagues, you can assist them in receiving help too. For more information on helping them, see the Resources section, including the information sheet *The Role of Co-Workers in Suicide Prevention.*

Consider Becoming Involved in Schoolwide Suicide Prevention

Identifying students at risk is a crucial part of a comprehensive approach to suicide prevention. As a school mental health provider, you can also be involved in other aspects of suicide prevention. The following list outlines the key components of a comprehensive school suicide prevention program:

- Schoolwide programs that promote connectedness and emotional well-being
- Policies and procedures for helping students at risk and in crisis
- Postvention
- Staff education and training
- Parent/guardian education and outreach
- Student programs
    - » Curricula for all students
    - » Skill-building for students at risk
    - » Peer leader programs
- Screening for at-risk students

For more information about a comprehensive school suicide prevention program, see *Preventing Suicide: A Toolkit for High Schools* in the Resources section.

Resources

After a Suicide: A Toolkit for Schools
By the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center (2011)
http://www.sprc.org/library_resources/items/after-suicide-toolkit-schools
This online resource provides basic information and practical tools for schools to use in developing and implementing responses to a suicide death of a student or staff person. It includes information about getting started, implementing crisis response actions, dealing with issues related to memorials, helping students cope, and working with social media and the community.

Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals (AMSR)
By the Suicide Prevention Resource Center and the American Association of Suicidology (revised October 2008)
http://www.sprc.org/training-institute/amsr
This is a one-day curriculum for mental health professionals. It combines lecture, video demonstrations, and exercises to learn to effectively assess suicide risk, plan treatment, and manage ongoing care of the at-risk client. Trainings are sponsored by community groups and facilitated by AMSR's nationwide roster of expert faculty.

Best Practices Registry for Suicide Prevention (BPR)
Produced and maintained by the Suicide Prevention Resource Center and the American Foundation for Suicide Prevention
http://www.sprc.org/bpr
This registry contains information on approximately 130 suicide prevention programs, including student curricula and peer leader programs, gatekeeper trainings, and trainings for health and mental health professionals. Several documents provide guidance and recommendations that practitioners can use while developing programs, practices, or policies for their own settings.

Los Angeles County Youth Suicide Prevention Project
http://preventsuicide.lacoe.edu/index.php
The website of this project has separate sections for school administrators, school staff, parents, and students. Each section contains information sheets, videos, and other helpful resources. The website also has links to resources on a variety of at-risk populations and special issues in suicide prevention.

Preventing Suicide: A Toolkit for High Schools
By the Substance Abuse and Mental Health Services Administration (2012)
http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669?WT
This toolkit helps high schools, school districts, and their partners design and implement strategies to prevent suicide and promote behavioral health among their students. It describes the steps necessary to implement all the components of a comprehensive school-based suicide prevention program and contains numerous tools to help carry out the steps.

Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians (RRSR)
By the American Association of Suicidology (2006)
http://www.suicidology.org/training-accreditation/recognizing-responding-suicide-risk
This is an advanced two-day interactive training for mental health clinicians. It covers the knowledge, skills, and attitudes required to effectively assess, manage, and treat individuals at risk for suicide. Instruction consists of an initial Web-based assessment, followed by a two-day, face-to-face classroom workshop, and an online post-workshop mentorship. Training is delivered by RRSR master trainers based throughout the United States.

Society for the Prevention of Teen Suicide (SPTS)
http://www.sptsusa.org
SPTS develops educational materials and training programs for teens, parents, and educators, and its website contains separate sections for each group. SPTS is the developer of the Lifelines suicide prevention, intervention, and postvention programs, and the online course *Making Educators Partners in Suicide Prevention* for educators and school staff.

Suicide Prevention among Lesbian, Gay, Bisexual, and Transgender Youth: Expanding the Frame and Broadening Our Approaches
By the Suicide Prevention Resource Center (2011)
http://www.sprc.org/training-institute/r2p-webinars/suicide-prevention-among-lesbian-gay-bisexual-and-transgender-youth-
This webinar focuses on reducing risk for suicide and increasing positive outcomes for LGBT youth. The presenters are Effie Malley, former Director, National Center for the Prevention of Youth Suicide, American Association of Suicidology; Caitlin Ryan, Director, Family Acceptance Project; and Dave Reynolds, Senior Public Policy and Research Manager, The Trevor Project.

Suicide Prevention among LGBT Youth: A Workshop for Professionals Who Serve Youth
By the Suicide Prevention Resource Center (2011)
http://www.sprc.org/training-institute/lgbt-youth-workshop
This workshop kit provides all the materials necessary to host a workshop to help staff in schools, youth-serving organizations, and suicide prevention programs take action to reduce suicidal behavior among lesbian, gay, bisexual, and transgender (LGBT) youth. It includes a Leader's Guide, sample agenda, PowerPoint, sample script, handouts, and small group exercises.

Suicide Warning Signs (wallet card)
By the National Suicide Prevention Lifeline (2011)
http://www.suicidepreventionlifeline.org/getinvolved/materials.aspx
This wallet-sized card contains the warning signs for suicide and the toll-free number of the National Suicide Prevention Lifeline.

The Role of Co-Workers in Preventing Suicide

By the Suicide Prevention Resource Center (revised 2013)

http://www.sprc.org/sites/sprc.org/files/CoWorkers.pdf

This information sheet helps people in any type of workplace learn how to recognize and respond to the warning signs for suicide in their co-workers.

The Role of High School Teachers in Preventing Suicide

By the Suicide Prevention Resource Center (revised 2013)

http://www.sprc.org/sites/sprc.org/files/Teachers.pdf

This information sheet helps high school teachers recognize and respond to the warning signs and risk factors for suicide in their students.

The Trevor Project

http://www.thetrevorproject.org

The Trevor Project is a national organization with a focus on crisis and suicide prevention among lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. It provides a toll-free crisis phone line, an online social networking community for LGBTQ youth and their friends and allies, educational programs for schools, and advocacy initiatives.

Youth Suicide Prevention, Intervention, and Postvention Guidelines: A Resource for School Personnel

By Maine Youth Suicide Prevention Program (2009, 4th edition)

http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf

This guide describes the components of a comprehensive school-based suicide prevention program. It also includes an assessment form for schools to determine if they are ready to manage suicidal behavior; detailed guidelines for implementing suicide intervention and postvention in schools; and appendices with related materials, including forms and handouts.

Youth Suicide Prevention Program (YSPP)

http://www.yspp.org

YSPP is a suicide prevention education program focusing on youth. It sponsors awareness trainings for communities and professionals and has produced curricula for elementary, middle, and high school students. The YSPP website includes fact sheets, awareness materials, resource lists for adults and youth, and special sections for LGBTQ youth.

Youth Suicide Prevention School-Based Guide

By Louis de la Parte Florida Mental Health Institute, University of South Florida (2012 Update)

http://theguide.fmhi.usf.edu/

This guide provides a framework for schools to assess their existing or proposed suicide preven-tion efforts and resources, and information that school administrators can use to enhance or add to their existing programs. Topics covered include administrative issues, risk and protective factors, prevention guidelines, intervention and postvention strategies, and school climate.

In addition to these resources, the School section of the SPRC online library has many other materials. Go to http://www.sprc.org/search/library/School?filters=type%3Alibrary_resource.

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B. A School-Based Suicide Risk Assessment Strategy

While school nurses are often uniquely positioned to conduct suicide risk assessments, many school nurses feel poorly equipped to undertake this venture. This article outlines a plan to put a suicide risk assessment strategy in place.

Keywords: prevention; suicide; Kotter's steps; risk assessment

Every year in the United States, 4,600 youth ages 15 to 24 years die as a result of suicide. Approximately 1 in every 15 high school students attempts suicide every year (Centers for Disease Control and Prevention [CDC], 2013). Sadly, suicide is the third leading cause of death in this age group (American Association of Suicidology, 2013). Similar to other public health concerns, prevention should be the primary goal. Such an approach combines four public health activities: surveillance to determine rates and patterns of suicide, epidemiology to identify causal factors, design and evaluation of interventions to detect those at risk and prevent suicidal actions, and implementation of evidence-based programs (Yip, 2011). Therefore, it is useful to review background information about youth suicide, discuss the development of a school-based suicide risk assessment strategy, and examine how Kotter's (2011) eight transformational steps could be applied in the school setting.

Background

In order to develop strategies to prevent suicides, one must first determine suicide rates and patterns. According to 2009 data from the CDC, females are more likely than males to contemplate suicide (17.4% vs. 10.5%), plan a method of suicide (13.2% vs. 8.6%), and attempt suicide (8.1% vs. 4.6%). Males, however, are more likely than females to die as a result of a suicide attempt (11.45 vs. 2.76 per 100,000), due to the lethality of methods chosen. Suicide rates are highest among Native Americans, at 17.48 suicides per 100,000, followed by Whites at nearly 16 per 100,000, while Blacks have the lowest rate at approximately 6 per 100,000 (CDC, 2013).

Risk factors for youth suicide are well described in the literature and are helpful in indicating a need for suicide screening. Among these are academic difficulties, previous suicide attempt(s), alcohol or drug abuse, mental health disorders, gay or bisexual orientation, impaired relationships with parents or peers, family history of suicide, chronic health problems, social isolation, and access to lethal means (Shropshire & Thornton, 2011). Additionally, Varghese and Gray (2011) described the phenomenon of "suicide contagion," in which a suicide in a community garners attention that in turn influences others to also attempt suicide. Such an event may be promoted through the use of social networking sites where adolescents express unchecked emotional outbursts in an unregulated forum (Varghese & Gray, 2011). Similarly, the concept of bullying, which involves a repeated pattern of aggression designed to harm or bother the victim, has been linked to suicide. Cooper, Clements, and Holt (2012) determined that not only is the bullying aggressor at higher risk of suicide, but the victim and the on-lookers are as well, and those who have multiple roles are at the greatest suicide risk. Furthermore, these authors relate that in cases of cyber-bullying, in which technology forums such as social networking sites are employed to bully others, the victims are twice as likely to commit suicide.

Just as there are known risk factors for suicide, there are also known protective factors. Family cohesion, supportive relationships, religious affiliation, functional coping skills, beloved pets, extra-curricular interests and hobbies, and a safe school environment have all been associated with decreasing the risk of suicide (Varghese & Gray, 2011). While these factors may help buffer the effects of difficult circumstances, they do not necessarily prevent suicidal thoughts or actions.

School-Based Intervention

Adolescents spend many hours at school and most consider the school as a safe and stable environment. Because of this, the school setting is ideal for a public health approach to adolescent suicide risk assessment. School nurses

are uniquely situated to become students' confidants because their lack of academic or disciplinary roles results in students' perceptions of them as safe. Indeed, school nurses are more likely to see both bullies and victims, and students with chronic and mental health concerns as health room visitors (Cooper et al., 2012; Johnson & Parsons, 2012). Additionally, school nurses, because of their public health focus, are interested in various prevention strategies. Furthermore, while not regulated by the Joint Commission, schools may be wise to follow the Commission's Patient Safety Goal of "identifying patients at risk for suicide" (Boudreaux, McMullen, & Camargo, 2012). Thus, school nurses may wish to function as school leaders in implementing a school-based suicide prevention program, beginning with a risk assessment plan.

Applying Kotter's Steps

Kotter's (2011) classic work outlined steps to creating change in business organizations. These eight steps have also been successfully employed in various health care settings and could presumably also be used in an educational setting. Kotter's steps include establishing a sense of urgency, forming a powerful guiding coalition, creating and communicating the vision, empowering others to act on the vision, planning for and creating short-term wins, producing still more change, and institutionalizing new approaches. First, one must establish the sense of urgency. This involves identifying the organization's priorities. The idea for this project was the result of discussion with the Tacoma Public Schools' health services director, who suggested this priority, since no suicide prevention program is currently in place. Similarly, many other school districts could benefit from a suicide prevention program. Sharing statistics about the scope of the problem should be helpful in creating urgency for other school nurses. Unfortunately, a student's death as a result of suicide could be necessary to spur action from other school employees (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012).

To create change, Kotter (2011) suggests forming a powerful guiding coalition. It is common for school nurses to serve on health-related committees. In order to design and launch this project, a committee of five or six school nurses could be formed to develop a suicide risk assessment strategy for their individual schools or district. Membership should be voluntary and school nurses from elementary, middle, and high schools would be encouraged to participate. This guiding coalition would formulate and communicate the vision, determine best evidence for suicide risk assessment strategies, and communicate these methods to other school nurses.

An organization's vision can help direct the members' activities and focus their efforts on strategies to achieve the vision (Kotter, 2011). For this project, a vision statement could be: *School nurses will identify which students may be at risk for suicide and will screen these students with an evidence-based screening tool*. This type of statement can direct the needed activities. First, there must be a method to determine which students may be at risk for suicide. Second, there must be a screening tool to detect the risk level. Third, school nurses must be trained and ready to provide resources and referrals to prevent suicide and following any student deaths due to suicide. After the vision statement has been determined, it must be communicated to the other school nurses. Communication of the vision could occur through a variety of means including district emails, monthly school nurse staff meetings, state school nurse organizations, and educational offerings with continuing education hours.

While there are no suicide risk assessment tools designed specifically for the school setting, other proven tools could be used. Arming school nurses with the correct tools and strategies will empower them to conduct this important assessment. Because of the large number of students each school nurse may care for on any given day, it is not practical, or necessary, to screen every student for suicide risk. While a nurse should be

aware of the list of risk factors as described earlier in this article, a simple, easy-to-use approach is warranted. Cooper et al. (2012) related that children who are the victims or perpetrators of bullying visit the school nurse 4.7 times per school year. These authors suggested that nurses should consider risk assessment in students with more than 5 health room visits per year for somatic complaints. This is one method that could trigger further assessment. Additionally, school nurses would be wise to screen any students with one or more of the known risk factors, such as chronic health conditions or history of drug or alcohol abuse.

The ReACT Self-Harm Rule has been successfully used in the emergency department setting (Boudreaux et al., 2012; Steeg et al., 2012) and could be useful in the school setting as well. This brief rule quickly identifies those who need further assessment for suicide risk. ReACT is an acronym for *Recent* self-harm (in the past year), *Alone* or homelessness, *Cutting* as a method of harm, and *Treatment* for a psychiatric disorder. Those who identify more than one risk factor should have further assessment. While not specifically tested in the school setting, the ReACT Self-Harm Rule could function as a simple initial screening tool for school nurses.

The Patient Health Questionnaire-9 (see Table 1) is a more extensive tool used to identify adolescents with suicidal thoughts and depression (The MacArthur Initiative, 2009). This tool has been used in the primary care setting (Shropshire & Thornton, 2011; Varghese & Gray, 2011) and may also be beneficial in the school setting, as school health rooms often function as students' sole health provider. This nine-question tool is easy to complete and score, and the shorter two-question version, the Patient Health Questionnaire-2, which uses only the first two questions, has also been used as a screening tool for depression. Students with four or more checks in the gray shaded area of the questionnaire should be referred to a mental health care provider for screening. Similarly, students with at least two checks

Table 1. Patient Health Questionnaire-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	Add columns: ☐ + ☐ + ☐			
	Total: ☐			
10. If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____			

Source: Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display, or distribute.

in the gray shaded area, one of which must be for question one or two, should be referred for depression screening. Total score values have been used as a method to monitor the severity of a person's depression over time.

School nurses will require education and training in order to use any proposed tool. Such training could be accomplished at one or two monthly school nurse meetings or even via webinars or online learning modules. However, unless they are aware of where to refer students with a positive screen, school nurses may be unlikely to undertake a suicide risk assessment. Indeed, it would be unethical to identify students at risk and then take no further

action. Thus, a plan for such referrals will also need to be formulated and should include parent notification (SAMHSA, 2012).

Planning for and creating short-term wins may involve devoting time at school nurse meetings for nurses to share their experiences and successes in using the screening tools. This discussion would also encourage other nurses to begin incorporating the use of these tools into their practice. Following these wins, the coalition may begin to consider an expansion of the suicide prevention program. This could involve other staff members such as teachers, administrators, or counselors who are

interested in suicide prevention. It could also involve students who wish to help their peers. Numerous programs exist and could be useful in the school setting. Setting up a district-wide program may take a year or more. Ultimately, the goal would be a safer school environment where at-risk students could be identified and directed to the help they need. A district-wide approach could ensure that the actions of identification and assistance would become the standard of how the schools in the district operate.

Conclusion

Youth suicide is a preventable problem that should be considered a safety issue

and addressed in the school setting. School nurses, because of their access to students and their non-academic and non-disciplinarian status, are viewed as trustworthy by students. Education and easy-to-use assessment tools could help school nurses successfully screen students at risk for suicide. Identification of resources, including referrals for mental health, is necessary with any suicide risk screening. Kotter's steps for transformation in an organization could provide a suitable framework for a school-based suicide risk screening plan and even for a district-wide suicide prevention program. ■

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Kristie Nolta
MN, BSN, RN-BC, NCSN
Pediatric Nurse
Tacoma, WA
Kristie has been a pediatric nurse for more than 25 years. She has been a school nurse in the Tacoma Public School District for the last 5 years. She also serves on the Nurse Practice Advisory Group for School Nursing for the Washington State Nursing Commission.

B. Issue: Should Schools be Involved in Monitoring Students Identified as Suicidal Risk

For schools to monitor students identified as suicidal risks raise questions about whether this should be the school's role, and if so, who should do it.

Concerns arise about parental consent, privacy and confidentiality protections, staff qualifications, involvement of peers, negative consequences of monitoring (especially for students who are false positive identifications), and access and availability of appropriate assistance.

Examples of what one hears:

> *School staff are well-situated to keep an eye on kids who are at risk for suicide.*
>
> *Teachers can't be expected to take on another task and aren't qualified to monitor such students.*
>
> *Such monitoring can be done by qualified student support staff.*
>
> *Monitoring infringes on the rights of families and students.*
>
> *It's irresponsible not to monitor anyone who is a suicidal risk.*
>
> *It's inappropriate to encourage kids to "spy" on each other.*
>
> *Monitoring is needed so that steps can be made to help quickly.*
>
> *Monitoring has too many negative effects.*

Formal Positions:

- *Pro* – Those arguing that schools should monitor stress that it is essential to monitor anyone who is a suicidal risk so that help can be provided quickly. Moreover, they believe school staff are well-situated to do so, and staff (and even students) can be trained to do it appropriately and with effective safeguards for privacy and confidentiality, and that the positive benefits outweigh any negative effects.

- *Con* – As with many practices related to mental health in schools, a basic argument against monitoring students identified "at risk" is the position that the practice infringes on the rights of families and students. Other arguments stress that teachers should not be distracted from teaching and , moreover, teachers and other non-clinically trained school staff are ill-equipped to do the monitoring. And, it is inappropriate to encourage students to play a monitoring role. Additionally, it is stressed that existing monitoring practices are primarily effective in following those that have already attempted suicide and that monitoring others has too many negative effects (e.g., costs are seen as outweighing potential benefits).

Examples of Documents Related to the Issue:

>>*Youth Suicide Prevention Programs: A Resource. Chapter 2: School Gatekeeper Training*
    by The Center for Disease Control
    http://www.cdc.gov/ncipc/dvp/Chapter%202.PDF

>>*Youth Suicide Prevention Programs: A Resource. Chapter 5: Screening Programs*
    by The Center for Disease Control
    http://www.cdc.gov/ncipc/dvp/Chapter%205.PDF

>>*Surgeon General's Call to Action to Prevent Suicide*
    by the Department of Health and Human Services
    http://www.surgeongeneral.gov/library/calltoaction/calltoaction.pdf

>>Child Suicide and the Schools
    Editorial in Pediatrics
    http://pediatrics.aappublications.org/cgi/content/full/106/5/1167

*Note: As with most issues related to mental health in schools, there remains a sparsity of research to support positions that could be enlightened by empirical study.

Summary of Key Issues

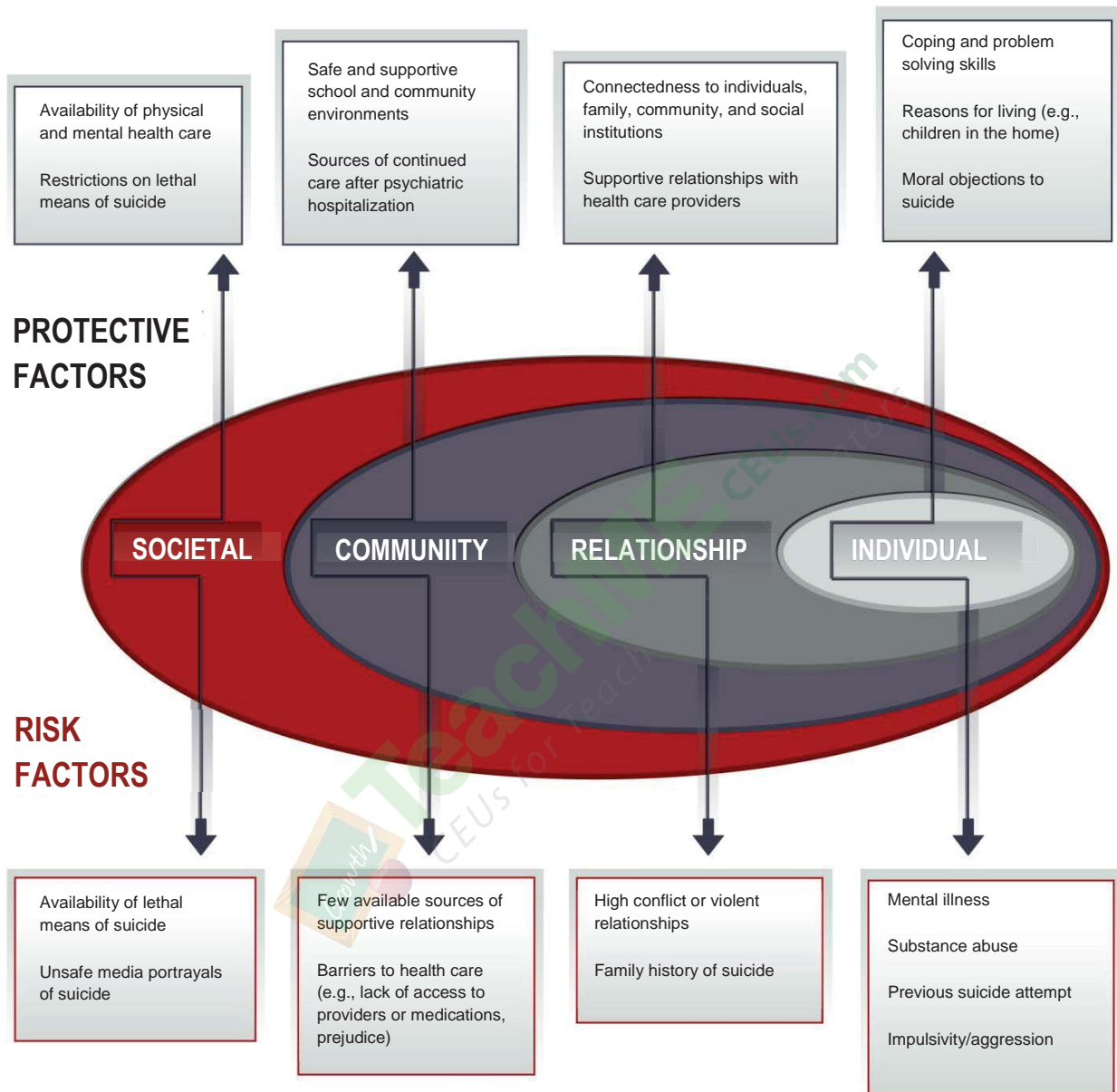| *Pro Arguments for School Involvement in Monitoring Students Identified as Suicidal Risks*	*Con Arguments for School Involvement in Monitoring Students Identified as Suicidal Risks*
• It is essential to monitor anyone who is a suicidal risk so that help can be provided quickly.	• The practice infringes on the rights of families and students.
• School staff are well-situated to do so.	• Teachers should not be distracted from teaching.
• Staff (and even students) can be trained to do it appropriately.	• Teachers and other non-clinically trained school staff are ill-equipped to do the monitoring.
• Effective safeguards for privacy and confidentiality.	• It is inappropriate to encourage students to play a monitoring role.
• positive benefits outweigh any negative effects.	• Existing monitoring practices are mainly useful for following the very few students who have already attempted suicide.
	• Negative effects of monitoring others outweighs potential benefits.

III. Examples of Models, Research, and Guides

A. Examples of Risk and Protective Factors in a Social Ecological Model

PROTECTIVE FACTORS

SOCIETAL	COMMUNITY	RELATIONSHIP	INDIVIDUAL
Availability of physical and mental health care Restrictions on lethal means of suicide	Safe and supportive school and community environments Sources of continued care after psychiatric hospitalization	Connectedness to individuals, family, community, and social institutions Supportive relationships with health care providers	Coping and problem solving skills Reasons for living (e.g., children in the home) Moral objections to suicide

RISK FACTORS

SOCIETAL	COMMUNITY	RELATIONSHIP	INDIVIDUAL
Availability of lethal means of suicide Unsafe media portrayals of suicide	Few available sources of supportive relationships Barriers to health care (e.g., lack of access to providers or medications, prejudice)	High conflict or violent relationships Family history of suicide	Mental illness Substance abuse Previous suicide attempt Impulsivity/aggression

B. School-Based Gatekeeper Training to Identify at Risk Youth

Identifying and Referring Youths at Risk for Suicide Following Participation in School-Based Gatekeeper Training.
D.S. Condron, L.G. Garraza, C.M. Walrath, R. McKeon, D.B. Goldston, & N.S. Heilbron (2015), *Suicide and Life-Threatening Behavior, 45*, 461–476.   1   1111   121 2

Abstract: Gatekeeper training is a core strategy of the Garrett Lee Smith Memorial Suicide Prevention Act of 2004. Using data gathered from school-based gatekeeper trainings implemented by GLS grantees, this analysis examines training and gatekeeper factors associated with (1) identification and referral patterns and (2) services at-risk youths receive. Time spent interacting with youths was positively correlated with the number of gatekeeper identifications and knowledge about service receipt. Gatekeepers who participated in longer trainings identified proportionately more at-risk youths than participants in shorter trainings. Most gatekeeper trainees referred the identified youths to services regardless of training type.

Introduction: Implementation of suicide prevention activities is a major public health priority in the United States, as evidenced by the recently revised National Strategy for Suicide Prevention (NSSP; U.S. Department of Health and Human Services, Office of the Surgeon General, and National Action Alliance for Suicide Prevention, 2012) and the continuation of the Garrett Lee Smith Memorial Suicide Prevention Act (GLSMA) of 2004. In youth suicide prevention efforts, gatekeeper training is cited as one of the most commonly implemented approaches. Indeed, training for those who might have contact with suicidal individuals is specifically mentioned as an area of emphasis in the GLSMA.

Gatekeeper training is predicated on the observation that individuals who are at risk for suicidal behavior often do not seek help (Isaac et al., 2009; Rodi et al., 2012). In particular, youths who are feeling distressed or suicidal are often reluctant to ask adults for assistance (McCarty et al., 2011; Pisani et al., 2012; Saunders, Resnick, Hobernan, & Blum, 1994). "Gatekeepers," who have contact with individuals at heightened risk, may be in an advantageous position to (1) recognize risk, (2) assess whether the individual is suicidal, or (3) otherwise intervene. When appropriate, the gatekeeper may intervene or refer the individual for treatment. Presumably, this response should result in reduced risk for suicidal behavior. The focus of this suicide prevention approach is to provide education and training for gatekeepers so that they can better recognize individuals at risk for suicidal behaviors and take appropriate action to reduce risk.

Significant differences exist in the approaches and the training required for different gatekeeper training programs. These approaches differ in (1) training (amount and intensity) and (2) response—whether individuals are trained to intervene directly with someone who is suicidal, or are encouraged make a referral to a mental health provider, whenever possible. For example, Question, Persuade, Refer (QPR; Quinnett, 1995) is a 1-hour training for gatekeepers that emphasizes questioning individuals who may be at risk for suicidal behavior, persuading them to seek help, and referring them for assistance whenever possible. By contrast, Applied Suicide Intervention Skills Training (ASIST; Ramsay, Tanney, Tierney, & Land, 1999) is a 14-hour workshop for gatekeepers designed to help them better connect with and give assistance to suicidal individuals. Gatekeepers are taught to collaborate with suicidal individuals on developing safety plans and to help the suicidal individuals connect with mental health services, when appropriate. An assumption also exists that the ASIST intervention—in and of itself, in some circumstances—may be sufficient to reduce the risk of suicidal behavior. In a review of gatekeeper training programs, Isaac et al. (2009) suggested that there is evidence that gatekeeper training often results in increased knowledge and skills, and may help change attitudes about helping and intervening with suicidal individuals. Much less is known about the effects of gatekeeper training on referral patterns, or whether implementation of these programs ultimately results in a reduction in suicidal behavior.

In addition to a relative paucity of research on referral patterns, there is a critical lack of information regarding the factors affecting outcomes associated with gatekeeper training programs. Little is known about the characteristics of individuals who may benefit most from gatekeeper training, or the factors associated with whether training leads to identification of youths at risk for suicidal behaviors. For example, in one study of the implementation of QPR in schools, the trainings resulted in increased appropriate referrals by teachers with suicidal students. However, the trainings did not result in increased appropriate referrals by school support staff (Wyman et al., 2008).

As part of the Garrett Lee Smith (GLS) suicide prevention programs, it has been estimated that 96% of the states, tribes, and campuses awarded suicide prevention grants have implemented some form of gatekeeper training program (ICF International, 2011). Despite their popularity, the choices of gatekeeper training programs by grantees may reflect different perceptions of needs and other cultural and contextual factors, and so outcomes associated with gatekeeper training programs in different settings may partly reflect the different circumstances or sites within which the programs are implemented. With that caveat acknowledged, the widespread implementation of gatekeeper training programs in the GLS suicide prevention programs does provide an opportunity to preliminarily examine the degree to which these programs are associated with referrals of suicidal individuals, and the proportion of trained individuals who make referrals. The GLS suicide prevention programs also provide an opportunity to examine, in a correlational manner, the characteristics of training programs and gatekeepers (e.g., professional roles, time interacting with youths) that may affect referral patterns associated with gatekeeper training, as well as the proportion of referred youths who actually receive services.

Gatekeeper trainings occur in a variety of contexts and settings. Many GLS grantees take a community-based approach focused on providing training to a wide array of potential gatekeepers—from emergency responders to child welfare professionals. Conversely, a number of GLS grantees use a school-based approach to training, focusing on training professionals who are most likely to come into contact with at-risk youths. In this study, we focus on school-based gatekeepers as a way to address the research questions being posed in a homogenous setting. Additionally, some of the more recent and promising research (e.g., Wyman et al., 2008) also focused on school settings, which provides an opportunity to extend the knowledge base around school-based gatekeeper training programs.

In this study we examined the factors related to posttraining behavior for school-based gatekeepers, with a particular interest in the type of training to which gatekeepers were exposed. Based on the findings, a secondary goal was to estimate the number of youths identified and the number of youths connected to services by trained gatekeepers working in school settings. The specific research questions addressed in this study are as follows:

- Which participant characteristics are predictive of gatekeeper behavior after the training, in particular, the number of youth at risk identified; the proportion of those youth referred to service; whether the participant is aware of follow-up information; and the proportion of youth that appear to receive the service they were referred to.

- Does the type of training predict posttraining behavior (after accounting for other individual level differences)?

- What estimated number of youths are identified and then connected to services by trained gatekeepers working in school settings?

III. Examples of Models, Research, and Guides

C. Research on Relationship to Attachment

Adolescent attachment security, family functioning, and suicide attempts. A.H. Sheftall, C.W. Mathias, R.M. Furr, & D.M. Dougherty (2013). *Attachment & Human Development, 15,* 368-383.
http://www.tandfonline.com/doi/abs/10.1080/14616734.2013.782649

Abstract: Theories of suicidal behavior suggest that the desire to die can arise from disruption of interpersonal relationships. Suicide research has typically studied this from the individual's perspective of the quality/frequency of their social interactions; however, the field of attachment may offer another perspective on understanding an individual's social patterns and suicide risk. This study examined attachment along with broader family functioning (family adaptability and cohesion) among 236 adolescent psychiatric inpatients with (n = 111) and without (n = 125) histories of suicide attempts. On average, adolescents were 14 years of age and Hispanic (69%). Compared to those without suicide attempts, adolescent attempters had lower self-reported maternal and paternal attachment and lower familial adaptability and cohesion. When comparing all three types of attachment simultaneously in the logistic regression model predicting suicide attempt status, paternal attachment was the only significant predictor. Suicide attempt group was also significantly predicted by self-rated Cohesion and Adaptability; neither of the parent ratings of family functioning were significant predictors. These findings are consistent with the predictions of the Interpersonal Theory of Suicide about social functioning and support the efforts to develop attachment-based interventions as a novel route towards suicide prevention.

D. Suicide Prevention among LGBT Youth: A Workshop for Professionals Who Serve Youth

Suicide Prevention among LGBT Youth: A Workshop for Professionals Who Serve Youth is a free workshop kit to help staff in schools, youth-serving organizations, and suicide prevention programs take action to reduce suicidal behavior among lesbian, gay, bisexual, and transgender (LGBT) youth.

Topics covered include suicidal behavior among LGBT youth, risk and protective factors for suicidal behavior, strategies to reduce the risk, and ways to increase school or agency cultural competence.

The kit contains everything you need to host a workshop: a Leader's Guide, sample agenda, PowerPoint presentations, sample script, and handouts. The workshop includes lecture, small group exercises, and group discussion. All these can be adapted to meet the needs of your audiences.

Download a Zip file for the LGBT Youth workshop kit
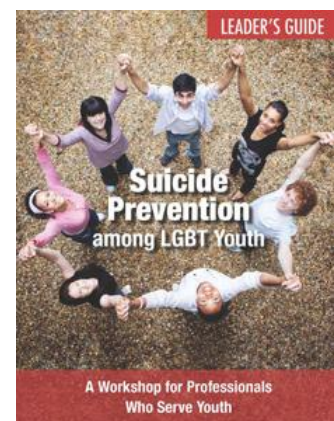
More Research

A Comparison of Adolescents Engaging in Self-Injurious Behaviors With and Without Suicidal Intent: Self-Reported Experiences of Adverse Life Events and Trauma Symptoms. M. Zetterqvist, L.G. Lundh, & C.G. Svedin (2013). *Journal of Youth and Adolescence, 42,* 1257–1272. http://link.springer.com/article/10.1007/s10964-012-9872-6

Abstract: Research comparing adolescents engaging in suicidal and non-suicidal self-injury (NSSI), both separately and in combination, is still at an early stage. The purpose of the present study was to examine overlapping and distinguishable features in groups with different types of self-injurious behaviors, using a large community sample of 2,964 (50.6 % female) Swedish adolescents aged 15–17 years. Adolescents were grouped into six categories based on self-reported lifetime prevalence of self-injurious behaviors. Of the total sample, 1,651 (55.7 %) adolescents reported no self-injurious behavior, 630 (21.2 %) reported NSSI 1–4 times, 177 (6.0 %) reported NSSI 5–10 times, 311 (10.5 %) reported NSSI C 11 times, 26 (0.9 %) reported lifetime prevalence of suicide attempt and 169 (5.7 %) adolescents reported both NSSI and suicide attempt. After controlling for gender, parental occupation and living conditions, there were significant differences between groups. Pairwise comparisons showed that adolescents with both NSSI and suicide attempt reported significantly more adverse life events and trauma symptoms than adolescents with only NSSI, regardless of NSSI frequency. The largest differences (effect sizes) were found for interpersonal negative events and for symptoms of depression and posttraumatic stress. Adolescents with frequent NSSI reported more adversities and trauma symptoms than those with less frequent NSSI. There were also significant differences between all the NSSI groups and adolescents without any self-injurious behavior. These findings draw attention to the importance of considering the cumulative exposure of different types of adversities and trauma symptoms when describing self-injurious behaviors, with and without suicidal intent.

A systematic review of school-based suicide prevention programs. C. Katz, S.L. Bolton. L.Y. Katz, C. Isaak, et al. (2013). *Depression and Anxiety, 30,* 1030-1045. http://www.ncbi.nlm.nih.gov/pubmed/23650186

Abstract
OBJECTIVE: Suicide is one of the leading causes of death among youth today. Schools are a cost-effective way to reach youth, yet there is no conclusive evidence regarding the most effective prevention strategy. We conducted a systematic review of the empirical literature on school-based suicide prevention programs.

METHOD: Studies were identified through MEDLINE and Scopus searches, using keywords such as "suicide, education, prevention and program evaluation." Additional studies were identified with a manual search of relevant reference lists. Individual studies were rated for level of evidence, and the programs were given a grade of recommendation. Five reviewers rated all studies independently and disagreements were resolved through discussion.

RESULTS: Sixteen programs were identified. Few programs have been evaluated for their effectiveness in reducing suicide attempts. Most studies evaluated the programs' abilities to improve students' and school staffs' knowledge and attitudes toward suicide. Signs of Suicide and the Good Behavior Game were the only programs found to reduce suicide attempts. Several other programs were found to reduce suicidal ideation, improve general life skills, and change gatekeeper behaviors.

CONCLUSIONS: There are few evidence-based, school-based suicide prevention programs, a combination of which may be effective. It would be useful to evaluate the effectiveness of general mental health promotion programs on the outcome of suicide. The grades assigned in this review are reflective of the available literature, demonstrating a lack of randomized controlled trials. Further evaluation of programs examining suicidal behavior outcomes in randomized controlled trials is warranted.

D. Criteria for Identification

(1) Criteria for Diagnosis of Major Depressive Episode (DSM - V)

(2) Criteria for Diagnosis (American Academy of Pediatrics)

Emotions and Moods: Sadness and Related Symptoms

Sadness Variation

Sadness Problem

Major Depressive Disorder

Dysthymic Disorder

Bipolar I Disorder, Bipolar II

Disorder

Emotions and Moods: Suicidal Thoughts or Behaviors

Thoughts of Death Variation

Thoughts of Death Problem

Suicidal Ideation and

Attempts

As can be seen on the following page, The Diagnostic and Statistical Manual for Mental Disorders - V (DSM-V) focuses specifically on psychopathology & major disorders.

Such problems are put into a broader context in the Classification Child and Adolescent Mental Diagnoses in Primary Care – which is the system published by the American Academy of Pediatrics.

D. Criteria for Identification (cont.) ⭐

(1) DSM

Major Depression in Children and Adolescents

DIAGNOSIS & ASSESSMENT

DSM-5 Criteria
>5 or more symptoms present during a 2 week period; (1) depressed or irritable mood and (2) loss of interest or pleasure and any three of the following:

1. Significant weight loss or decrease in appetite (more than 5 percent of body weight in a month)
2. Insomnia or hypersomnia
3. Psychomotor agitation or retardation
4. Fatigue or lack of energy
5. Feelings of worthlessness or guilt
6. Decreased concentration or indecisiveness
7. Recurrent thoughts of death or suicide

In addition to the above DSM-5 criteria, children and adolescents may also have some of the following symptoms:
- Persistent sad or irritable mood
- Frequent vague, non-specific physical complaints
- Frequent absences from school or poor performance in school
- Being bored
- Alcohol or substance abuse
- Increased irritability, anger or hostility
- Reckless behavior

Symptoms cause significant distress or impairment in functioning.

Depression Scales such as the Beck Depression Inventory, Children's Depression Inventory or the Reynolds Adolescent Depression Inventory can be used to establish severity, baseline functioning, and to monitor the progress of treatment.

Screening and Evaluation
Clinicians should screen all children for key depressive symptoms including sadness, irritability and a loss of pleasure in previously enjoyed activities. If these symptoms are present most of the time, affect psychosocial functioning and are not developmentally appropriate, refer for a full evaluation.

A thorough evaluation for depression should include determining the presence of other co-morbid psychiatric and medical disorders, interviews with the child and parents/caregivers, and if an adolescent, try to meet with him/her alone. Additionally, collect information from teachers, primary care physician, and other social service professionals.

- Assess for Suicidal Ideation/Crisis
    1. If the patient has a plan, the means or has recently attempted, hospitalize.
    2. If the situation is unclear, refer to a behavioral health practitioner.
    3. Evaluate level of impulsivity and if patient can commit to not harming himself; seek help if the ideation becomes overwhelming.
    4. Refer to a psychiatrist or behavioral health professional if symptoms are severe, there are co-morbid conditions, there are significant psychosocial stressors, and/or substance abuse.

- Assess for presence of on-going or past exposure to negative events such as abuse, neglect, family psychopathology, family dysfunction, and exposure to violence.

- If a child or adolescent is discharged from an inpatient hospitalization, s/he needs to be seen by an outpatient behavioral health clinician within 7 days of discharge.

TREATMENT

- Treatment with medication should always include acute and continuation phases. Some children may require maintenance treatment.
- May be seen more frequently during the first month and subsequent two months based on the needs of the child and the family.
- Each phase of treatment should include psychoeducation, supportive management, family and school involvement.
- Education, support, and case management appear to be sufficient for treatment of uncomplicated or brief depression.
- For children and adolescents who do not respond to the above or have more complicated depression, a trial of CBT and/or medication is indicated.
- Kennard, et. al. (2009) found that adolescents treated with a combination of an anti-depressant and CBT will remit earlier than those who receive either treatment alone and improvement is superior to that of both monotherapies.
- To consolidate the response to acute treatment and avoid relapse, treatment should always be continued for 6–12 months.
- Treatment should include the management of comorbid conditions.
- Progress in treatment should be monitored with rating scales such as the Beck Depression Inventory, Children's Depression Inventory or Reynolds Adolescent Depression Inventory.
- Abrupt discontinuation of anti-depressants is not recommended.

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Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition TR (2013) American Psychiatric Association.

Birmaher B, AACAP Work Group on Quality Issues. Practice Parameter for the assessment and treatment of children and adolescents with depressive disorders. Washington (DC): American Academy of Child and Adolescent Psychiatry (AACAP); 2007.

Kennard, Betsy D., et. al. (2009). Remission and Recovery Rates in the Treatment for Adolescents with Depression Study: Acute and Long-Term Outcomes. Journal of the American Academy of Child and Adolescent Psychiatry, vol. 48 (2): 186–195.

American Psychiatric Assoc. & American Academy of Child and Adolescent Psychiatry (2010) The Use of Medication in Treating Childhood and Adolescent Depression: Information for Physicians. ParentsMedGuide.org.

D. Criteria for Identification (cont.)

(2) American Academy of Pediatrics

*Emotions and Moods: Sadness and Related Symptoms**

Definitions and Symptoms

Sadness, irritability, or a loss of interest in normally pleasurable activities is a common and normal response to disappointment, failure, or loss. Such mood changes only represent a problem if they persist more than a few days and if they represent intense distress or significantly impair the child's ability to function or relate to others at home, school, or play. It is recommended that assessment of suicidal ideation, plan, and intent be undertaken routinely when these symptoms are present. Children and adolescents may not present with sadness, but may report aches and pains, low energy, or moods such as apathy, irritability or even anxiety. The mood disorders include major depressive disorder, dysthymic disorder, bipolar disorders, and cyclothymic disorder. To meet criteria for major depressive disorder, children must present with: 1) depressed or irritable mood, or 2) markedly diminished interest or pleasure in all, or almost all, activities. Bereavement is an intense grief response after a major loss (e.g., death of parent) and is usually a normal reaction involving mood and sleep or appetite changes. When bereavement symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness or suicidal ideation, major depressive disorder can be diagnosed.

Approximately one third of teenagers with depression receive treatment. This is particularly problematic given the recurrent nature of depressive episodes) the possibility of suicide, and the heightened risk of greater frequency and severity of depressive disorders in adulthood for patients with early onset (before 20 years of age). Risk factors include depressed parent(s), a strong family history of depression, anxiety disorder, alcoholism, family and marital discord, substance abuse, uncertainty about sexual orientation, and a history of previous depressive episodes. The presence of suicidal ideation, a history of suicide attempt(s), or suicidal behavior among family members or friends should trigger a prompt and thorough evaluation of suicide potential.

Epidemiology

Symptoms of depression are more prevalent in adolescence than in younger children and the rise may be due to a function of puberty rather than chronological age. Depressive disorders become more frequent during adolescence with a possible parallel shift in the sex ratio from a male preponderance before puberty to a female preponderance after puberty. Immediate grief reaction's following bereavement tend to be milder and of a shorter duration in younger children compared with those in adolescence or adulthood. In the 14- to 18-year-old age group, the 1-year total incidence of depressive disorders is estimated to be 7.7%; most cases meet the criteria for a major depressive disorder. Prevalence and incidence rates are approximately twice as high for girls as for boys; this gender difference appears to emerge at about 12 to 13 years of age. Depression is I V2 to 3 times more common among first-degree biological relatives of persons with major depressive disorder than in the general population.

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care.
(1996) American Academy of Pediatrics.

Emotions and Moods: Sadness and Related Symptoms*

Sadness Variation

Transient depressive responses or mood changes to stress are normal in otherwise healthy populations.

Bereavement

Sadness related to a major loss that typically persists for less than 2 months after the loss. However, the presence of certain symptoms that are not characteristic of a "normal" grief reaction may be helpful in differentiating bereavement from a major depressive disorder. These include guilt about things other than actions taken or not taken by the survivor at the time of death, thoughts of death, and morbid preoccupation with worthlessness.

Infancy
The infant shows brief expressions of sadness, which normally first appear in the last quarter of the first year of life, manifest by crying, brief withdrawal, and transient anger.

Early Childhood
The child may have transient withdrawal and sad affect that may occur over losses and usually experiences bereavement due to the death of a parent or the loss of a pet or treasured object.

Middle Childhood
The child feels transient loss of self-esteem aver experiencing failure and feels sadness with losses as in early childhood.

Adolescence
The adolescent's developmental presentations are similar to those of middle childhood but may also include fleeting thoughts of death. Bereavement includes loss of a boyfriend or girlfriend, friend, or best friend.

A normal process of bereavement occurs when a child experiences the death of or separation from someone (person or pet) loved by the child. There are normal age-specific responses as well as responses related to culture, temperament, the nature of the relationship between the child and the one the child is grieving, and the child's history of loss. While a child may manifest his or her grief response for a period of weeks to a couple of months, it is important to understand that the loss does not necessarily go away within that time frame. Most children will need to revisit the sadness at intervals (months or years) to continue to interpret the meaning of the loss to their life and to examine the usefulness of the coping mechanisms used to work through the sadness. A healthy mourning process requires that the child has a sense of reality about the death and access to incorporating this reality in an ongoing process of life. Unacknowledged, invalidated grief usually results in an unresolving process and leads to harmful behaviors toward self or others. Symptoms reflecting grief reaction may appear to be mild or transient, but care must be taken to observe subtle ways that unexpressed sadness may be exhibited.

Children in hospitals or institutions often experience some of the fears that accompany a death or separation. These fears may be demonstrated in actions that mimic normal grief responses.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics.

Emotions and Moods: Sadness and Related Symptoms*

Sadness Problem

Sadness or irritability that begins to include some symptoms of major depressive disorders in mild form.

- depressed/irritable mood
- diminished interest or pleasure
- weight loss/gain, or failure to make expected weight gains
- insomnia/hypersomnia
- psychomotor agitation/retardation
- fatigue or energy loss
- feelings of worthlessness or excessive or inappropriate guilt
- diminished ability to think/concentrate

However, the behaviors are not sufficiently intense to qualify for a depressive disorder.

These symptoms should be more than transient and have a mild impact on the child's functioning. Bereavement that continues beyond 2 months may also be a problem.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in primary Care*. (1996) American Academy of Pediatrics

Notes: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
The infant may experience some developmental regressions, fearfulness, anorexia, failure to thrive, sleep disturbances, social withdrawal, irritability, and increased dependency, which are responsive to extra efforts at soothing and engagement by primary caretakers.

Early Childhood
The child may experience similar symptoms as in infancy, but sad affect may be more apparent. In addition, temper tantrums may increase in number and severity, and physical symptoms such as constipation, secondary enuresis (...), encopresis (...), and nightmares may be present.

Middle Childhood
The child may experience some sadness that results in brief suicidal ideation with no clear plan of suicide, some apathy, boredom, low self-esteem, and unexplained physical symptoms such as headaches and abdominal pain (...).

Adolescence
Some disinterest in school work, decrease in motivation, and day-dreaming in class may begin to lead to deterioration of school work. Hesitancy in attending school, apathy, and boredom may occur.

SPECIAL INFORMATION

Sadness is experienced by some children beyond the level of a normal developmental variation when the emotional or physiologic symptoms begin to interfere with effective social interactions, family functioning, or school performance. These periods of sadness may be brief or prolonged depending on the precipitating event and temperament of the child. Reassurance and monitoring is often needed at this level. If the sad behaviors are more severe, consider major depressive disorders.

The potential for suicide in grieving children is higher. Evaluation of suicidal risk should be part of a grief workup for all patients expressing profound sadness or confusion or demonstrating destructive behaviors toward themselves or others.

Behavioral symptoms resulting from bereavement that persist beyond 2 months after the loss require evaluation and intervention. Depressed parents or a strong family history of depression or alcoholism (...) puts youth at very high risk for depressive problems and disorders. Family and marital discord, ... exacerbates risk. Suicidal ideation should be assessed (see Suicidal Thoughts or Behaviors cluster).

Lying, stealing, suicidal thoughts (see Suicidal Thoughts or Behaviors cluster), and promiscuity may be present. Physical symptoms may include recurrent headaches, chronic fatigue, and abdominal pain (...).

<div style="text-align: center; border: 2px solid black; padding: 20px;">

Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, 1994)*

</div>

DISORDERS

Major Depressive Disorder

Significant distress or impairment is manifested by five of the nine criteria listed below, occurring nearly every day for 2 weeks.

These symptoms must represent a change from previous functioning and that either depressed or irritable mood or diminished interest or pleasure must be present to make the diagnosis.

- depressed/irritable
- diminished interest or pleasure
- weight loss/gain
- insomnia/hypersomnia
- psychomotor agitation/retardation
- fatigue or energy loss
- feelings of worthlessness
- diminished ability to think/concentrate
- recurrent thoughts of death and suicidal ideation

(see *DSM-IV* Criteria ...)

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
True major depressive disorders are difficult to diagnose in infancy. However, the reaction of some infants in response to the environmental cause is characterized by persistent apathy, despondency (often associated with the loss of a caregiver or an unavailable [e.g., severely depressed] caregiver), nonorganic failure-to-thrive (often associated with apathy, excessive withdrawal), and sleep difficulties. These reactions, in contrast to the "problem" level, require significant interventions.

Early Childhood
This situation in early childhood is similar to infancy.

Middle Childhood
The child frequently experiences chronic fatigue, irritability, depressed mood, guilt, somatic complaints, and is socially withdrawn (...). Psychotic symptoms (hallucinations or delusions) may be present.

Adolescence
The adolescent may display psychomotor retardation or have hypersomnia. Delusions or hallucinations are not uncommon (but not part of the specific symptoms of the disorder).

SPECIAL INFORMATION

Depressed parents or a strong family history of depression or alcoholism puts youth at very high risk for depressive disorder (...). Risk is increased by family and marital discord (...), substance abuse by the patient (...), and a history of depressive episodes. Suicidal ideation should be routinely assessed.

Sex distribution of the disorder is equivalent until adolescence, when females are twice as likely as males to have a depressive disorder.

Culture can influence the experience and communication of symptoms of depression, (e.g., in some cultures, depression tends to be expressed largely in somatic terms rather than with sadness or guilt). Complaints of "nerves" and headaches (in Latino and Mediterranean cultures), of weakness, tiredness, or "imbalance" (in Chinese and Asian cultures), of problems of the "heart" (in Middle Eastern cultures), or of being heartbroken (among Hopis) may express the depressive experience.

Subsequent depressive episodes are common. Bereavement typically improves steadily without specific treatment. If significant impairment or distress is still present aver 2 months following the acute loss or death of a loved one, or if certain symptoms that are not characteristic of a "normal" grief reaction are present (e.g., marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation), consider diagnosis and treatment of major depressive disorder.

Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, l994)*

DISORDER

Dysthymic Disorder

The symptoms of dysthymic disorder are less severe or disabling than those of major depressive disorder but more persistent.

Depressed/irritable mood for most of the day, for more days than not (either by subjective account or observations of others) for at least 1 year.

Also the presence, while depressed/ irritable, of two (or more) of the following:

• poor appetite/overeating
• insomnia/hypersomnia
• low energy or fatigue
• poor concentration/difficulty making de-cisions
• feelings of hopelessness

(see *DSM-IV* Criteria ...)

Adjustment Disorder With Depressed Mood

(see DSM-IV Criteria ...)

Depressive Disorder, Not Otherwise Specified

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Not diagnosed.

Early Childhood
Rarely diagnosed.

Middle Childhood and Adolescence
Commonly experience feelings of inadequacy, loss of Interest/pleasure, social withdrawal, guilt, brooding, irritability or excessive anger, decreased activity/productivity. May experience sleep/ appetite/weight changes and psychomotor symptoms. Low self-esteem is common.

SPECIAL INFORMATION

Because of the chronic nature of the disorder, the child may not develop adequate social skills.

The child is at risk for episodes of major depression.

Note: Dots (...) indicate that the original text has a reference to another section of the resource that was omitted here because that section was not included in this guide.

DISORDER

Bipolar I Disorder, With Single Manic Episode

(see DSM-IV CRITERIA...)

Bipolar II Disorder, Recurrent Major Depressive Episodes With Hypomanic Episodes

Includes presence (or history) of one or more major depressive episodes, presence of at least one hypomanic episode, there has never been a manic episode (similar to manic episodes but only need to be present for 4 or more days and are not severe enough to cause marked impairment in function) or a mixed episode. The symptoms are not better accounted for by schizoaffective disorder, schizophrenia, delusional disorder, or psychotic disorder. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Not diagnosed.

Early Childhood
Rarely diagnosed.

Middle Childhood
The beginning symptoms as described for adolescents start to appear.

Adolescence
During manic episodes, adolescents may wear flamboyant clothing, distribute gifts or money, and drive recklessly. They display inflated self-esteem, a decreased need for sleep, pressure to keep talking, flights of ideas, distractibility, unrestrained buying sprees, sexual indiscretion, school truancy and failure, antisocial behavior, and illicit drug experimentation.

SPECIAL INFORMATION

Substance abuse is commonly associated with bipolar disorder (...).

Stimulant abuse and certain symptoms of attention-deficit/ hyperactivity disorder may mimic a manic episode (see Hyperactive/ Impulsive Behaviors cluster).

Manic episodes in children and adolescents can include psychotic features and may be associated with school truancy, antisocial behavior (...), school failure, or illicit drug experimentation. Long-standing behavior problems often precede the first manic episode.

One or more manic episodes (a distinct period of an abnormally and persistently elevated and expansive or irritable mood lasting at least 1 week if not treated) frequently occur with one or more major depressive episodes. The symptoms are not better accounted for by other severe mental disorders (e.g., schizoaffective, schizophrenegenic, delusional, or psychotic disorders). The symptoms cause mild impairment in functioning in usual social activities and relationships with others.

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care. (1996) American Academy of Pediatrics

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

General Medical Condition
Endocrine abnormalities, e.g., thyroid disorders
Malignancies
Malnutrition
Mononucleosis
Chronic fatigue syndrome
Neurologic disorders
Autoimmmune disorders
Metabolic disorders

Almost any medical condition can cause fatigue, loss of energy, insomnia, changes in appetite, and other symptoms of depression.

If a general medical condition is producing mood disturbance problems, the medical condition should be coded, and mood disorder due to a general medical condition should be coded as **293.83.**

Substances - Examples include:
Alcohol abuse
Drug abuse
Prescription drug side effects (reserpine, glucocorticoids, anabolic steroids)
Over-the-counter drugs containing synthetic narcotics

Code substance-induced mood disorder

Mental Disorders
309.0   Adjustment disorder with depressed mood
314.xx Attention-deficit/hyperactivity disorder
300.82 Somatization disorder
293.83 Mood disorders due to a general medical condition

**Other Comorbid Mental Health Conditions -
Examples include::**

300.3   Obsessive-compulsive disorder
307.80 Panic disorders
312.81 Conduct disorder childhood onset
312.82 Conduct disorder adolescent onset
313.81 Oppositional defiant disorder
305   Substance abuse disorder
314.xx Attention-deficit / hyperactivity disorder
295.   Schizophrenia
299.00 Autistic disorder
307.1   Anorexia nervosa
307.51 Bulimia nervosa
300.02 Generalized anxiety disorder
309.81 Posttraumatic stress disorder
309.21 Separation anxiety disorder

In children, major depressive disorders occur more frequently in conjunction with other mental disorders (especially disruptive behavior and anxiety disorders, and attention-deficit / hyperactivity disorder).

Other General Medical Conditions
that are acute, chronic, or disabling.

Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care. (1996) American Academy of Pediatrics

Note: Dots (...) indicate that the original text has a reference to another section of the resource that was omitted here because that section was not included in this guide.

Especially prevalent in chronic conditions that significantly affect appearance or ability to engage in age-appropriate activities (e.g., diabetes, cystic fibrosis). If this occurs, code both conditions.

III. Examples of Models, Research, and Guides

D. Criteria for Identification (cont.)

(2) American Academy of Pediatrics (cont.)

*Emotions and Moods: Suicidal Thoughts or Behaviors**

Definition and Symptoms

Suicidal behavior includes a child's stated or unstated thoughts about causing intentional selfinjury or death (suicidal ideation) and acts that cause intentional self-injury (suicide attempts) or death (suicide). Intent to cause harm to oneself is an essential ingredient in defining suicidal behavior. Intent may be explicit and strong, or it may be ambiguous and not well defined. Three categories of problems should prompt the primary care physician to probe further regarding suicidal risk: 1) psychiatric problems, depression, substance abuse, conduct problems, psychosis, past suicidal threats or behavior; 2) poor social adjustment (school failure, legal problems, social isolation, interpersonal conflict); and 3) family/environmental problems (interpersonal loss, abuse or neglect, runaway or home-less, family history of psychiatric disorder or suicide, exposure to suicide). It is important for the physician to ask directly about suicidal ideation and plans. Routine clinical inquiry will not elicit these thoughts and concerns from an individual. Those with a specific plan and/or intent or specific risk factors should be considered at most risk. Among patients who present to primary care physicians, the following are indicative of high risk for suicidal behavior: 1) presenting complaint that involves a mental health problem; 2) recent history of physical or sexual assault; 3) history of suicidal behavior; and 4) those exposed to suicide through school or media. Among those with chronic illness, suicidal ideation and behavior may be more common in those with diabetes and epilepsy.

Epidemiology

Suicide is the second leading cause of death among older adolescents. Between 12% and 25% of primary school and high school children have some form of suicidal ideation. The rate of suicide has tripled since the 1950s, which may be due to the increased availability and use of alcohol and firearms among youth. In addition, the rate of suicidal behavior has become much more common to the extent that 4% of high school students have made an attempt within the previous 12 months and 8% have made an attempt in their lifetime. Only one in eight suicide attempts is brought to the attention of a medical professional.

Among children and adolescents, the suicide rate and the rate of attempted suicide increase with age. The rate of completed suicide is much higher among males; however, the rate of attempted suicides is much higher among females. This higher rate of completed suicides among males is thought to be attributed to the more violent means utilized by males. The suicide rate is also much higher among whites than blacks, although the rates in both groups have increased. Native Americans have been reported to have a particularly high suicide rate. Socioeconomic status in general does not affect the rate of suicide, but a low status appears to be associated with higher rates of attempts. Uncertainty about sexual orientation also increases risk for suicide.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.*
(1996) American Academy of Pediatrics.

Suicidal Thoughts or Behaviors*

DEVELOPMENTAL VARIATION

Thoughts of Death Variation

Anxiety about death on early childhood

Focus on death in middle childhood or adolescence.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Not relevant at this age.

Early Childhood
In early childhood anxiety about dying may be present.

Middle Childhood
Anxiety about dying may occur in middle childhood, especially after a death in the family.

Adolescence
Some interest with death and morbid ideation may be manifest by a preference for black clothing and an interest in the occult. If this becomes increased to a point of preoccupation, a problem or a serious ideation should be considered.

PROBLEM

Thoughts of Death Problem

The child has thoughts of or a preoccupation with his or her own death.

If the child has thoughts of suicide, consider suicidal ideation and attempts.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Unable to assess.

Early and Middle Childhood
The child may express a wish to die through discussion or play. This often follows significant punishment or disappointment.

Adolescence
The adolescent may express nonspecific ideation related to suicide.

SPECIAL INFORMATION

Between 12% and 25% of primary school and high school children have some form of suicidal ideation. Those with a specific plan or specific risk factors should be considered at most risk.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics.

DISORDER

Suicidal Ideation and Attempts

The child has thoughts about causing intentional self-harm acts that cause intentional self-harm or death.

This code represents an unspecified mental disorder. It is to be used when no other condition is identified.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Unable to assess.

Early Childhood
The child expresses a wish and intent to die either verbally or by actions.

Middle Childhood
The child plans and enacts self-injurious acts with a variety of potentially lethal methods.

Adolescence
The adolescent frequently shows a strong wish to die and may carefully plan and carry out a suicide.

SPECIAL INFORMATION

A youngster's understanding that death is final is not an essential ingredient in considering a child or adolescent to be suicidal. How-ever, very young children, such as preschoolers who do not appreciate the finality of death, can be considered to be suicidal if they wish to carry out a self-destructive act with the goal of causing death. Such behavior in preschoolers is often associated with physical or sexual abuse (...).

Prepubertal children may be protected against suicide by their cognitive immaturity and limited access to more lethal methods that may prevent them from planning and executing a lethal suicide attempt despite suicidal impulses.

The suicide rate and rate of attempted suicide increase with age and with the presence of alcohol and other drug use. Psychotic symptoms, including hallucinations, increase risk as well.

Because of societal pressures, some homosexual youth are at increased risk for suicide attempts (...).

In cases of attempted suicide that are carefully planned, adolescents may leave a note, choose a clearly lethal method, and state their intent prior to the actual suicide. In contrast, most suicide attempts in adolescence are impulsive, sometimes with little threat to the patient's life. The motivation for most attempts appears to be a wish to gain attention and/or help, escape a difficult situation, or express anger or love. However, irrespective of motivation, all suicide attempts require careful evaluation and all patients with active intent to harm themselves should have a thorough psychiatric evaluation.

Although suicidal ideation and attempts is not a disorder diagnosis, more extensive evaluation may identify other mental conditions (e.g., major depressive disorder).

Note:Dots (...) indicate that the original text has a reference
to another section of the book that was omitted here because that section was not included in this guide.

DIFFERENTIAL DIAGNOSIS

General Medical Condition
Not relevant.

Substances

Mental Disorders
Not relevant

COMMONLY COMORBID CONDITIONS

**Other Comorbid Mental Health Conditions -
Examples include::**

296.2x, Major depressive disorder
296.3x
309.xx Adjustment disorder
305 Substance abuse disorder
295.xx Schizophrenia
296.xx Bipolar disorders
V62.82 Bereavement
301.83 Borderline personality disorder

Other General Medical Conditions
Chronic illness may predispose to suicidal ideation and
suicide attempts (based on specific studies with diabetes
and epilepsy).

*Adapted from *The Classification of Child and Adolescent
Mental Diagnoses in Primary Care*. (1996) American
Academy of Pediatrics

Note: Dots (...) indicate that the original text has a
reference to another section of the resource that was
omitted here because that section was not included in this
guide.

SPECIAL INFORMATION

Suicidal ideation can occur simultaneously with any general
medical condition

Intoxication can exacerbate suicidal behaviors or ideation and should be considered a
significant risk factor.

No medical disorders would be coded in place of suicidal ideation but do frequently
occur simultaneously as described under Other Comorbid Mental Health Conditions.

SPECIAL INFORMATION

Individuals with borderline personality disorder display recurrent suicidal behavior,
gestures or threats, or self-mutilating behavior. Completed suicide occurs in 8% to
10% of such individuals, and self-mutilating acts (e.g., cutting or burning) and suicide
threats and attempts are very common. Recurrent suicidality is often the reason that
these individuals present for help.

Only consider borderline personality disorder in later adolescence and early adulthood
when a personlaity disorder can be diagnosed more reliably.

Mental disorders can frequently be associated with suicidal ideations, these include
depression (See Sadness and Related Symptoms cluster, p 153) or conduct
problems (see Aggressive/Oppositional Behaviors cluster, p 119).

IV. *Intervention Planning and Training*

A. *Responding to Suicidal Crisis*

(1) When a Student Talks of Suicide . . .

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

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

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

What to do:

- Send someone for help; you'll need back-up.

- Remain calm; remember the student is overwhelmed and confused as well as ambivalent.

- Get vital statistics, including student's name, address, home phone number and parent's work number.

- Encourage the student to talk. Listen! Listen! Listen! And when you respond, reflect back what you hear the student is saying. Clarify, and help him or her to define the problem, if you can.

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

- Clarify some immediate options (e.g., school and/or community people who can help).
-
- If feasible, get an agreement to no-suicide ("No matter what happens, I will not kill myself.")

- Involve parents for decision making and follow-through and provide for ongoing support and management of care (including checking regularly with parents and teachers).

What to avoid:

- Don't leave the student alone and don't send the student away

- Don't minimize the student's concerns or make light of the threat

- Don't worry about silences; both you and the student need time to think

- Don't fall into the trap of thinking that all the student needs is reassurance

- Don't lose patience

- Don't promise confidentiality -- promise help and privacy

- Don't argue whether suicide is right or wrong

A.   Responding to Suicidal Crisis (cont.)

(2) When a Student Attempts Suicide . . .

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

What to do:

- Be directive. Tell the student, "Don't do that; stand there and talk with me." "Put that down." "Hand me that." "I'm listening."

- Mobilize someone to inform an administrator and call 911; get others to help you; you'll need back-up.

- Clear the scene of those who are not needed.

- An "administrator" should contact parents to advise them of the situation and that someone will call back immediately to direct the parent where to meet the youngster.

- Look at the student directly. Speak in a calm, low voice tone. Buy time. Get the student to talk. Listen. Acknowledge his or her feelings "You are really angry." "You must be feeling really hurt."

- Secure any weapon or pills; record the time any drugs were taken to provide this information to the emergency medical staff or police.

- Get the student's name, address and phone.

- Stay with the pupil; provide comfort.

- As soon as feasible, secure any suicidal note, record when the incident occurred, what the pupil said and did, etc.

- Ask for a debriefing session as part of taking care of yourself after the event.

What to avoid:

- Don't moralize ("You're young, you have everything to live for.")

- Don't leave the student alone (even if the student has to go to the bathroom).

- Don't move the student.

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

A.   Responding to Suicidal Crisis (cont.)

(3) Follow-Through Steps After Assessing Suicidal Risk --

Checklist

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

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

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

___(4)   Try to contact parents by phone to
        a) inform about concern
        b) gather additional information to assess risk
        c) provide information about problem and available resources
        d) offer help in connecting with appropriate resources
   Note: if parents are uncooperative, it may be necessary to report child endangerment after taking the following steps.

____(5)   If a student is considered to be in danger, only release her/him to the parent or someone who is equipped to provide help. In high risk cases, if parents are unavailable (or uncooperative) and no one else is available to help, it becomes necessary to contact local public agencies (e.g., children's services, services for emergency hospitalization, local law enforcement). Agencies will want the following information:
       *student's name/address/birthdate/social security number
       *data indicating student is a danger to self (see Suicide Assessment -- Checklist)
       *stage of parent notification
       *language spoken by parent/student
       *health coverage plan if there is one
       *where student is to be found

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

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

____(8)   Report child endangerment if necessary.

School-Based Suicide Prevention: Content, Process, and the Role of Trusted Adults and Peers.
S.V. Joshi, S.N. Hartley, M. Kessler, & M. Barstead (2015). *Child and Adolescent Psychiatric Clinics of North America, 24,* 353–370.
http://www.sciencedirect.com/science/article/pii/S1056499314001254

Key points
- Suicide accounts for more deaths among youth and young adults in the United States than do all natural causes combined.
- Most deaths by suicide occur in people who have had mental health conditions, such as depression or severe anxiety, for at least a year.
- Prevention efforts must focus on school-based mental health education and promotion.
- Currently available programs focus on varying areas, including (1) Awareness/Education Curricula; (2) Screening; (3) Gatekeeper Training; (4) Skills Training; and (5) Peer Leadership.
- Behavior change for either self or a friend with regard to help-seeking for suicidal behaviors is an important focus for research.
- Process considerations are paramount and guide the nurturing of relationships and the building (and maintenance) of trust with school staff and administrators in enacting school-based strategies that highlight not only suicide prevention, but also health/wellness promotion and structural changes where indicated.

****

School Personnel Experiences in Notifying Parents About Their Child's Risk for Suicide: Lessons Learned.
E. Nadeem, C.D. Santiago, S.H. Kataoka, V.Y. Chang, & B.D. Stein (2016). Journal of School Health, 86, 3–10.
http://onlinelibrary.wiley.com/doi/10.1111/josh.12346/abstract

Abstract

BACKGROUND: Schools across the nation are increasingly implementing suicide prevention programs that involve training school staff and connecting students and their families to appropriate services. However, little is known about how parents are engaged in such efforts.

METHODS: This qualitative study examined school staff perspectives on parent involvement in the implementation of a district-wide suicide prevention program by analyzing focus group and interview data gathered on the program implementation processes. Participants included middle school teachers, administrators, and other school personnel.

RESULTS: Study results revealed that in the immediate wake of a crisis or concern about suicide, school staff routinely contacted parents. However, substantial barriers prevent some students from receiving needed follow-up care (eg, lack of consistent follow-up, financial strain, parental stress, availability of appropriate services). Despite these challenges, school staff identified strategies that could better support parents before, during, and after the crisis. In particular, school-based services increased the success of mental health referrals.

CONCLUSIONS: Our study suggests that systematic postcrisis follow-up procedures are needed to improve the likelihood that students and families receive ongoing support. In particular, school-based services and home visits, training and outreach for parents, and formal training for school mental health staff on parent engagement may be beneficial in this context.

Adolescence, when suicidal ideation and behaviors often begin, might offer an important window to understand the causes and prevent the progression of suicide phenomena. The need for frameworks to organize the fragmented field has been noted, but few studies are theoretically driven. An important recent contribution to understanding suicidality is Joiner's (2005) Interpersonal-Psychological Theory of Suicide (IPTS). This article reviews the evidence for the applicability of the IPTS in adolescence. Seventeen studies of adolescents that specifically tested or interpreted findings in the light of Joiner's theory or the IPTS were located. In addition, several recent reviews of the literature on suicidality in adolescence covered information relevant to the IPTS. There is some support for the theory in adolescence, particularly with regard to its most novel component, the association between acquired capability and suicide attempt. In summary, we find this theory to be a promising heuristic to organize the disparate studies in suicide research. Future challenges and directions for researchers seeking to test and elaborate the applicability of the IPTS in adolescence include: adaptations of instruments to the developmental stage, capturing of imminent risk, and consideration of whether the current model is underspecified. Age might moderate adult findings that give impulsivity an indirect role in suicide attempts.

B. Model School District Policy on Suicide Prevention
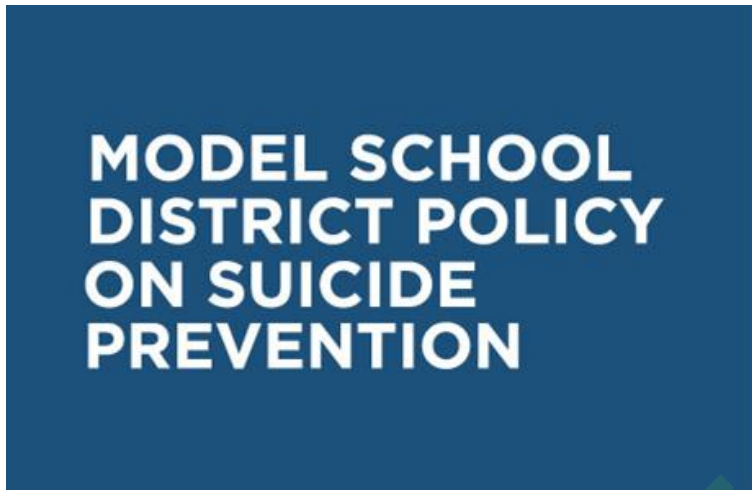
http://www.thetrevorproject.org/pages/modelschoolpolicy

Reducing the risk of youth suicide requires making positive changes. To help make it easier for schools to prevent, assess, intervene in, and respond to suicidal behavior, The Trevor Project has collaborated to create a Model School District Policy for Suicide Prevention. This modular, adaptable document will help educators and school administrators implement comprehensive suicide prevention policies in communities nationwide. Download our fact sheet and full policy today – by adopting or advocating for this model policy in your school district, you can help protect the health and safety of all students.

This model policy was created in collaboration with the American Foundation for Suicide Prevention, the American School Counselor Association, and the National Association of School Psychologists.

Webinar

View our recorded webinar on the Model School District Policy (http://thetrevorproject.adobeconnect.com/p4z1v9eyvl9/)

View a PDF of the webinar presentation slides (/page/-/files/resources/Model-Policy-Webinar-Slides.pdf)

Fast Facts: Model School District Policy on Suicide Prevention

Although suicide is the third leading cause of death among youth ages 10-19 in the U.S., many school districts do not have comprehensive policies and procedures in place relating to youth suicide and its prevention. In a typical high school, it is estimated that three students will attempt suicide each year, while even more seriously consider attempting suicide or report feeling sad or hopeless almost every day for weeks at a time. School district policies and procedures can help schools ensure that students in crisis are referred to supportive resources and that suicides within the school community are addressed appropriately. By having clear policies and procedures in place concerning suicide prevention, intervention, and postvention, schools can act to reduce the risk of suicide and to prevent suicide contagion.

The Model School District Policy is available here:
http://www.thetrevorproject.org/pages/modelschoolpolicy

Contributing Groups

The model is a collaborative effort of the American Foundation for Suicide Prevention, the American School Counselor Association, the National Association of School Psychologists, and The Trevor Project.

How to Use the Model School District Policy on Suicide Prevention

This model will serve as a tool for school staff, school board members, advocates, parents, and students for the development and implementation of comprehensive school district policies on suicide prevention. Employing language from strong local policies throughout the country and the expertise of the contributing groups, the model policy:

- Is a comprehensive, yet modular document that school districts may use to draft new or amend their own district policies based on the unique needs of the district.
- Can complement existing state laws requiring suicide prevention training for school personnel or education for students.
- Is intended to be paired with other policies and programs that support the emotional and behavioral well-being of youth.

Suicide is very rare among elementary school youth, therefore the language and concepts covered by the model are most applicable to middle and high schools.

Model School District Policy Components

The model provides school districts with recommended language for school district policies that address preventing, assessing the risk of, intervening in, and responding to youth suicidal behavior. The model also contains commentary, best practices, and resources pertaining to youth suicide prevention.

V. On Aftermath Assistance & Prevention of Contagion
Postvention . . .

These resources can help you
learn more
about postvention as prevention and
take action.

Learn More

SPARK Talks: Suicide Postvention as Suicide Prevention

http://sparktalks.sprc.org

Speaker: Ken Norton, LICSW, Executive Director, New Hampshire Chapter of the National Alliance on Mental Illness (NAMI). (2014).
SPRC's SPARK Talks are **S**hort, **P**rovocative, **A**ction-oriented, **R**ealistic, and **K**nowledgeable videos of leaders in the suicide prevention movement who describe a new development or direction in the field that can have an impact on the burden of suicide.

Essential Questions on Suicide Bereavement and Postvention

http://www.mdpi.com/1660-4601/9/1/24

Authors: Andriessen, K., & Krysinska, K. (2012). *International Journal of Environmental Research and Public Health, 9*(1), 24–32.
This article discusses key questions about suicide bereavement and postvention as it is now and how it may develop in the future. These questions include "What are the needs of suicide survivors?" and "What is postvention from a clinical perspective and from a public health perspective?" The article ends with recommendations to strengthen the possibilities of postvention as prevention.

Take Action

Responding to Grief, Trauma, and Distress after a Suicide: U.S. National Guidelines

http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/NationalGuidelines.pdf

Author: Survivors of Suicide Loss Task Force of the National Action Alliance for Suicide Prevention, 2015. These guidelines provide a blueprint for the development of suicide postvention in a wide range of settings. They are useful for anyone who is in contact with or wants to help people impacted by a suicide loss. The goal is to reduce the negative effects of exposure to suicide and facilitate the process of healing from a suicide loss on both the individual and community levels.

Connect Postvention Protocols and Trainings Website

http://www.theconnectprogram.org/training/reduce-suicide-risk-and-promote-healing-suicide-postvention-training

Author: Connect, a program of the National Alliance on Mental Illness, New Hampshire (n.d.).
Connect, a program of NAMI New Hampshire, provides protocols, training, and consultation for general audiences as well as versions tailored for specific audiences, including first responders, mental health providers, funeral directors, faith leaders, police officers, and other provider groups as well as American Indians and Alaskan Natives. More than "just training," Connect fosters relationship building, and the exchange of resources among participants. The six-hour training includes activities, interactive case scenarios, discussion, PowerPoint presentations, and printed materials. A three-day training for trainers is also available.

LOSS Team Postvention Workshops and Training Website

http://www.lossteam.com/About-LOSSteam-2010.shtml

Author: Campbell & Associates Consulting, LLC. (2013).
A LOSS Team (Local Outreach to Suicide Survivors) is an active model of postvention. The team is made up of suicide survivors who have been trained to assist the bereaved at the scene of a suicide by providing support and referrals. The primary goal is to let suicide survivors know that resources exist in order to shorten the time between the death of the loved one and survivors finding help. Frank Campbell, PhD, founder of LOSS Teams, leads many trainings and workshops where you can learn more about the LOSS team concept and how to set up a Loss team in your area.

After a Suicide: A Toolkit for Schools

http://www.sprc.org/sites/sprc.org/files/library/AfteraSuicideToolkitforSchools.pdf?sid=35963

Authors: American Foundation for Suicide Prevention and Suicide Prevention Resource Center. (2011).
This toolkit is designed to assist schools in the aftermath of a suicide (or other death) in the school community. It is a practical resource for schools facing real-time crises to help them determine what to do and when and how to do it. The toolkit reflects consensus recommendations developed in consultation with a diverse group of national experts. It incorporates existing material and research findings as well as references, templates, and links to additional information and assistance.

A Manager's Guide to Suicide Postvention in the Workplace: 10 Action Steps for Dealing with the Aftermath of Suicide

http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Managers-Guidebook-To-Suicide-Postvention-Web.pdf

Authors: Carson J. Spencer Foundation, Crisis Care Network, National Action Alliance for Suicide Prevention, and American Association of Suicidology. (2013).
This guide provides clear steps for postvention, including information for workplace leadership on how to respond immediately to a suicide, how to plan in the short-term for recovery, and what long-term strategies to consider for helping employees cope. It contains succinct procedures with checklists and flow charts and can be useful to managers at all levels.

Riverside Trauma Center Postvention Guidelines

http://traumacenter.wpengine.com/wp-content/uploads/2015/03/Postventionguidelines.pdf

Authors: Berkowitz, L., McCauley, J., and Mirick, R. (n.d.).
This document offers guidelines for schools, organizations, and communities to follow after a suicide occurs. Special attention is paid to balancing the needs for commemorating the deceased and preventing a possible contagion effect, as well as addressing trauma issues that may be present.

Tragedy Assistance Program (TAPS) Website

http://www.taps.org

TAPS is the 24/7 tragedy assistance resource for anyone who has suffered the loss of a military loved one, regardless of the relationship to the deceased or the circumstance of the death. It provides immediate and long-term care through comprehensive services and programs, including peer-based emotional support, casework assistance, connections to community-based care, and grief and trauma resources.

What Emergency Responders Need to Know about Suicide Loss: A Suicide Postvention Handbook

http://www.co.delaware.pa.us/intercommunity/PDFs/SuicideBooklet.pdf

Author: Montgomery County Emergency Service. (2005).
This brief handbook on postvention helps police officers, EMS providers, and crisis intervention specialists understand how to help family members, friends, and others close to a person who has just died by suicide.

Recommendations for Reporting on Suicide

http://reportingonsuicide.org/

Authors: American Foundation for Suicide Prevention; Annenberg Public Policy Center; Columbia University Department of Psychiatry; National Alliance on Mental Illness, New Hampshire; Substance Abuse and Mental Health Services Administration, and Suicide Awareness Voices of Education. (2011).
Recommendations for Reporting on Suicide was developed by leading experts in suicide prevention in collaboration with several international suicide prevention and public health organizations, schools of journalism, media organizations, and key journalists as well as Internet safety experts. The research-based recommendations include suggestions for online media, message boards, bloggers, and "citizen journalists." Although not specific to postvention, these guidelines are particularly important in the aftermath of a suicide.

Framework for Successful Messaging

http://suicidepreventionmessaging.actionallianceforsuicideprevention.org/

Author: National Action Alliance for Suicide Prevention. (2014).
The *Framework for Successful Messaging* is a resource to help people develop messages about suicide that are strategic, safe, and positive, and make use of relevant guidelines and best practices. It is for suicide prevention *messengers* rather than the media. It addresses "public messaging," which is any communications released into the public domain, including posters, public service announcements (PSAs), social media, websites, newsletters, fundraising appeals, event publicity, press interactions, public talks, and advocacy efforts.

Lifeline Online Postvention Manual

http://www.sprc.org/sites/sprc.org/files/library/LifelineOnlinePostventionManual.pdf

Author: National Suicide Prevention Lifeline. (n.d.).
This manual discusses the role of the Internet in postvention and how postvention initiatives can target existing online communities when there is a suicide death. The recommendations cover how to safely memorialize someone who has died by suicide. They can also be applied to online memorials and online messages about those who have died.

Facilitating Suicide Bereavement Support Groups: A Self-Study Facilitator Package

http://www.custompromostore.com/afspstore/products/Facilitating-Suicide-Bereavement-Support-Groups%3A-A-Self%252dStudy-Facilitator-Package.html

Author: American Foundation for Suicide Prevention. (n.d.).

This package contains a 95-page guide to effective support group facilitation titled *Facilitating Suicide Bereavement Support Groups: A Self-Study Manual,* and a 90-minute companion DVD titled *Facilitating Suicide Bereavement Support Groups: Skill-Building and Special Challenges.* The DVD features experienced facilitators, who demonstrate specific strategies for handling difficult situations and share their own personal advice.

Pathways to Purpose and Hope: A Guide to Creating a Sustainable Suicide Bereavement Support Program for Families and Friends after a Suicide Death

http://www.friendsforsurvival.org/pathways.html

Author: Friends for Survival, Inc. (2013).
This publication offers guidance on how to create a sustainable program for survivors of suicide loss, including how to form a sustainable organization, raise funds, recruit members and volunteers, and much more. The guide will be useful to individuals and organizations looking to start a new program or to expand the capacity or strengthen the sustainability of an existing one.

After a Suicide: Recommendations for Religious Services and Other Public Memorial Observances

http://www.sprc.org/library/aftersuicide.pdf

Author: Suicide Prevention Resource Center. (2004).
This brief guide was created to aid clergy and other faith community leaders in the aftermath of a suicide death. It provides background information, suggests ways to care for and support survivors, and offers recommendations for planning a memorial observance. The suggestions are based on scientific research as well as extensive consultations with clergy and counselors who represent the broadest range of religions and cultural communities and who have provided care after a suicide.

Help at Hand: Supporting Survivors of Suicide Loss: A Guide for Funeral Directors

http://www.sprc.org/sites/sprc.org/files/library/funeraldirectors.pdf

Authors: Suicide Prevention Action Network USA and Suicide Prevention Resource Center. (2008).
This 16-page brochure for funeral directors who may have to work with suicide survivors. It explains the differences of suicide deaths, addresses the complex needs of survivors, and covers compassion fatigue.

IASP Special Interest Group – Postvention (Suicide Bereavement) Website

http://iasp.info/postvention.php

Author: International Association for Suicide Prevention (IASP). (2014).
This webpage contains a number of postvention resources, including a guide to starting a support group for survivors and guides to survivor organizations and services around the world.

V. On Aftermath Assistance & Prevention of Contagion
Postvention . . . (cont.)

After a Suicide

http://www.yspp.org/schools/crisis_response_after.htm

Nothing should be done to glamorize or dramatize the event, but doing nothing can be as dangerous as doing too much. Every school should have policies and procedures that address the needs of the administrators, teachers/staff, students and parents after a suicide.

Maureen Underwood and Karen Dunne-Maxim in their book, Managing Sudden Traumatic Loss in the Schools, identify the following:

Administrators need:
- Information about the death
- Information about the deceased
- A system for contacting necessary crisis resources
- A strategy for responding to media requests
- Support

Teachers/Staff need:
- Information about the death
- Information about the school's crisis response plan
- Permission to grieve and a place to grieve
- Preparation for students' reactions
- Guidance in structuring school activities
- Involvement in identifying high-risk students
- Information about resources within the school and community
- Support

Students need:
- Information about the death
- Permission to grieve and a place to grieve
- Outreach to those most impacted by the death
- Information about resources within the school and community

Parents need:
- Information about the death
- Information about the school's response
- Preparation for children's reactions
- Information about community resources
- Support
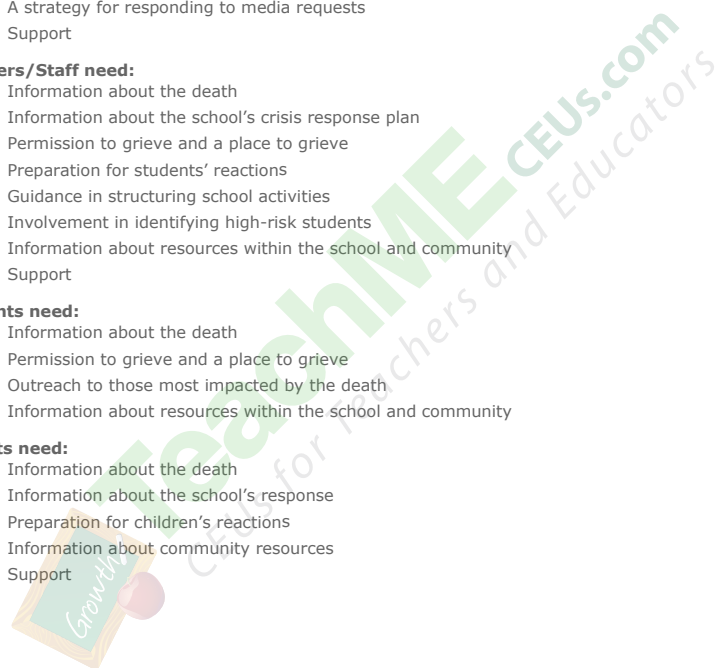
Introduction and Executive Summary

Suicide in a school community is tremendously sad, often unexpected, and can leave a school with many uncertainties about what to do next. Faced with students struggling to cope and a community struggling to respond, schools need reliable information, practical tools, and pragmatic guidance.

The American Foundation for Suicide Prevention (AFSP) and the Suicide Prevention Resource Center (SPRC), two of the nation's leading suicide prevention organizations, have collaborated to produce this toolkit to assist schools in the aftermath of a suicide (or other death) in the school community. Both organizations have often been contacted by schools in the aftermath of a suicide death. Because neither AFSP nor SPRC have the capacity to provide customized technical assistance in these circumstances, this toolkit was created to help schools determine what to do, when, and how. It is a highly practical resource for schools facing real-time crises. While designed specifically to address the aftermath of suicide, schools will find it useful following other deaths as well.

The toolkit reflects consensus recommendations developed in consultation with a diverse group of national experts, including school-based personnel, clinicians, researchers, and crisis response professionals. It incorporates relevant existing material and research findings as well as references, templates, and links to additional information and assistance. It is not, however, intended to be a comprehensive curriculum. For more resources, see **Additional Information**.

After a Suicide: A Toolkit for Schools includes an overview of key considerations, general guidelines for action, do's and don'ts, templates, and sample materials, all in an easily accessible format applicable to diverse populations and communities. Principles that have guided the development of the toolkit include the following:

- Schools should strive to treat all student deaths in the same way. Having one approach for a student who dies of cancer (for example) and another for a student who dies by suicide reinforces the unfortunate stigma that still surrounds suicide and may be deeply and unfairly painful to the deceased student's family and close friends.

- At the same time, schools should be aware that adolescents are vulnerable to the risk of suicide contagion. It is important not to inadvertently simplify, glamorize, or romanticize the student or his/her death.

- Schools should emphasize that the student who died by suicide was likely struggling with a mental disorder, such as depression or anxiety, that can cause substantial psychological pain but may not have been apparent to others (or that may have shown as behavior problems or substance abuse).

- Help is available for any student who may be struggling with mental health issues or suicidal feelings.

Specific areas addressed in the toolkit are listed below:

Crisis Response

A suicide death in a school community requires implementing a coordinated crisis response to assist staff, students, and families who are impacted by the death and to restore an environment focused on education. Whether or not there is a Crisis Response Plan already in place, the toolkit contains information that can be used to initiate a coordinated response once the basic facts about the death have been obtained. Included are a Team Leader's Checklist (who does what), talking points for use with students, staff, parents, and the media; sample handouts; meeting guidelines; and links to additional resources.

Helping Students Cope

Most adolescents have mastered basic skills that allow them to handle strong emotions encountered day to day, but these skills may be challenged in the face of a school suicide. Moreover, adolescence marks a time of increased risk for difficulties with emotional regulation, given the intensification of responses that come with puberty and the structural changes in the brain that occur during this developmental period. Schools should provide students with appropriate opportunities to express their emotions and identify strategies for managing them, so that the school can return to its primary focus of education.

Working with the Community

Because schools exist within the context of a larger community, it is important that in the aftermath of a suicide (or other death) the school administrative team establish and maintain open lines of communication with community partners such as the coroner/medical examiner, police department, mayor's office, funeral director, clergy, and mental health professionals. Even in those realms where the school may have limited authority (such as the funeral), a collaborative approach allows for the sharing of important information and coordination of strategies. A coordinated approach can be especially critical when the suicide receives a great deal of media coverage and when the community is looking to the school for guidance, support, answers, and leadership.

Memorialization

School communities often wish to memorialize a student who has died, reflecting a basic human desire to remember those we have lost. It can be challenging for schools to strike a comfortable balance between compassionately meeting the needs of distraught students while preserving the ability of the school to fulfill its primary purpose of education. In the case of suicide, schools must also consider how to appropriately memorialize the student who has died without risking suicide contagion among those surviving students who may themselves be at risk. It is very important that schools strive to treat all deaths in the same way.

Social Media

Social media such as texting, Facebook, and Twitter are rapidly becoming the primary means of communication for people of all ages, especially youth. While these communications generally take place outside of school (and may therefore fall outside of the school's control or jurisdiction), they can nevertheless be utilized as part of the school's response after a student's suicide. By working in

partnership with key students to identify and monitor the relevant social networking sites, schools can strategically use social media to share prevention-oriented safe messaging, offer support to students who may be struggling to cope, and identify and respond to students who could be at risk themselves.

Suicide Contagion

Contagion is the process by which one suicide may contribute to another. In fact, in some cases suicide(s) can even follow the death of a student from other causes, such as an accident. Although contagion is comparatively rare (accounting for between 1 percent and 5 percent of all suicide deaths annually), adolescents appear to be more susceptible to imitative suicide than adults, largely because they may identify more readily with the behavior and qualities of their peers. If there appears to be contagion, school administrators should consider taking additional steps beyond the basic crisis response, including stepping up efforts to identify other students who may be at heightened risk of suicide, collaborating with community partners in a coordinated suicide prevention effort, and possibly bringing in outside experts.

Bringing in Outside Help

School crisis team members should remain mindful of their own limitations and consider bringing in trained trauma responders from other school districts or local mental health centers to help them as needed.

Going Forward

In the ensuing months, schools may wish to consider implementing suicide awareness programs to educate teachers, other school personnel, and students themselves about the causes of suicidal behavior in young people and to identify those who may be at risk.

Additional Information*

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B. Websites

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Comprehensive Approach to Suicide Prevention -- http://www.lollie.com/blue/suicide.html

Facts for Families -- http://www.aacap.org/

Gay Bisexual Male Youth Suicide Studies == http://www.youth-suicide.com/gay-bisexual/

Internet & International Crisis Resources & Information == http://www.faqs.org/faqs/suicide/resources/

Light for Life Foundation --http://www.yellowribbon.org

National Center for Injury Prevention and Control (NCIPC) -- http://www.cdc.gov/ncipc/osp/data.htm

National Depressive and Manic-Depressive Association -- http://www.ndmda.org

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

National Strategy for Suicide Prevention -- http://www.mentalhealth.org/suicideprevention/

Samaritans of Boston -- http://www.samaritansofboston.org/

San Francisco Suicide Prevention -- http://www.sfsuicide.org

SPRC Library Catalog -- http://library.sprc.org/browse.php?catid=65717

Suicide Awareness / Voices of Education -- http://www.save.org

Suicide Information and Education Centre -- http://www.suicideinfo.ca/

Suicide: Read This First -- http://www.metanoia.org/suicide/

Youth Risk Behavior Surveillance System -- http://www.cdc.gov/nccdphp/dash/yrbs

Youth Suicide Prevention Program -- http://www.yspp.org