Technical Assistance Sampler on:

School Interventions to Prevent Youth Suicide

This document is a hardcopy version of a resource that can be downloaded at no cost from the Center's website http://smhp.psych.ucla.edu

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SCHOOL INTERVENTIONS TO PREVENT YOUTH SUICIDE

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Introduction...

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

"The Surgeon General's Call To Action To Prevent Suicide," outlines more than a dozen steps that can be taken by individuals, communities, organizations and policymakers.

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

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

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

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

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

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

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

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

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

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

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

I. ON SUICIDE AND ITS PREVENTION

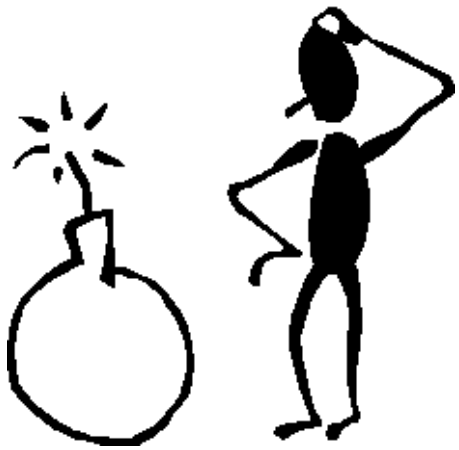
A. About Youth Suicide/Depression/Violence

B. Basic Facts and Stats

C. Common Myths

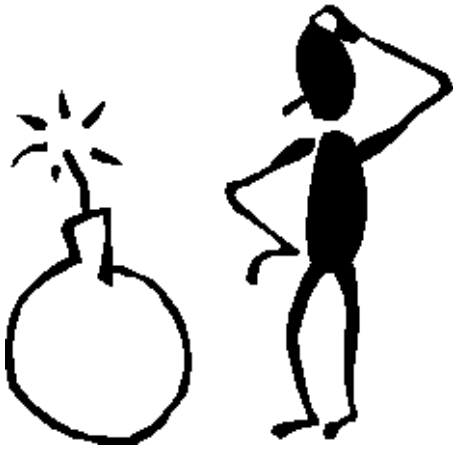
D. A General Model of Youth Suicide

E. About Prevention



I. ON SUICIDE AND ITS PREVENTION

A. About Youth Suicide/Depression/Violence



SCHOOL MENTAL HEALTH PROJECT UCLA

Addressing Barriers to Learning

New ways to think . . .

Better ways to link

Mental Health in Schools Center Training and Technical Assistance

Volume 4, Number 3
Summer, 1999

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

Alfie Kohn, 1999

Youth Suicide/ Depression/Violence

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

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

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

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

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

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

About Violence

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

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

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

About Suicide and Depression

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

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

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

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

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

Linked Problems

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

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

Risk Factors

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

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

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

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

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

E. 19. Constitutional Factors

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

General Guidelines for Prevention

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

- Systemic changes designed to both minimize threats to and enhance feelings of competence, connectedness, and self-determination (e.g., emphasizing a caring and supportive climate in class and school-wide, personalizing instruction). Such changes seem easier to accomplish when smaller groupings of students are created by establishing smaller schools within larger ones and small cooperative groups in classrooms.
- Ensure a program is integrated into a comprehensive, multifaceted continuum of interventions.
- Build school, family, and community capacity for participation.
- Begin in the primary grades and maintain the whole continuum through high school.
- Adopt strategies to match the diversity of the consumers and interveners (e.g., age, socio economic status, ethnicity, gender, disabilities, motivation).
- Develop social, emotional, and cognitive assets and compensatory strategies for coping with deficit areas.
- Enhance efforts to clarify and communicate norms about appropriate and inappropriate behavior (e.g., clarity about rules, appropriate rule enforcement, positive "reinforcement" of appropriate behavior; campaigns against inappropriate behavior).

Suicide Prevention

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

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

Enhancing Protective Factors and Building Assets

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

Community and School Protective Factors

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

Family and Peer Protective Factors

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

Individual Protective Factors

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

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

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

Emotional

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

Cognitive

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

Behavioral

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

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

What Makes Youth Development Programs Effective?

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

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

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

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

System Change

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

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

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

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

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

What is a psychological sense of community?

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

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

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

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

Knowing What to Look For & What to Do

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

Concluding Comments

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

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

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

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

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

Cited References and A Few Resource Aids

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

Kohn, A. (Sept. 1999). Constant frustration and occasional violence: The legacy of American high schools. *American School Board Journal.* On the web at: http://www.asbj.com/security/contents/0999kohn.html

The Surgeon General's Call to Action to Prevent Suicide 1999. Available from the U.S. Dept. of Health & Human Services, Click here

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

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

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

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

Some Websites:

Safe and Drug Free Schools Office, U.S. Dept. of Educ. http://www.ed.gov/offices/OESE/SDFS
National Institute of Mental Health http://www.nimh.nih.gov
National School Safety Center http://nssc1.org
Youth Suicide Prevention Program http://www.yspp.org/
Suicide Resources on the Internet http://psychcentral.com/helpme.htm

I. ON SUICIDE AND ITS PREVENTION

B. Basic Facts and Stats

- ? Suicide as a Public Health Problem
- ? Vital Statistics: Youth Risk Behavior Surveillance Data 2001
- ? USA Suicide: 2000 Official Final Data
- ? U.S. Suicide Rates by Age, Gender, and Racial Group
- ? Suicide: Cost to the Nation

Suicide as a Public Health Problem

The following excerpt is taken from "The Surgeon General's Call to Action to Prevent Suicide, 1999" and can be found at: Click here

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

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

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

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

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

Note: All references from the Surgeon General's Report are included in the reference section of this sampler (Section V.B.1).

VITAL STATISTICS

Excerpts from the

Youth Risk Behavior Surveillance Data - 2001

(Centers for Disease Control and Prevention, http://www.cdc.gov)

Sadness and Hopelessness

- Nationwide, during the 12 months preceding the survey, 28.3% of students had felt so sad or hopeless almost every day for 2 weeks in a row that they stopped doing some usual activities.
- Overall, female students (34.5%) were significantly more likely than male students (21.6%) to feel sad or hopeless almost every day for 2 weeks. This significant sex difference was identified for all the racial/ethnic and grade subpopulations.
- Overall, Hispanic students (34%) were significantly more likely than Black and White students (28.8% and 26.5%, respectively) to have felt sad or hopeless almost every day for 2 weeks. Hispanic female students (42.3%) were significantly more likely than White female students (32.3%) and Hispanic male students (25.4%) were significantly more likely than White male students (20.5%) to report this behavior.
- Prevalence of feeling sad or hopeless ranged from 20.5% to 30.7% (median: 27.2%) across state surveys and from 24.2% to 35.3% (median: 31.1%) across local surveys.

Suicide Ideation

- During the 12 months preceding the survey, 19% of students had seriously considered attempting suicide.
- Female students (23.6%) were significantly more likely than male students (14.2%) to have considered attempting suicide. This significant sex difference was identified for all the racial/ethnic subpopulations and students in grades 9, 10, and 11.
- Overall, White and Hispanic students (19.7% and 19.4%, respectively) were significantly more likely than Black students (13.3%) to have considered attempting suicide. Hispanic and white female students (26.5% and 24.2%, respectively) were significantly more likely than black female students (17.2%), and white male students (14.9%) were significantly more likely than Black male students (9.2%) to have considered attempting suicide.
- Prevalence of seriously considering suicide ranged from 14.6% to 21.9% (median: 18.4%) across state surveys and from 10% to 21% (median: 16%) across local surveys.
- During the 12 months preceding the survey, 14.8% of students nationwide had made a specific plan to attempt suicide.
- Overall, female students (17.7%) were significantly more likely than male students (11.8%) to have made a suicide plan. This significant sex difference was identified for all the racial/ethnic subpopulations and students in grades 9, 10, and 11.

(Continued on next page)

- Overall, White and Hispanic students (15.3% and 14.1%, respectively) were significantly more likely than Black students (10.3%) to have made a suicide plan.White female students (18%) were significantly more likely than black female students (13%), and white male students (12.5%) were significantly more likely than black male students (7.5%) to have made a suicide plan.
- Overall, students in grade 9 (16%) were significantly more likely than students in grade 12 (12.2%) to have made a suicide plan.
- Prevalence of having made a suicide plan ranged from 11.3% to 17.7% (median: 13.9%) across state surveys and from 7.9% to 16.9% (median: 13.3%) across local surveys.

Suicide Attempts

- Nationwide, 8.8% of students had attempted suicide $\geq$1 times during the 12 months preceding the survey.
- Female students (11.2%) were significantly more likely than male students (6.2%) to have attempted suicide. This significant sex difference was identified for white and Hispanic students and students in grades 9, 10, and 11.
- Overall, Hispanic students (12.1%) were significantly more likely than black and white students (8.8% and 7.9%, respectively) to have attempted suicide. This significant racial/ethnic difference was identified for Hispanic female students.
- Overall, students in grades 9, 10, and 11 (11%, 9.5%, and 8.3%, respectively) were significantly more likely than students in grade 12 (5.5%) to have attempted suicide.
- The percentage of students attempting suicide ranged from 6.3% to 13.4% (median: 8.6%) across state surveys and from 7.4% to 13% (median: 10.4%) across local surveys.
- Nationwide, 2.6% of students made a suicide attempt during the 12 months preceding the survey that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse.
- Overall, students in grades 9 and 10 (3.2% and 3%, respectively) were significantly more likely than students in grade 12 (1.6%) to have made a suicide attempt that required medical attention.
- Prevalence of injurious suicide attempts varied fourfold from 1.2% to 4.6% (median: 2.5%) across state surveys and varied threefold from 1.7% to 5.7% (median: 3.4%) across local surveys.

U.S.A. SUICIDE: 2000 OFFICIAL FINAL DATA

	Number	Per Day	Rate	% of Deaths
Nation	29,350	80.2	10.7	1.2
Elderly (65+ yrs)	5,306	14.5	15.3	0.3
Young (15-24 yrs)	3,994	10.9	10.4	12.8
Males	23,618	64.5	17.5	2.0
Females	5,732	15.7	4.1	0.5
Whites	26,475	72.3	11.7	1.3
Male	21,293		19.1	
Female	5,182		4.5	
Nonwhites	2,875	7.9	5.9	0.9
Male	2,325		9.9	
Female	550		2.1	
Blacks	1,962	5.4	5.6	0.7
Male	1,636		9.8	
Female	326		1.8	
Native American	297		12.2	
Asian/Pacific Islander	616		5.5	

Note: suicide rate was unchanged in 2000 after declines for six consecutive years.

- Adapted from the "Suicide Data Page: 2000," American Association of Suicidology (2002). http://www.suicidology.org

Completions:

- Average of 1 person every 18 minutes killed themselves.
- Average of 1 old person every 1 hour 39.3 minutes killed him/herself.
- Average of 1 young person every 2 hours 12 minutes killed him/herself (If the 307 suicides below age 15 are included, 1 young person every 2 hours 2.5 minutes).
- Suicide was the **11th ranking cause of death in U.S. – 3rd for young** (following Accidents and Homicides).
- 4.1 male deaths by suicide for each female death by suicide.
- Suicide ranks 11th as a cause of death overall; Homicide ranks 14th.

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

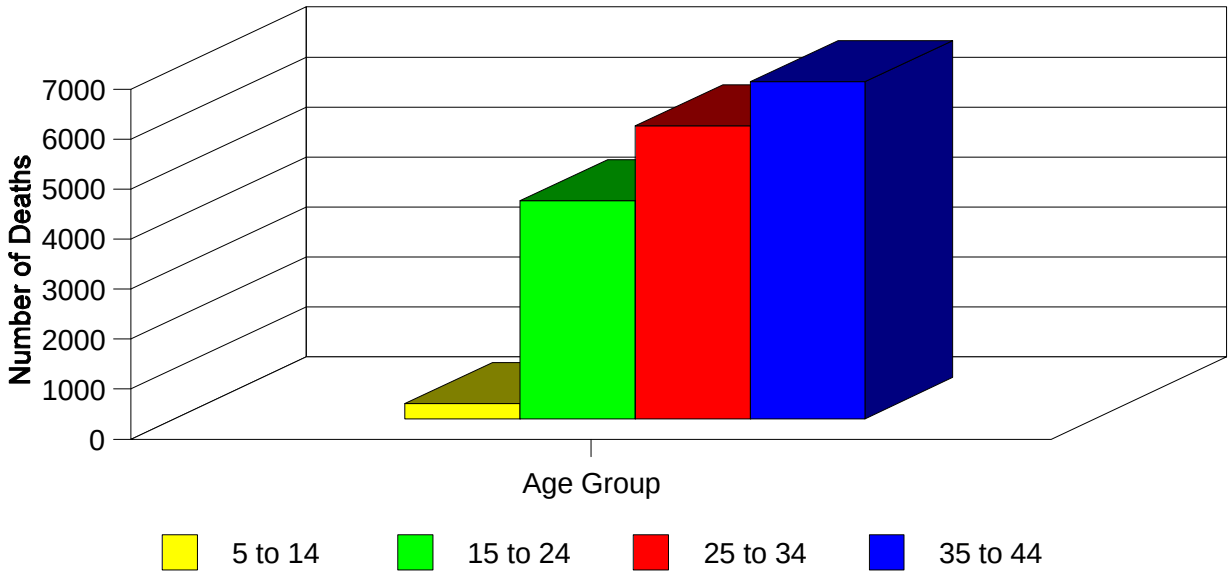
- 734,000 annual attempts in U.S.
- 25 attempts for every death by suicide for nation; 100-200:1 for young; 4:1 for elderly.
- 5 million living Americans (estimate) have attempted to kill themselves.
- 3 female attempts for each male attempt.

Suicide is the third leading cause of death for teenagers 15-24 years old (after unintentional injury and homicide). Suicide rates are increasing for children 14 years and younger.

- National Institute of Mental Health, December 1999

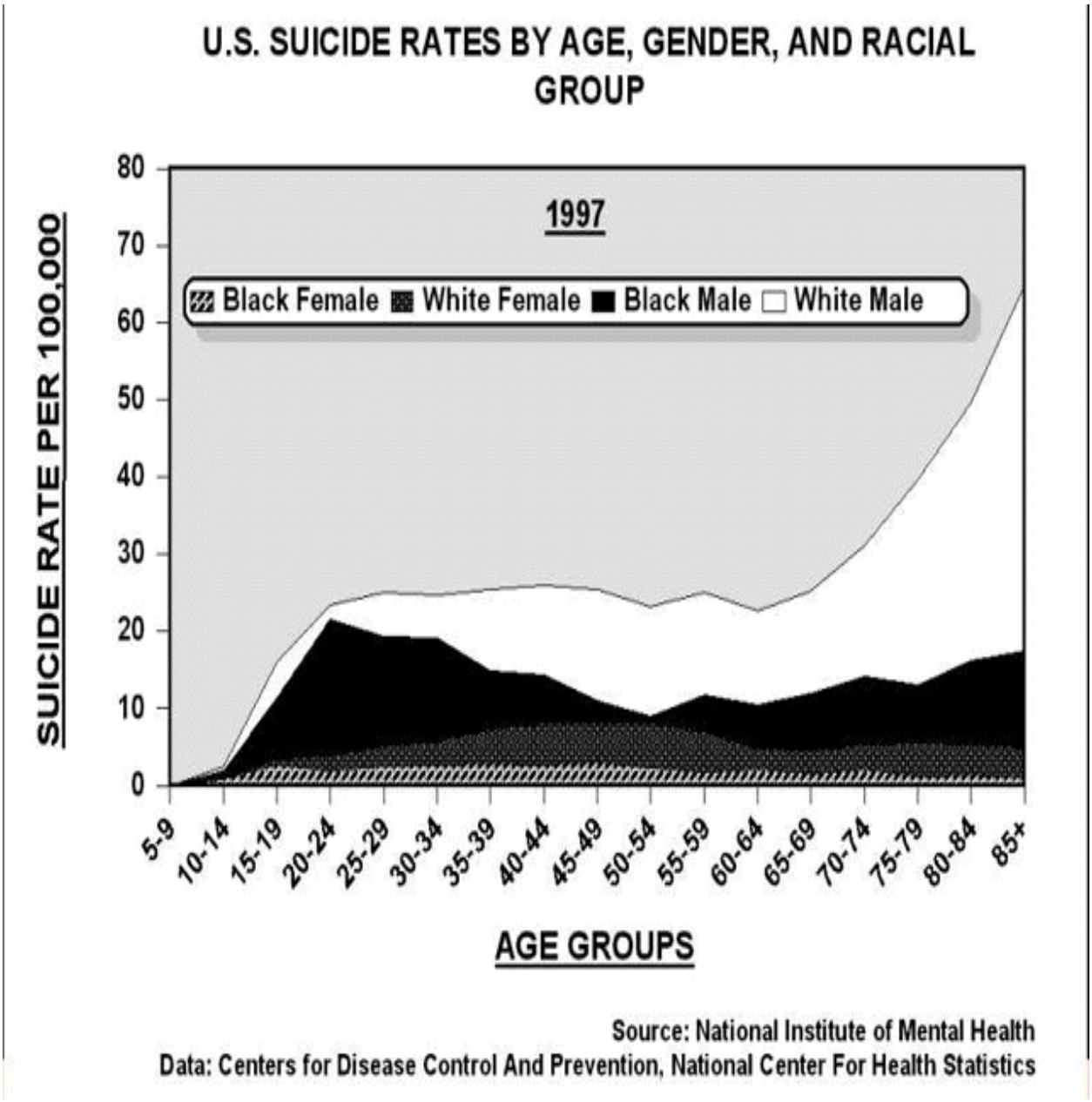
? The Strongest risk factors for attempted suicide in youth are depression, alcohol or other drugs use disorder, and aggressive or disruptive behaviors.

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



From 1980-1997, the rate of suicide among persons aged 15-19 years increased by 11% and among persons aged 10-14 years by 109%.

CDC, January 2000



-Center for Disease Control, 2002
http://www.nimh.nih.gov/suicideresearch/suichart.cfm

Suicide: Cost to the Nation

- Every day 86 Americans take their own life and over 1500 attempt suicide.
- For every two victims of homicide in the U.S. there are three deaths from suicide.
- There are now twice as many deaths due to suicide than due to HIV/AIDS.
- Between 1952 and 1995, the incidence of suicide among adolescents and young adults nearly tripled.
- In the month prior to their suicide, 75% of elderly persons had visited a physician.
- Over half of all suicides occur in adult men, aged 25-65.
- Many who make suicide attempts never seek professional care immediately after the attempt.
- Males are four times more likely to die from suicide than are females.
- More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease **combined**.
- Suicide takes the lives of more than 30,000 Americans every year.

- *National Strategy for Suicide Prevention: Goals and Objectives for Action.*
http://www.mentalhealth.org/suicideprevention/costtonation.asp

I. ON SUICIDE AND ITS PREVENTION

C. Common Myths

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

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

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

Fable: Suicide usually happens without warning.

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

Fable: Suicidal people fully intend to die.

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

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

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

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

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

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

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

And let's add one more:

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

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

I. ON SUICIDE AND ITS PREVENTION

D. A General Model of Youth Suicide

From:

***Children, Youth, and Suicide: Developmental Perspectives* (1994).**

By:

Gil G. Noam & Sophie Borst (Eds.). Jossey-Bass.

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

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

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

Excerpts from Noam and Borst (1994):

Suicide Trajectory Model

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

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

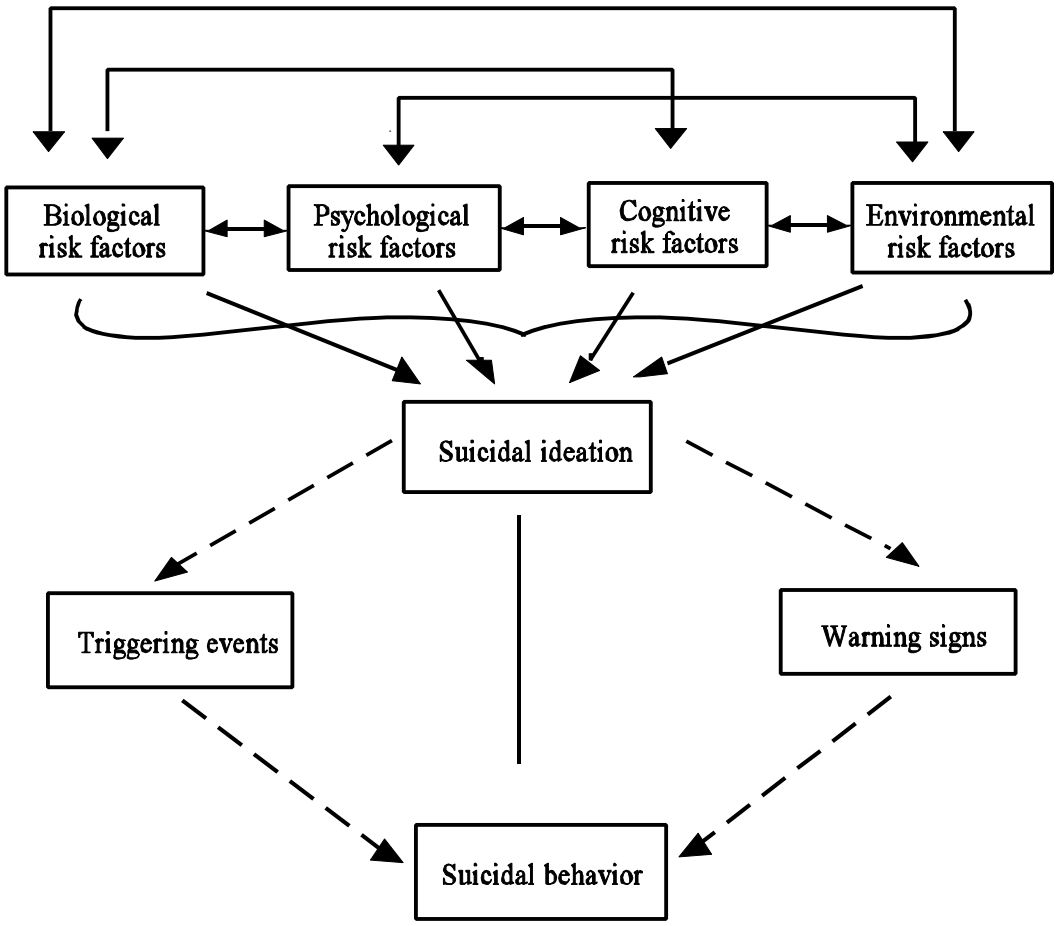


Table 1.2. Life-Cycle Commonalities and Age-Group-Specific Aspects of the Suicide Trajectory for Childhood and Adolescence

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

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

I. ON SUICIDE AND ITS PREVENTION

E. About Prevention

- ? Surgeon General's Blueprint for Preventing Suicide.
- ? National Strategy for Suicide Prevention: Goals and Objectives for Action
- ? Why Should Schools Get Involved?
- ? Guidelines for School Based Suicide Prevention Programs
- ? Some Concerns About Suicide Prevention Programs
- ? Findings from Two Prevention Programs

Surgeon General's Blueprint for Preventing Suicide

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

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

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

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

Methodology: Advance the science of suicide prevention.

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

- Promote public awareness that suicide is a public health problem and, as such, many suicides are preventable. Use information technology appropriately to make facts about suicide and its risk factors and prevention approaches available to the public and to health care providers.

- Expand awareness of and enhance resources in communities for suicide prevention programs and mental and substance abuse disorder assessment and treatment.

- Develop and implement strategies to reduce the stigma associated with mental illness, substance abuse, and suicidal behavior and with seeking help for such problems.

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

- Extend collaboration with and among public and private sectors to complete a National Strategy for Suicide Prevention.

- Improve the ability of primary care providers to recognize and treat depression, substance abuse, and other major mental illnesses associated with suicide risk. Increase the referral to specialty care when appropriate.

- Eliminate barriers in public and private insurance programs for provision of quality mental and substance abuse disorder treatments and create incentives to treat patients with coexisting mental and substance abuse disorders.

- Institute training for all health, mental health, substance abuse and human service professionals (including clergy, teachers, correctional workers, and social workers) concerning suicide risk assessment and recognition, treatment, management, and aftercare interventions.
- Develop and implement effective training programs for family members of those at risk and for natural community helpers on how to recognize, respond to, and refer people showing signs of suicide risk and associated mental and substance abuse disorders. Natural community helpers are people such as educators, coaches, hairdressers, and faith leaders, among others.
- Develop and implement safe and effective programs in educational settings for youth that address adolescent distress, provide crisis intervention and incorporate peer support for seeking help.
- Enhance community care resources by increasing the use of schools and workplaces as access and referral points for mental and physical health services and substance abuse treatment programs and provide support for persons who survive the suicide of someone close to them.
- Promote a public/private collaboration with the media to assure that entertainment and news coverage represent balanced and informed portrayals of suicide and its associated risk factors including mental illness and substance abuse disorders and approaches to prevention and treatment.

Methodology: Advance the science of suicide prevention

- Enhance research to understand risk and protective factors related to suicide, their interaction, and their effects on suicide and suicidal behaviors. Additionally, increase research on effective suicide prevention programs, clinical treatments for suicidal individuals, and culture-specific interventions.
- Develop additional scientific strategies for evaluating suicide prevention interventions and ensure that evaluation components are included in all suicide prevention programs.
- Establish mechanisms for federal, regional, and state interagency public health collaboration toward improving monitoring systems for suicide and suicidal behaviors and develop and promote standard terminology in these systems.
- Encourage the development and evaluation of new prevention technologies, including firearm safety measures, to reduce easy access to lethal means of suicide.

National Strategy for Suicide Prevention: Goals and Objectives for Action

The following goals and objectives come from the **National Strategy for Suicide Prevention: Goals and Objectives for Action**, a report designed to lay out a comprehensive framework for reducing the loss and suffering from suicidal behaviors in the United States. This is available from:
http://www.mentalhealth.org/publications/allpubs/SMA01-3518/index.htm

Goal 1: Promote Awareness that Suicide is a Public Health Problem that is Preventable
- Develop public education campaigns
- Sponsor national conferences on suicide and suicide prevention
- Organize special-issue forums
- Disseminate information through the Internet

Goal 2: Develop Broad-based Support for Suicide Prevention
- Organize a Federal interagency committee to improve coordination and to ensure implementation of the National Strategy
- Establish public/private partnerships dedicated to implementing the National Strategy
- Increase the number of professional, volunteer, and other groups that integrate suicide prevention activities into their ongoing activities
- Increase the number of faith communities that adopt policies designed to prevent suicide

Goal 3: Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse, and Suicide Prevention Services
- Increase the number of suicidal persons with underlying mental disorders who receive appropriate mental health treatment
- Transform public attitudes to view mental and substance use disorders as real illnesses, equal to physical illness, that respond to specific treatments and to view persons who obtain treatment as pursuing basic health care

Goal 4: Develop and Implement Suicide Prevention Programs
- Increase the proportion of States with comprehensive suicide prevention plans
- Increase the number of evidence-based suicide prevention programs in schools, colleges and universities, work sites, correctional institutions, aging programs, and family, youth, and community service programs
- Develop technical support centers to build the capacity across the States to implement and evaluate suicide prevention programs.

Goal 5: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm
- Educate health care providers and health and safety officials on the assessment of lethal means in the home and actions to reduce suicide risk
- Implement a public information campaign designed to reduce accessibility of lethal means
- Improve firearm safety design, establishing safer methods for dispensing potentially lethal quantities of medications and seeking methods for reducing carbon monoxide poisoning from automobile exhaust systems
- Support the discovery of new technologies to prevent suicide

Goal 6: Implement Training For Recognition of At-Risk Behavior and Delivery of Effective Treatment
- Improve education for nurses, physician assistants, physicians, social workers, psychologists, and other counselors
- Provide training for clergy, teachers and other educational staff, correctional workers, and attorneys on how to identify and respond to persons at risk for suicide
- Provide educational programs for family members of persons at elevated risk

Goal 7: Develop and Promote Effective Clinical and Professional Practices

- Chang procedures and/or policies in certain settings, including hospital emergency departments, substance abuse treatment centers, specialty mental health treatment centers, and various institutional treatment settings, designed to assess suicide risk
- Incorporate suicide-risk screening in primary care
- Ensure that individuals who typically provide services to suicide survivors have been trained to understand and respond appropriately to their unique needs (e.g., emergency medical technicians, firefighters, police, funeral directors)
- Increase the numbers of persons with mood disorders who receive and maintain treatment
- Ensure that persons treated for trauma, sexual assault, or physical abuse in emergency departments receive mental health services
- Foster the education of family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide.

Goal 8: Improve Access to and Community Linkages with Mental Health and Substance Abuse Services

- Increase the number of States that require health insurance plans to cover mental health and substance abuse care on par with coverage for physical health care
- Implement utilization management guidelines for suicidal risk in managed care and insurance plans
- Integrate mental health and suicide prevention into health and social services outreach programs for at-risk populations
- Define and implementing screening guidelines for schools, colleges, and correctional institutions, along with guidelines on linkages with service providers
- Implement support programs for persons who have survived the suicide of someone close

Goal 9: Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media

- Establish a public/private group designed to promote the responsible representation of suicidal behaviors and mental illness on television and in movies
- Increase the number of television programs, movies, and news reports that observe recommended guidelines in the depiction of suicide and mental illness
- Increase the number of journalism schools that adequately address reporting of mental illness and suicide in their curricula

Goal 10: Promote and Support Research on Suicide and Suicide Prevention

- Develop a national suicide research agenda
- Increase funds for suicide prevention research
- Evaluate preventive interventions
- Establish a registry of interventions with demonstrated effectiveness for prevention of suicide or suicidal behavior

Goal 11: Improve and Expand Surveillance Systems

- Develop and implementing standardized protocols for death scene investigations
- Increase the number of follow-back studies of suicides
- Increase the number of hospitals that code for external cause of injuries
- Increase the number of nationally representative surveys with questions on suicidal behavior
- Implement a national violent death reporting system that includes suicide
- Increase the number of States that produce annual reports on suicide
- Support pilot projects to link and analyze information on self-destructive behavior from various, distinct data systems

Why should schools get involved?

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

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

On Prevention

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

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

The following excerpt is from Sandoval, Davis, & Wilson, 1987, pp. 105-106:
A distinction is usually drawn between primary prevention which is aimed at the entire population, and secondary prevention which is aimed at those individuals who are at risk.

Primary Prevention

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

Secondary Prevention

Working with students who are at risk of attempting suicide constitutes secondary prevention. The individual most at risk is one who has attempted suicide in the past, but other students experiencing

loss or shame are also at risk. Secondary prevention is likely to occur in individual or small group sessions and takes place as needed when risk factors build.

The Pros and Cons of General Education Programs

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

Despite these potential benefits, research suggests that general education programs may not be as effective as school personnel and mental health professionals would hope. For instance, many studies have found that while general education programs may increase students' general knowledge about suicide and warning signs, they do little to change students' *attitudes* about suicide and help-seeking behaviors. This finding has held despite efforts such as using better trained instructors or more sensitive instruments. Furthermore, researchers have primarily examined suicide knowledge and attitudes and have not looked at actual behaviors.

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

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

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

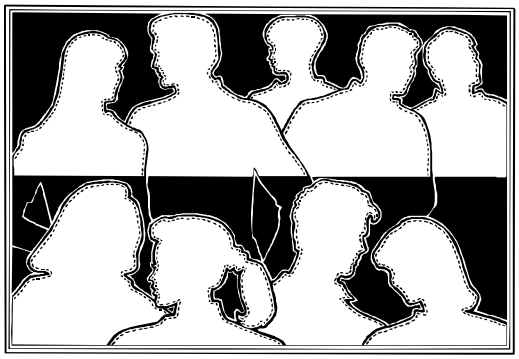
-Center for Disease Control

Intervention

Intervention can take many forms and should throughout the different stages in the process. Prevention includes education efforts to alert students and the community to the problem of teen suicidal behavior. Intervention with a suicidal student is aimed at protecting and helping the student who is currently in distress. Postvention occurs after there has been a suicide in the school community. It attempts to help those affected by the recent suicide. In all cases it is a good idea to have a clear plan in place in advance. It should involve staff members and administration. There should be clear protocols and clear lines of communication. Careful planning can make interventions more organized, and effective.

Prevention often involves education. This may be done in a health class, by the school nurse, school psychologist, guidance counselor or outside speakers. Education should address the factors that make individuals more vulnerable to suicidal thoughts. These would include depression, family stress, loss, and drug abuse. Other interventions may also be helpful. Anything that decreases drug and alcohol abuse would be useful. A study by Rich et al found that 67% of completed youth suicides involved mixed substance abuse. PTA meetings family spaghetti dinners can draw in parents so that they can be educated about depression and suicidal behavior. “Turn off the TV Week” campaigns can increase family communication if the family continues with the reduced TV viewing. Parents should be educated about the risk of unsecured firearms in the home. Peer mediation and peer counseling programs can make help more accessible. However, it is critical that students go to an adult if serious behaviors or suicidal issues emerge. Outside mental health professionals can discuss their programs so that students can see that these individuals are approachable.

- Excerpted from:
“Suicide and the School: Recognition and intervention for suicidal students in the school setting.” By Carol Watkins, MD
Available at: http://www.ncpamd.com/Suicide.htm



Excerpts from…

Guidelines for School Based Suicide Prevention Programs

American Association of Suicidology, 1999

http://www.suicidology.org

Conceptual Basis for Prevention Approaches

A clear conceptual basis gives us the rationale for choosing a particular prevention strategy for a particular problem, with a particular population, in a particular setting. Part of the effort to build the conceptual base for prevention in general has resulted in typology intended to clarify prevention methodology (Institute of Medicine,1994) which included:

1 *Universal* interventions, which are directed at an entire population rather than selected subpopulations or individuals.

2 *Selective* interventions, which are targeted to subpopulations that are characterized by shared exposure to some epidemiologically determined risk factor(s).

3 *Indicated* interventions are targeted to specific individuals who are already preclinical levels of a disorder and who have been identified through screening procedures.

Universal Suicide Prevention Approaches

The goal of universal approaches is *to raise the overall supportiveness and responsiveness of the at risk youths' environment.* The role of the school is seen as critical, but limited. All schools are not assumed to possess the resources to treat suicidal or emotionally disturbed students. They *can* enhance their capacity to identify and get help for these students as part of their mandate to socialize and protect their students.

The overall goals of the universal program are to increase the likelihood that school gatekeepers (administrators, faculty, and staff) **and peers** who come into contact with at-risk youth can more readily identify them, provide an appropriate initial response to them, will know how to obtain help for them, and are consistently inclined to take such action.

Protective Factors & Wellness Promotion

Some longitudinal research indicates that the presence of protective factors may have a stronger influence on the likelihood that risk behaviors will occur than the presence of risk factors. These protective factors include personal characteristics such as social problem solving competencies; and, environmental characteristics such as contact with a caring adult and a school climate that promotes students' involvement, contribution, and sense of connection with their school. One caveat concerning resilient youth is in order. Research indicates that youth who come from high risk environments and yet do well in school and peer relations still evidence a greater prevalence of anxiety and depression than peers who do not come from such environments. Anxiety and depression are significant risk factors for suicide, and these internalizing disorders are more likely to go undetected than the externalizing behaviors.

Selective Suicide Prevention Programs

While subgroups that are at greater risk for suicide will by definition be exposed to universal programs, these programs are aimed more at their peers and may not be of sufficient dosage or focus to affect specific vulnerable subpopulations such as disenfranchised or depressed students.

Some of these students may become known to school officials, particularly if school personnel and parents are educated to identify troubled students before they make overt statements or attempts. Thus gatekeeper training is a common selective program that has shown promise for increasing identification and referral. There is some evidence that students are more likely to use telephone crisis and referral services because they are anonymous, and don't require fees, transportation, or appointments. Publicizing these services (e.g. through wallet cards continuously available throughout the school) and linking them to established screening teams can facilitate contact with at risk youth. However, these services are still underutilized by males.

Indicated Suicide Prevention Programs

The goal of indicated programs is to reduce the incidence of suicidal behaviors among students who already display risk factors or early warning signs associated with suicide such as frequent suicidal thoughts, previous attempts, depression, or substance abuse.

Indicated programs require the presence in schools of individuals who are trained to screen students and to provided the indicated programs. School faculty or special services staff such as guidance counselors can be trained to provide the programs, but professionals such as psychologists or social workers would have to conduct the screening. There are a growing number of school-linked services (community gatekeepers who provide assessment and counseling services on site) and school based service centers or clinics that can house indicated interventions.

The overall goals of indicated programs are to identify at risk students, preferably through existing school procedures, and provide them with accessible, brief interventions that include support, skill training, and opportunities to bond with the school and maintain contact with a caring adult.

Requirements for Effective Prevention Programs

? Conceptually & empirically grounded goals and objectives.
? Clearly articulated and packaged components (lesson outlines and plans, detailed instructor guidelines that include typical student responses and how to respond to these, all handouts, and references for additional materials).
? Comprehensive: address all levels of targeted organization.
? Ecological: address the multiple contexts in which participants interact.
? Conform to the context/culture/values of the target population and organization.

Comprehensive School Based Suicide Prevention Programs

This document is intended as a set of general guidelines for **school based** prevention programs and not a of specific programs. However, the basic components of a comprehensive program can be listed. Comprehensive programs are multilevel, multicomponent interventions that include the following components, usually implemented in this order:

1. *Administrative consultation* to ensure that policies and procedures for responding to at risk students, attempts, and completions are in place; and to ensure that community linkages exist for close coordination of referrals to, and return of students from, community gatekeepers.

2. *School gatekeeper training* for all faculty and staff (including such staff as bus drivers and cafeteria workers) on the identification of, initial response to, and effective referral of troubled and at risk students. This sometimes includes the establishment of in school crisis response teams made up of faculty, staff, and administrators.

3. *Parent training* covering similar material as the school gatekeeper training, as well as means restriction strategies.

4. *Community gatekeeper training* that incorporates policies and procedures for effective response and coordination with schools and families. This sometimes includes training in the treatment of depressed and suicidal adolescents. Community crisis teams and media campaigns have also been implemented.

5. *Student classes* usually consist of 4 to 5 class periods included in the health curriculum. Classes include a variety of media, and involve students in discussions and roleplays to prepare them to recognize and respond to troubled peers, and to destigmatize seeking adult help.

6. *Postvention interventions* that are provided by external consultants to schools and communities in which a suicide completion or serious attempt has occurred. These interventions consist of standard steps designed to process faculty, student, and community reactions to the event; facilitate grief work; and, prevent imitative acts among identified vulnerable peers.

Some Concerns About Suicide Prevention Programs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Findings from Two Prevention Programs

- ***Klingman and Hochdorf*** report positive effects in reducing suicide risk for junior-high students in Israel. In a randomized trial with 237 8th grade students, the 12-week group cognitive-behavioral program produced significant reductions in suicidality among treated boys. Effects for girls did not reach significance.

  Klingman, A., & Hochdorf, Z. (1993). Coping with distress and self-harm: The impact of a primary prevention program among adolescents. *Journal of Adolescence, 16,* 121-140.

- ***Orbach and Bar-Joseph***, using a randomized trial examining 393 students (including some conduct disordered students), report a significant reduction in suicidality, in this case among 11th grade students from 6 high schools in Israel. Across all schools, the authors report significant effects on suicidal tendencies, coping skills, and ego identity.

  Orbach, I., & Bar-Joseph, H. (1993). The impact of a suicide prevention program for adolescents on suicidal tendencies, hopelessness, ego identity and coping. *Suicide and Life Threatening Behavior, 23,* 120-129.

II. ON ASSESSING SUICIDE RISK

A. Identifying and Addressing Risk

B. Risk and Protective Factors

C. Suicide Assessment--Checklist

D. Follow-through Steps After Assessing for Suicidal Risk--Checklist

E. Criteria for Diagnosis

II. ON ASSESSING SUICIDE RISK

A. Identifying and Addressing Risk

- The Public Health Approach
- The Public Health Approach Applied to Suicide Prevention
- Some Things You Should Know About Preventing Teen Suicide

A. Identifying and Addressing Risk

The following excerpts ("Identifying and Addressing Risk" and "The Public Health Approach") are taken from "The Surgeon General's Call to Action to Prevent Suicide, 1999" and can be found at: Click here

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

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

The Public Health Approach

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

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

(continued on the next page)

The Public Health Approach Applied to Suicide Prevention

Defining the Problem

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

Identifying Causes and Protective Factors

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

Developing and Testing Interventions

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

Implementing Interventions

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

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

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

Some Things You Should Know About Preventing Teen Suicide

If your teenager has been depressed, you should look closely for signs that he or she might be thinking of suicide:

- ? Has his personality changed dramatically?
- ? Is he having trouble with a girlfriend (or, for girls, with a boyfriend)? Or is he having trouble getting along with other friends or with parents? Has he withdrawn from people he used to feel close to?
- ? Is the quality of his schoolwork going down? Has he failed to live up to his own or someone else's standards (when it comes to school grades, for example)?
- ? Does he always seem bored, and is he having trouble concentrating?
- ? Is he acting like a rebel in an unexplained and severe way?
- ? Is she pregnant and finding it hard to cope with this major life change?
- ? Has he run away from home?
- ? Is your teenager abusing drugs and/or alcohol?
- ? Is she complaining of headaches, stomachaches, etc., that may or may not be real?
- ? Have his eating or sleeping habits changed?
- ? Has his or her appearance changed for the worse?
- ? Is he giving away some of his most prized possessions?
- ? Is he writing notes or poems about death?
- ? Does he talk about suicide, even jokingly? Has he said things such as, "That's the last straw," "I can't take it anymore," or "Nobody cares about me?" (Threatening to kill oneself precedes four out of five suicidal deaths.)
- ? Has he tried to commit suicide before?

If you suspect that your teenager might be thinking about suicide, do not remain silent. **Suicide is preventable**, but you must act quickly.

- ? Ask your teenager about it. Don't be afraid to say the word "suicide." Getting the word out in the open may help your teenager think someone has heard his cries for help.
- ? Reassure him that you love him. Remind him that no matter how awful his problems seem, they can be worked out, and you are willing to help.
- ? Ask her to talk about her feelings. Listen carefully. Do not dismiss her problems or get angry at her.
- ? Remove all lethal weapons from your home, including guns, pills, kitchen utensils and ropes.
- ? Seek professional help. Ask your teenager's pediatrician to guide you. A variety of outpatient and hospital-based treatment programs are available.

-Excerpted from “Some Things You Should Know About Preventing Teen Suicide.” American Academy of Pediatrics. http://www.aap.org/advocacy/childhealthmonth/prevteensuicide.htm

II. ON ASSESSING SUICIDE RISK

B. Risk and Protective Factors

- Risk Factors
- Protective Factors
- A Few Examples of Assessing Risk
- Adolescent Suicide Attempts: Risks and Protectors
- Are Gay and Lesbian Youth at Higher Risk for Suicide?
- Suicide in Teenagers
- The Columbia Teen Screen Suicide Prevention Program

B. Risk and Protective Factors

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

Risk Factors

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

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

Risk factors include:

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

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

Protective Factors

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

Protective factors include:

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

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

A Few Examples of Assessing Risk...

EVALUATION OF SUICIDE RISK AMONG ADOLESCENTS

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

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

Prof. Rotheram-Borus has moved to UCLA and can be contacted at: 310/794–8278
Email: mjrotheram@npimain.medsch.ucla.edu

A MEASURE OF ADOLESCENT POTENTIAL FOR SUICIDE (MAPS)

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

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

Adolescent Suicide Attempts: Risks and Protectors

From: Borowsky, IW, Ireland, M, & Resnick, MD (2001). Adolescent suicide attempts: Risks and protectors. Pediatrics 107(3): 485-493.

Risk and protective factors for suicide attempts in adolescents were studied using interview data from the National Longitudinal Study of Adolescent Health (Add Health). The original in-school survey had 90,118 student participants from grades 7 to 12. The one-year follow-up data from 13,110 students were analyzed for patterns in risk and protective factors among non-Hispanic black, Hispanic, and non-Hispanic white youth.

- Overall, 3.6% of the students had attempted suicide (5.1% of girls, 2.0% of boys) in the preceding year.
- Suicide attempts were most prevalent in white and Hispanic girls (5.6% and 5.5%, respectively), and least prevalent in black and white boys (1.6% and 1.9%, respectively).

- **Risk Factors (All sub-groups)**: previous suicide attempt, violence victimization, violence perpetration, alcohol use, marijuana use, and school problems.
- **Risk Factors (Girls)**: somatic symptoms, a friend who attempted or died by suicide, other illicit drug use, and history of mental health treatment.
- **Risk Factors (Boys)**: weapon-carrying at school, and same-sex romantic attraction.

- **Protective Factors (All sub-groups)**: Perceived parent and family connectedness.
- **Protective Factors (Girls)**: emotional well-being. [For some girls, availability of counseling services at school and parental presence at key times].
- **Protective Factors (Boys)**: grade point average. [For some boys, high parental expectations for school achievement, more people in the household, and religiosity].

Note: The author's caution that the study results may be limited by a) small numbers of youth in the gender and racial/ethnic subsamples who attempted suicide, and b) a 1-year follow-up period rather than a longer follow-up interval.

Are Gay and Lesbian Youth at High Risk for Suicide?

With regard to **completed suicide**, there are no national statistics for suicide rates among gay, lesbian or bisexual (GLB) persons. Sexual orientation is not a question on the death certificate, and to determine whether rates are higher for GLB persons, we would need to know the proportion of the U.S. population that considers themselves gay, lesbian or bisexual. Sexual orientation is a personal characteristic that people can, and often do choose to hide, so that in psychological autopsy studies of suicide victims where risk factors are examined, it is difficult to know for certain the victim's sexual orientation. This is particularly a problem when considering GLB youth who may be less certain of their sexual orientation and less open. In the few studies examining risk factors for suicide where sexual orientation was assessed, the risk for gay or lesbian persons did not appear any greater than among heterosexuals, once mental and substance abuse disorders were taken into account.

With regard to **suicide attempts**, several state and national studies have reported that high school students who report to be homosexually and bisexually active have higher rates of suicide thoughts and attempts in the past year compared to youth with heterosexual experience. Experts have not been in complete agreement about the best way to measure reports of adolescent suicide attempts, or sexual orientation, so the data are subject to question. But they do agree that efforts should focus on how to help GLB youth grow up to be healthy and successful despite the obstacles that they face. Because school based suicide awareness programs have not proven effective for youth in general, and in some cases have caused increased distress in vulnerable youth, they are not likely to be helpful for GLB youth either. Because young people should not be exposed to programs that do not work, and certainly not to programs that increase risk, more research is needed to develop safe and effective programs.

-NIMH, Frequently Asked Questions about Suicide

http://www.nimh.nih.gov/suicideprevention/suicidefaq.cfm

Controversy Around Suicidality in Sexual Minorities

A recent research report (Russell & Joyner, 2001) found evidence for an association between sexual orientation and suicide attempts. They asked a nationally representative sample of 11,940 high school students questions about romantic attractions, romantic relationships, and suicidality with computer-based interviews. Their study found that youth reporting either same-sex attraction or relationships were about twice as likely as their peers to attempt suicide. A large part of the risk was mediated by other suicide risk factors: hopelessness, depression, alcohol abuse, suicidality in friends or relatives, and physical victimization. However, increased risk remained after taking such factors into account.

On the other hand, some have questioned the results of many studies on methodological grounds. Savin-Williams and Ritch (2001), for example, inquired about the measurement of sexual identity and suicide attempts. Many studies employ broad criteria when defining sexual minorities, often assigning the label based on a single attraction or relationship. Savin-Williams and Ritch further distinguish between "true" and "false" suicide attempts (i.e., behavior vs. serious ideation). They report that a more detailed measure "eliminated over half of suicide attempt reports among sexual minorities because they were false attempts" (p.983).

Russell, ST, & Joiner, K (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health, 91*(8): 1276-1281.

Savin-Williams, RC (2001). Suicide attempts among sexual-minority youths: Population and measurement issues. *Journal of Consulting and Clinical Psychology. 69*(6): 983-991.

Suicide in Teenagers

Adapted from: Zametkin, AJ, Alter, MR, & Yemini, T (2001). Suicide in teenagers: Assessment, management, and prevention. *JAMA, 286* (24): 3120-3125.

Risk Factors for Suicide

- Previous suicide attempt no matter how minor (including so-called "gestures")
- Mood disorder
- Substance abuse disorder (esp. in males)
- 16yrs or older, male, living alone
- History of physical/sexual abuse
- Conduct disorder or Anxiety disorder

Warning Signs

- Recent dramatic personality change
- Psychosocial stressor (trouble with family, friends, boyfriend/girlfriend, or disciplinary crisis).
- Writing, thinking, or talking about death or dying
- Altered mental status (agitation, hearing voices, delusions, violence, intoxication)

Biological Factors

Genetics. Suicide may run in families. Studies have found that even after taking into account the increased rates of psychiatric disorders in the families of suicide attempters, the first-degree relatives were still more likely to attempt suicide compared to the relatives of controls. This indicates that aspects of suicidal behavior may be inherited independently from psychiatric disorders. Most likely multiple genes are involved in the inheritance of suicidal behavior.

Neurotransmitters. The neurotransmitter serotonin is strongly associated with suicidal behavior. Serotonin has also been linked to the control of impulsivity, aggression, and depression; factors that can contribute to suicidal behavior. Researchers have examined several genes linked to serotonin, but results have been inconsistent. As yet, there are no clinically useful biological markers for suicide risk.

Interventions

Hospitalization. There is no evidence-based data that psychiatric hospitalization prevents immediate or eventual suicide, despite overwhelming clinical consensus that immediate hospitalization is a critical component in preventing both adult and teenaged suicidal patients from completing suicide. Studies comparing the efficacy of hospitalization compared to home/outpatient treatment have found no significant differences.

Psychotherapy. No treatment program has demonstrated a reduction in subsequent attempts by adolescent suicide attempters. This may be due to a lack of established treatments with proven long-term efficacy for disorders such as conduct disorder and substance abuse. An additional problem is that adolescents are generally not compliant with psychiatric treatment. More research is needed in this area. The recommended approach is conscientious clinical follow-up of teenagers to ensure that they are engaged in treatment. Unless the general practioner, internist, or pediatrician has particular training or expertise in suicide prevention, teenagers with suicidal ideation, multiple risk factors, or a suicide attempt should be referred for a complete mental health evaluation and careful treatment.

Pharmacotherapy. The selective serotonin reuptake inhibitor (SSRI) antidepressants unequivocally reduce symptoms of major depression and generalized anxiety in adults. It has been more difficult to demonstrate consistent effects among teenagers. Additionally, although antidepressants might be efficacious for depression, little evidence exists that antidepressants significantly lower suicide rates.

There is strong and conclusive evidence that in adults with bipolar disorder, lithium as a part of long-term treatment acts as a protective factor against suicidal behavior. Especially in later adolescence, bipolar illness has classic adult features (grandiosity, pressured speech, decreased sleep, agitation, intense irritability). However, much academic controversy exists about the identification of bipolar illness in very young adolescents and prepubertal children. More research is needed to determine whether lithium is also effective at reducing suicide risk in teenagers.

Community-based suicide prevention. There is limited empirical data on the measurable effects of school-based programs and hotline crisis services on suicidal behavior. The value of many programs remains untested. Thus, further research is also warranted in this area.

The Columbia Teen Screen Suicide Prevention Program

In Brief…

At Columbia University's Division of Child and Adolescent Psychiatry, they began implementing a program in 1991 that:

- Employs advanced computer technology, sensitive interviewing design and self-reporting techniques to detect dangerous levels of depression among young people, as well as other warning signs that can lead to suicide; and
- Provides intensive treatment and follow-up services for adolescents afflicted with a range of mental health disorders.

The Screening Process

1. Parental and participant consent
2. Students complete a brief self-report questionnaire – The Columbia Teen Screen – during one of their regular classes.
3. Those who might be at elevated risk are further assessed through the use of a computerized version of the DISC (Diagnostic Interview Schedule for Children). At the end of the session, the computer generates a symptom profile and diagnostic report for students at risk.
4. At risk students are interviewed personally by a trained clinician who evaluates each student and makes a triage decision: further psychiatric evaluation, psychological counseling, crisis care, or no treatment at all.
5. The program's case manager contacts the parents and meets with participants who need further evaluation or treatment to discuss the recommended course of action and again secure all parties' consent to proceed.

More information:
The Columbia Teen Screen Suicide Prevention Program website
http://www.teenscreen.org/

II. ON ASSESSING SUICIDE RISK

*C. Suicidal Assessment - Checklist **

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

(Suggested points to cover with student/parent)

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

Does the individual have frequent suicidal thoughts?	*Y N*
Have there been suicide attempts by the student or significant others in his or her life?	*Y N*
Does the student have a detailed, feasible plan?	*Y N*
Has s/he made special arrangements as giving away prized possessions?	*Y N*
Does the student fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife?	*Y N*

(2) REACTIONS TO PRECIPITATING EVENTS

Is the student experiencing severe psychological distress?	*Y N*
Have there been major changes in recent behavior along with negative feelings and thoughts?	*Y N*

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

(3) PSYCHOSOCIAL SUPPORT

Is there a lack of a significant other to help the student survive?	*Y N*
Does the student feel alienated?	*Y N*

(4) HISTORY OF RISK-TAKING BEHAVIOR

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

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

II. ON ASSESSING SUICIDE RISK

D. 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.

II. ON ASSESSING SUICIDE RISK

E. Criteria for Diagnosis

- Criteria for Diagnosis of Major Depressive Episode (DSM - IV)
- 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 (p. 54), The *Diagnostic and Statistical Manual for Mental Disorders - IV (DSM-IV)* focuses specifically on psychopathology & major disorders.

Such problems are put into a broader context in *the Classification of Child and Adolescent Mental Diagnoses in Primary Care* – which is the system published in 1996 by the American Academy of Pediatrics (see pages 55 thru 65.)

Criteria for Diagnosis of Major Depressive Episode

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

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

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

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

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

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

(8) insomnia or hypersomnia nearly every day

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

(10) fatigue or loss of energy nearly every day

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

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

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

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

*Emotions and Moods: Sadness and Related Symptoms**

Presenting Complaints	
sad/depressed	appetite changes
apathetic	decreased energy
loss of pleasure	decreased concentration
agitation	low self-esteem
sleep disturbance	crying irritability

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*

DEVELOPMENTAL VARIATION

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.

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

COMMON DEVELOPMENTAL PRESENTATIONS

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.

SPECIAL INFORMATION

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.

Emotions and Moods: Sadness and Related Symptoms*

PROBLEM

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 (...).

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)*

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

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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	COMMON DEVELOPMENTAL PRESENTATIONS
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-lV Criteria ...) Depressive Disorder, Not Otherwise Specified	**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.

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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

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

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DIFFERENTIAL DIAGNOSIS	SPECIAL INFORMATION
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	

COMMONLY COMORBID CONDITIONS	SPECIAL INFORMATION
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.	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.

*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.

*Emotions and Moods: Suicidal Thoughts or Behaviors**

Presenting Complaints
thinking that life is not worth living
passive or active wish to die
thinking about hurting oneself
intending to hurt oneself
having a plan to hurt oneself
history of attempting suicide

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 homeless, 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.

*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
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).

DIFFERENTIAL DIAGNOSIS

General Medical Condition
Not relevant.

Substances

Mental Disorders
Not relevant

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.

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).

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).

*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.

III. INTERVENTION PLANNING AND TRAINING

A. Responding to Suicidal Crisis

- When a Student Talks of Suicide...
- When a Student Attempts Suicide...

B. Training Programs for:

? Community Members

? Teachers and School Staff

C. Counseling Approaches

When a Student Talks of Suicide . . .

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

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

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

IIIA. Responding to Suicidal Crisis

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.

IIIB. Training Programs

Training programs for community members

From: Youth Suicide Prevention Programs: A Resource Guide, U.S Department of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Injury Prevention and Control (09/01/1992).
http://wonder.cdc.gov/wonder/prevguid/p0000024/P0000024.asp

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

Adolescent Suicide Awareness Program (ASAP)

Diane Ryerson, MSW, Director,
Counseling and Education Services
South Bergen Mental Health Center
516 Valley Brook Avenue
Lyndhurst, NJ 07071
(201) 935-3322

Targets: Police, clergy, emergency room personnel, staff of pediatricians' and family practice physicians' offices.
Years in operation: 9
Description: ASAP sponsors a basic training curriculum for police recruits, a 1.5-hour awareness program for all municipal and county police, and an intensive program for juvenile officers. A multitiered training program will be established for clergy, involving seminarians, parochial school teachers, funeral directors, and youth ministers. To supplement instructional units, a "Clergy Specific" information package will be developed and widely distributed. Police were trained in identifying, managing, and obtaining professional help for suicidal teenagers. Specific operating procedures were provided Clergy were trained in crisis intervention skills and increased information, especially in regard to identifying warning signs, will equip clergy with a focused, more effective approach to counseling troubled teens and their families.

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

Center for Indian Youth Program Development

Sally Davis, Director
Division of School Health
University of New Mexico School of Medicine
Albuquerque, NM 87131
(505) 277-4462

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

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

Jail Suicide Prevention Program

Lindsay M. Hayes, M.S., Assistant Director
National Center on Institutions and Alternatives
40 Lantern Lane
Mansfield, MA 02048
(508) 337-8806

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

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

LivingWorks Education, Inc.

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

Targets: Community members, employee assistance staff, mental health caregivers, police, corrections agency personnel, school personnel (at all levels of expertise).
Years in operation: 10
Description: The core of this program is the Intervention Workshop, originally modeled after the American Heart Association's 'Heart Saver' Program. Based on an adult education model of continuing professional education, the program is designed for all caregiver groups, including, but not limited to, often under-served community "gatekeepers." Its content is fully described in the Suicide Intervention Skills Workshop of the California Department of Mental Health also included in this chapter. A "Training for Trainers" course certifies trainers to present the workshop and other components of the program. Other activities are integrated with the workshop presentation and include sensitization and awareness education, bereavement intervention training, advanced treatment seminars, and refresher training.

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

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

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

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

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

Suicide Intervention Skills Workshop

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

Targets: Community members, mental health personnel, school personnel, social services personnel,

and law enforcement officers.
Years in operation: 5
Description: The "Suicide Intervention Skills Workshop" is identical to the "Intervention Workshop" of LivingWorks Education, Inc., Calgary, Alberta, also described in this chapter. The curriculum features a series of large and small group activities, minilectures, audiovisuals, and role playing exercises designed to help people increase both their abilities and level of confidence when working with suicidal individuals. The workshop includes 14 hours of learning experiences. The first day focuses upon the examination of caregivers' attitudes and specific assessment skills. The second day concentrates upon intervention strategies and skill building through the use of large group simulations and small group role plays that involve all participants.

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

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

Youth Suicide Prevention Program

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

Targets: Students, parents, professionals, and the general public of Prince William County.
Years in operation: 4
Description: This is a comprehensive community program aimed at promoting positive mental health attitudes. Program staff members train school personnel how to identify and help suicidal youths and help them to develop crisis teams. They will also conduct suicide prevention classes and provide postvention support when asked. Program staffers already work with junior and senior high schools and are starting to move into elementary schools. There is also a community group on suicide prevention called the "Prince William Youth Suicide Prevention Coalition," whose activities include an annual "Love Life Day" and the providing of grants to schools to establish prevention activities. Another component is a student group ("Friends Are Needed" (FAN) Club) concerned with suicide prevention. School representatives attend training sessions to learn how to initiate suicide prevention programs in their schools. In addition, the coalition produces parent and teen directories of warning signs, actions to take, and sources of help, and is involved in legislative efforts to limit methods of committing suicide.

Bongar, B., and Harmatz, M. Clinical psychology graduate education in the study of suicide: availability, resources, and importance. Suicide and Life Threatening Behavior 1991;21:231-244.

Hayes, L., and Rowan, J. National Study of Jail Suicide: Seven Years Later. Alexandria (VA): National Center on Institutions and Alternatives, 1988.

Johnson, F.G., Ferrence, R., and Whitehead, P.C. Self-injury: identification and intervention. Canadian Psychiatry Association Journal 1973;18:101-105.

Tierney, R.J. Comprehensive evaluation for suicide intervention training [dissertation]. Calgary, Alberta: University of Calgary, 1988.

Suggested Additional Reading

Ramsay, R.F., Cooke, M.A., Lange, W.A. Alberta suicide prevention training programs: a retrospective comparison with Rothman's developmental resource model. Suicide and Life Threatening Behavior 1990;24:335-351.

State of California Department of Mental Health. The California Helpers Handbook for Suicide Intervention. Sacramento, CA, 1987.

IIIB. Training Programs

Training programs for teachers and school staff/students

From: Youth Suicide Prevention Programs: A Resource Guide
U.S Department of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Injury Prevention and Control
Publication date: 09/01/1992
http://wonder.cdc.gov/wonder/prevguid/p0000024/P0000024.asp

Adolescent Suicide Prevention Program

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

Targets: School personnel
Years in operation: 8
Description: The aim of this program is to help teachers and school staff become aware of and able to identify suicide-prone youths. The program includes a crisis management plan for schools to use in handling the aftermath of suicides and other crises that affect both the staff and student populations. The plan involves community agencies as well as school personnel.

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

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

BRIDGES (Building Skills to Reach Suicidal Youth)

Charlsetta Sutton, ACSW, BCD
Karen Dunne-Maxim, R.N., M.S.
UMDNJ--CMHC
671 Hoes Lane , Piscataway, NJ 08855-1392
(908) 463-4109

Targets: School personnel (guidance staff, teachers) , Agency staff who work with youth
Years in operation: 7
Description: School personnel training lasts 16 hours (2 days). BRIDGES trains school personnel to accurately distinguish students at risk for suicidal behavior from those who are depressed. Personnel learn to assess students' risks, to intervene when appropriate, to work with families and peers, to follow referral procedures, and to develop school policy and procedures with regard to suicide prevention and postvention. No formal evaluations have yet been made of this program.

Crisis Intervention

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

Targets: All students.
Years in operation: 5
Description: Dade County established a Department of Teenage Pregnancy and Suicide Prevention in 1987, which in turn became the Department of Crisis Intervention, whose purpose is to prepare staff at the district, region, and school levels to identify, assist, and refer students at risk. The department trains "crisis care core teams" in every school to counsel staff and the community in times of crisis. A hotline is available to assist administrators, counselors, and other support staff. Training of crisis core teams in the schools is done by the District Crisis Team, which consists of one counselor and one psychologist. Training consists of a 3-hour program. Crisis teams are present in all schools; this is a county-mandated requirement. School staff includes counselors, teachers, social workers, occupational specialists, college advisors, psychologists, bus drivers, cafeteria workers, students, peer counselors, and parents.

Pennsylvania Network for Student Assistance Services (PNSAS)

Roberta Chuzie
Student Assistance Services Station Square
200 Commerce Court Building, 2nd Floor Pittsburgh, PA 15219
(412) 394-5837

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

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

Project SOAR (Suicide: Options, Awareness, Relief)

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

Target: Teachers, staff, and counselors.
Years in operation: 3
Description: Project SOAR is a comprehensive program that covers prevention, intervention, and postvention. Prevention consists of suicide awareness lessons for teachers and staff. Intervention consists of training school counselors in all secondary and elementary schools in risk assessment of potential suicides through personal verbal interviews. A crisis team does postvention for students and teachers. There is also a peer support system and a section called Quest on esteem building. A committee of community mental health professionals advises the suicide and crisis management program.

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

All other elementary and secondary school counselors who are not designated as the primary caregiver receive 6 hours of instruction. All counselors, including the primary caregivers, receive 3 hours of follow-up training each year. The trainers, members of the Dallas Independent School District (DISD) Psychological/Social Services Crisis Team, are always available for consultation. A school psychologist or home school coordinator will assist with high-risk cases. The course was adapted for use by other student services personnel: school psychologists, home school coordinators, parent ombudsmen, special education crisis staff, nurses, and drug counselors.

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

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

STAR -- Services for Teens At Risk

Dr. David Brent, Director
WPIC (Western Psychiatric Institute and Clinic)
Pittsburgh, PA 15213
(412) 624-5211

Targets: School personnel, at-risk youth.
Years in operation: 4 (for both the Outreach and Outpatient Clinic programs).
Description: STAR Center offers three programs designed specifically to help school personnel identify and refer at-risk

youths.

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

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

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

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

Suicide Prevention Center Programs

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

Targets: Students (junior high and high school), teachers & staff.
Years in operation: 10
Description: The Suicide Prevention Center (SPC) provides training as part of a broad range of crisis support Services, including a 24-hour crisis hotline, training of professionals (teachers, service providers, clergy, physicians, police), and a crisis response team for postvention work for individuals or groups. The program provides in-service training on recognition of depression and suicidal behavior; short-term crisis intervention; school and community resources; and factual information about suicide. Specific programs operating as part of Project Lifesaver are:

Staying Alive: A program that targets minorities and uses other community members, such as barbers and hairstylists.
Finding Hope: Training program for parents.
Life Saver III: A 3-year pilot program training undergraduate, graduate, and postgraduate students (teachers, administrators, school counselors, and nurses).

Weld County Suicide Prevention Program

Susy Ruof, M.A.
5290 Mesquite Court, Johnstown, CO 80534
(303) 587-2336

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

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

References:

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

PSYCHSOCIAL TREATMENTS FOR ADOLESCENT DEPRESSION

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

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

Cognitive techniques (COG)
- Constructive thinking (rational emotive therapy, cognitive therapy)
- Positive self-talk
- Being your own coach
- Coping skills
- Self-change skills (self-monitoring, goal setting, self-reinforcement)

Family context (FAM)
- Conflict resolution
- Communication skills
- Parenting skills

Behavioral (BEH)
- Problem-solving skills
- Increasing pleasant activities
- Social skills (assertiveness, making friendships, role modeling)

Affective education and management (AEM)
- Relaxation
- Anger Management

IIIC. A Few Examples of Counseling Approaches

BRIEF COGNITIVE-BEHAVIORAL FAMILY THERAPY FOR SUICIDAL ADOLESCENTS

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

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

TREATING DEPRESSION IN CHILDREN AND ADOLESCENTS

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

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

STUDY ON SUICIDE (SOS)

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

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

IIIC. A Few Examples of Counseling Approaches

Excerpts from…

DEPRESSION IN YOUTH: PSYCHOSOCIAL INTERVENTIONS

Asarnow, JR, Jaycox, LH, Tompson, MC (2001).
Journal of Clinical Child Psychology, 30 (1), 33-47.

This article reviews the literature on psychosocial interventions for depression in youth and offers a working model to guide the treatment of depressed youth. The article begins with a brief overview of the model based primarily on cognitive-behavioral theory.

A review of the treatment efficacy and prevention literature follows. The review includes a summary of the research literature to date. The article also includes a table providing an overview of randomized clinical intervention trials for depressed children. The studies supported the efficacy of psychosocial / cognitive-behavioral interventions for youth with depressive symptoms or subsyndromal depression. The authors note that additional research is needed to determine if the results will generalized to samples with diagnosable depressive disorders.

The article then provides a brief overview of family interventions (brief educational and extended) as well as efforts to prevent depression by targeting normal youth before the development of depressive symptoms.

DEPRESSION AMONG YOUTH IN PRIMARY CARE MODELS
FOR DELIVERING MENTAL HEALTH SERVICES

Asarnow, JR, Jaycox, LH, Anderson, M (2001).
Child and Adolescent Psychiatric Clinics of North America, 11 (3), 477-497.

This article emphasizes the promise of efforts to improve care for depression within the primary care setting. These efforts, however face a number of potential obstacles. We have reviewed the literature on the detection and treatment of depression among youth in primary care settings and argue that primary care offers underutilized potential for reaching out to youth and improving access to high-quality care for depression. Much work remains to be done before this potential can be realized. The recommendations below highlight crucial directions for future research and clinical efforts:

1. Traditional primary care practices offer an opportunity to identify and reach youth who need care for depression. To reach youth who do not present in typical primary care settings, outreach is needed to emergency services, urgent care, and obstetric-gynecologic settings. The increased emphasis on developing school-based and school-linked health centers may also prove helpful for increasing the number of youth who are seen in primary care because there centers bring the services to a setting that is easily accessible to most youth.

2. Strategies for improving detection of depression in primary care settings must be developed and tested. Given the constraints of primary care visits, these strategies must be relatively brief and not require extensive primary care provider time. Use of nonphysicians such as practice assistants, nursing staff or associated mental health workers will be needed to support physician efforts. Furthermore, although brief self-report instruments may be useful in identifying a broad group of youth who may benefit from care, available instruments are likely to lead to over-identification and will require additional screening and triage of youth to appropriate services. Some identified youth

may be require or want care; others may require further evaluation; others can be treated through primary care resources; and others will have complex conditions that require specialty consultation or referral.

3. Low rates of detection and evidence-based treatment for depression in primary care settings underscore the urgent need to understanding the barriers to care within primary care settings and to develop interventions that reduce potential barriers and improve access to high-quality care.

4. Detection efforts within primary care settings are likely to yield a somewhat different population than the population of youth identified in specialty mental health clinics or schools. Notable, physical health problems are likely to be more common in primary care populations. The limited extent data also suggest that, as in most non-primary care samples of depressed youth, youth with depression seen in primary care settings are likely to present with a number of comorbid mental health conditions. Thus, there is a need to test extent treatments within primary care settings, and adaptation may be required to meet the needs of youth seen through primary care.

5. Motivation for treatment is likely to be lower for youth identified through primary care than for those seen in specialty care, particularly when youth have not identified themselves as requiring treatment. Strategies need to be developed and tested to enhance motivation and to target treatment efforts at those youth who are most likely to benefit from services.

6. The confidential nature of the patient-provider relationship, particularly in primary care settings where youth have sought care for sensitive issues (e.g., pregnancy, birth control), underscores the need to develop effective strategies for working with families and mobilizing parents to support treatment and recovery. In primary care settings, parents may be less likely to be aware of youth problems, and youth may be reluctant to disclose difficulties to their parent.

7. Research is needed to identify service-delivery strategies that are practical in real-world settings and are associated with improved quality of care and outcomes in children and adolescents treated for depression in primary care settings.

8. Collaborative models of service delivery seem to be promising. These models build on the strengths of primary care settings and relationships and support primary care providers with resources that enables them to expand with diagnostic and treatment targets to include depression and other mental health problems.

The recent and ongoing studies reviewed in this article provide some examples of these models. Future research is needed to clarify the effectiveness, costs, and benefits of this approach.

IIIC. A Few Examples of Counseling Approaches

Excerpts from…

OUTPATIENT CARE OF ADOLESCENT SUICIDE ATTEMPTERS

Boergers, J, & Spirito, A (1999). *Clinical Child Psychology Newsletter*, Spring 1999.

Suicide is the third-leading cause of death among adolescents in the United States. In the 1997 Youth Risk Behavior Survey, 21% of high school students reported suicidal ideation in the year preceding the survey, and 8% reported having made a suicide attempt… Additionally, suicidal behavior is consistently related to other problem behaviors, including depression, conduct problems, and school difficulties…

The Problem of Treatment Noncompliance. The majority of adolescent suicide attempters are referred for outpatient mental health services. However, follow-up studies of these adolescents have typically found very poor compliance with outpatient treatment…

Improving Treatment Compliance. What can clinicians do to enhance the likelihood that adolescents will enter and complete a course of outpatient psychotherapy following a suicide attempt? Some promising systematized programs have been designed to enhance treatment compliance. Common features in such programs include making a highly specific referral (indicating time, place, and provider), reviewing expectations and misconceptions about therapy, directly addressing any resistance toward therapy, utilizing telephone reminders, and explicitly contracting with families about anticipated treatment length and/or goals…

Psychotherapy Approaches. Of the treatment approaches available to clinicians who treat adolescent suicide attempters, cognitive behavioral therapy is most frequently advocated because it is highly structured and can address the cognitive distortions so common among suicide attempters…

Problem solving is another commonly advocated technique. Adolescent suicide attempters have been found to demonstrate significant deficits in problem solving, including limited flexibility, difficulty generating alternative solutions, and limited ability to identify positive consequences of potential solutions…

Of course, a key component of any therapeutic intervention with these youth is the regular assessment of suicidal risk. Common guidelines for managing risk include regular assessment of suicidal intent (both verbal and non-verbal indicators); negotiation (and re-negotiation) of a no-suicide contract; and provision of 24-hour emergency back-up. Impulsivity, hopelessness, and anger should also be closely monitored, as these characteristics have been closely linked to suicidal behavior among adolescents. Clinicians should instruct parents to increase their level of supervision, to take all suicidal statements seriously, and to restrict access to any potentially lethal means, including both prescription and nonprescription medication, firearms and other weapons, toxic household chemicals, and motor vehicles.

IIIC. A Few Examples of Counseling Approaches

Intervention Research Update…

AN INTERVENTION TRIAL TO IMPROVE ADHERENCE TO COMMUNITY TREATMENT BY ADOLESCENTS AFTER A SUICIDE ATTEMPT

Spirito, A, Boergers, J, Donaldson, D, Bishop, D, & Lewander, W (2002). *Journal of the American Academy of Child and Adolescent Psychiatry, 41* (4), 435-442.

Objective: To determine whether a problem-solving intervention would increase adherence to outpatient treatment for adolescents after a suicide attempt.

Method: Sixty-three adolescents who had attempted suicide and were evaluated in an emergency department between 1997 and 2000 were randomly assigned to undergo standard disposition planning or a compliance enhancement intervention using a problem-solving format. At 3 months after the intervention, all evaluable adolescents, guardians, and outpatient therapists were contacted to determine adherence to outpatient treatment.

Results: At 3-month follow-up, the compliance enhancement group attended an average of 7.7 sessions compared with 6.4 sessions for the standard disposition group, but this difference was not statistically significant. However, after covarying barriers to receiving services in the community (such as being placed on a waiting list and insurance coverage difficulties), the compliance enhancement group attended significantly more treatment sessions that the standard disposition-planning group (mean = 8.4 versus 5.8 sessions).

Conclusion: Interventions designed to improve treatment attendance must address not only individual and family factors but also service barriers encountered in the community that can impede access to services.

IIIC. A Few Examples of Counseling Approaches

Excerpts from…

REDUCING SUICIDE: A NATIONAL IMPERATIVE **(In Summary…)**

Every year approximately 30,000 people in the United States and one million worldwide die as a result of suicide. Over the last 100 years, suicides have out-numbered homicides by at least 3:2. Concerned with high suicide rates, several federal agencies joined together and asked the Institute of Medicine to convene the Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide to examine the state of the science base, gaps in our knowledge, strategies for prevention, and research designs for the study of suicide.

Risk and Protective Factors

Biological, genetic, psychological, and cultural factors significantly impact the risk of suicide in any individual. Risk factors associated with suicide include serious mental illness, alcohol and drug abuse, childhood abuse, loss of a loved one, joblessness and loss of economic security, and other cultural and societal influences, while resiliency and coping skills can reduce risks. Further, social support and close relationships serve as protective factors. However, despite advances, we still do not understand how these factors work in concert, either in inducing suicidal behavior or preventing it.

Treatment and Prevention

Suicidality can be treated. Pharmacotherapy and psychotherapy can be effective, particularly when used in combination. Continued contact with a health care provider has proven effective in reducing the risk of suicide, especially in the early weeks after discharge from a hospital.

A number of prevention programs show promise for reducing incidences of suicide and suicidal behaviors. Programs that address risk and protective factors at multiple levels are likely to be most effective.

Many of those who commit suicide visit a nonmental health clinician within the last month of their lives. This finding points to the important role primary care providers can play in identifying risk factors for suicide and in referring patients with suicidal intentions.

Enhancing the Database on Suicide

Because suicide is a low base-rate event, special efforts are needed to ensure collection of sufficient data to allow for meaningful analysis of risk factors and interventions. Currently, the reporting of suicide is non-uniform across jurisdictions, and the quality of data collected on suicide attempts is even more tenuous than that of completed suicides. Thus, improved surveillance is necessary.

Clinical trials of psychoactive medications usually exclude participants at risk for suicide. Unfortunately, this practice precludes evaluation of treatments that could potentially improve outcomes for suicidal individuals. With appropriate safeguards, patients at risk for suicide can be safely and ethically included in clinical trials.

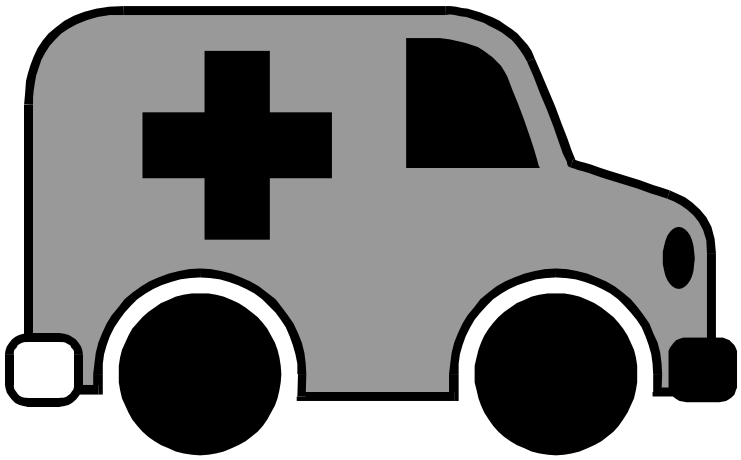
Next Steps

The report provides a blueprint for addressing the tragic and costly problem of suicide. Recommendations aim to improve the monitoring of suicide, to increase recognition of key risk factors for suicide in primary care, and to expand efforts in prevention. The committee also recommends enhancing the research infrastructure by creating population research centers to conduct long-term, inter-disciplinary efforts that will lead to improved research, prevention, and treatment interventions.

IV. ON AFTERMATH ASSISTANCE & PREVENTION OF CONTAGION

A. Postvention

B. Procedures to Follow in the Aftermath of a Suicide



IV. ON AFTERMATH ASSISTANCE & PREVENTION OF CONTAGION

A. Postvention

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

When a Student Commits Suicide

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

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

> According to 1993 data, the most common method of suicide for individuals under 25 was firearms (two-thirds), followed by hanging and poisoning.
>
> - CDC, January 2000

IV. ON AFTERMATH ASSISTANCE & PREVENTION OF CONTAGION

B . Procedures to Follow in the Aftermath of a Suicide

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

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

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

Components of the School Plan for Postvention...

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

V. ADDITIONAL RESOURCES

A. Hotlines

B. References

- ? from the Surgeon General's Report
- ? Books and Book Chapters
- ? Journal Articles, Briefs, and Reports

C. Websites

D.Consultation Cadre Contacts

E.Other Resources from our Center

V. ADDITIONAL RESOURCES

A. Hotline and Internet Resources on School Interventions to Prevent Youth Suicide

The following is a list of hotlines and websites which may be helpful.

Hotlines

American Suicide Foundation	(800)531-4477
Crisis Helpline (for any kind of crisis)	(800) 233-4357
Crisis Intervention Center	(800) 333-4444
Crisis Line for the Handicapped	(800) 426-4263
Depression Awareness	(800) 421-4211
Gay & Lesbian Youth Crisis Hotline	(800) 866-9600
Gay & Lesbian Youth Depression Hotline	(800) 799-7233
Gay & Lesbian Youth Suicide Hotline	(800) 999-9999
Help Now Hotline	(800) 435-7609
National Adolescent Suicide Hotline	(800) 621-4000
National Child -At Risk Hotline	(800) 792-5200
National Hopeline Network	(800) SUI-CIDE
National Hotline Boys Town	(800) 448-3000
National Youth Crisis Hotline	(800) 442-HOPE
Sanctuary Crisis Line	(800) 548-5222
Youth Crisis Hotline	(800) 448-4663

V. ADDITIONAL RESOURCES

B. References... from the Surgeon General's Report

1. Peters KD, Kochanek KD, Murphy SL. Deaths: final data for 1996. In: CDC. National vital statistics reports, vol. 47, no. 9. Hyattsville, Maryland: National Center for Health Statistics, 1998.
2. McCraig LF, Strussman BJ. National Hospital Ambulatory Care Survey: 1996. In: CDC. Emergency department summary. Advance Data from Vital and Health Statistics, no. 293. Hyattsville, Maryland: National Center for Health Statistics, 1997.
3. Conwell Y, Brent D. Suicide and aging I: patterns of psychiatric diagnosis. Int Psychogeriatr 1995;7:149-64.
4. Harris EC, Barraclough BB. Suicide as an outcome for mental disorders. Br J Psychiatry 1997; 170:205-28.
5. Murray CJL, Lopez, AD. The global burden of disease, vol. I. Boston: Harvard School of Public Health, 1996.
6. Ness DE, Pfeffer CR. Sequelae of bereavement resulting from suicide. Am J Psychiatry 1990; 147: 279-85.
7. World Health Organization. Prevention of suicide: guidelines for the formulation and implementation of national strategies. Geneva: World Health Organization, 1996.
8. Mó´scicki EK, O'Carroll P, Regier DA, Rae DS, Roy A, Locke BZ. Suicide attempts in the Epidemiologic Catchment Area Study. Yale J Biol Med 1988;61:259-68.
9. Kachur S, Potter L, James S, Powell K. Suicide in the United States, 1980-1992. Violence Surveillance Summary Series, no. 1. Atlanta: CDC, National Center for Injury Prevention and Control, 1995.
10. CDC. National mortality statistics. Available at: http://www.cdc.gov/ ncipc/osp/usmort.htm.
11. CDC. Suicide among children, adolescents, and young adults—United States, 1980-1992. MMWR Morb Mortal Wkly Rep 1995; 44(15):289-91.
12. CDC. Ten leading causes of death for the United States. Available at: http://www.cdc.gov/ncipc/osp/leadcaus/10lc96.htm.
13. Carney SS, Rich CL, Burke PA, Fowler RC. Suicide over 60: the San Diego study. J Am Geriatr Soc 1994;42:174-80.
14. Dorpat TL, Anderson WF, Ripley HS. The relationship of physical illness to suicide. In: Resnik HP, editor. Suicide behaviors: diagnosis and management. Boston: Little, Brown, 1968:209-19.
15. Pearson JL, Conwell Y, Lyness JM. Late-life suicide and depression in the primary care setting. In: Schneider LS, editor. Developments in geriatric psychiatry. New directions for mental health services (no. 76). San Francisco: Jossey-Bass:1997:13-38.
16. Wallace LJD, Calhoun AD, Powell KE, O'Neil J, James SP. Homicide and suicide among Native Americans, 1979-1992. Violence Surveillance Summary Series, no. 2. Atlanta: CDC, National Center for Injury Prevention and Control, 1996.
17. Indian Health Service. Trends in Indian Health 1997. Available at http://www.ihs.gov/PublicInfo/Publications/trends97/trends97.asp.
18. CDC. Suicide among black youths, United States, 1980-1995. MMWR Morb Mortal Wkly Rep 1998;47(10):193-6.
19. Clark DC, Horton-Deutsch SL. Assessment in absentia: the value of psychological autopsy method for studying antecedents of suicide and predicting future suicides. In: Maris RW, Berman AL, Maltsberger JT, Yufit RI, editors. Assessment and prediction of suicide. New York: Guilford, 1992:144-181.
20. Gibbs J.T. Conceptual, methodological, and sociocultural issues in black youth suicide: Implications for assessment and early intervention. Suicide Life Threat Behav 1988;18(1):73-89.
21. O'Carroll PW. Validity and reliability of suicide mortality data. Suicide Life Threat Beh 1989;19:1-16.
22. Jamison, K, Baldessarini RJ, editors. Effects of medical interventions on suicidal behavior. J Clin Psychiatry 1999;60(suppl 2):4-6,117-22.
23. Brent DA, Kolko DJ, Birhamer B, et al. Predictors of treatment efficacy in a clinical trial of three psychosocial treatments for adolescent depression. J Am Acad Child Adolesc Psychiatry 1998;37:906-14.

24. Cornelius JR, Salloum IM, Cornelius MD, et al. Fluoxetine trial in suicidal depressed alcoholics. Psychopharmacol Bull 1993;29:195-9.
25. Evans K, Tyrer P, Catalan J, et al. Manual-assisted cognitive behaviour therapy (MACT): a randomized controlled trial of brief intervention with bibliotherapy in the treatment of deliberate self-harm. Psychol Med 1999;29:19-25.
26. Hawton K, Arensman E, Townsend E, et al. Deliberate self harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition. Br Med J 1998;317:441-7.
27. Linehan MM, Heard HL, Armstrong HE. Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. Arch Gen Psychiatry 1993;50:971-4.
28. Meltzer HY, Okayli G. Reduction in suicidality during clozapine treatment of neuroleptic- resistant schizophrenia: impact on risk-benefit assessment. Am J Psychiatry 1995;152:183-90.
29. Rhimer Z, Rutz W, Pihlgren H. Depression and suicide on Gotland: an intensive study of all suicides before and after a depression-training programme for general practitioners. J Affective Disord 1995;35:147-52.
30. Verkes RJ, Van der Mast RC, Hengevold VW, et al. Reduction by paroxetine of suicidal behavior in patients with repeated suicide attempts but not major depression. Am J Psychiatry 1998;155:543-7.
31. Blumenthal SJ. Suicide: a guide to risk factors, assessment, and treatment of suicidal patients. Med Clin North Am 1988;72:937-71.
32. Jenkins R. Principles of prevention. In: Paykel ES, Jenkins R, editors. Prevention in psychiatry. London: Gaskell,1994:11-24.
33. Silverman MM, Felner RD. Suicide prevention programs: issues of design, implementation, feasibility, and developmental appropriateness. Suicide Life Threat Behav 1995; 25: 92-103.
34. Blumenthal SJ, Kupfer DJ, editors. Suicide over the life cycle. Washington, DC: American Psychiatric Press, 1990.
35. Gibbs JT. African-American suicide: a cultural paradox. Suicide Life Threat Behav 1997; 27: 68-79.
36. Mann JJ. The neurobiology of suicide. Nat Med 1988;4:25-30.
37. Mo´scicki EK. Epidemiology of suicide. In: Jacobs DG, editor. Harvard Medical School guide to suicide assessment and intervention. San Francisco: Jossey-Bass, 1999:40-51.
38. Roberts RE, Chen YR, Roberts CR. Ethnocultural differences in prevalence of adolescent suicidal behaviors. Suicide Life Threat Behav 1997;27(2):208-17.
39. Stoff DM, Mann JJ, editors. The neurobiology of suicide. Ann NY Acad Sci 1997; 836:1- 363.
40. Henriksson M, Marttunen M, Heikkinen M, et al. Mental disorders and comorbidity in suicide. Am J Psychiatry 1993;150:935.
41. Cornelius JR, Salloum IM, Mezzich J, et al. Disproportionate suicidality in patients with comorbid major depression and alcoholism. Am J Psychiatry 1995;152: 358-64.
42. Brent DA, Johnson BA, Perper J, et al. Personality disorder, personality traits, impulsive violence, and completed suicide in adolescents. J Am Acad Child Adolesc Psychiatry 1994;33(8):1080-6.
43. Isacsson G, Holmgren P, Druid H, Bergman U. The utilization of antidepressants: a key issue in the prevention of suicide: an analysis of 5281 suicides in Sweden during the period 1992-1994. Acta Psychiatrica Scandinavia 1997;96:94-100.
44. Oquendo MA, Malone KM, Ellis SP, Sackeim HA, Mann JJ. Inadequacy of antidepressant treatment for patients with major depression who are at risk for suicidal behavior. Am J Psychiatry 1999;156:190-4.
45. Vieland V, Whittle B, Garland A, et al. The impact of curriculum-based suicide prevention programs for teenagers: an eighteen–month follow-up. J Am Acad Child Adolesc Psychiatry 1991;30:811-5.
46. O'Carroll PW, Potter LB. Suicide contagion and the reporting of suicide: Recommendations from a national workshop. MMWR 1994;43(No. RR-6): 9-18.
47. Gould M. Suicide clusters and media exposure. In: Blumenthal SJ, Kupfer DJ, editors. Suicide over the life cycle. Washington, DC: American Psychiatric Press, 1990:517-32.
48. Potter LB, Rosenberg ML, Hammond WR. Suicide in youth: a public health framework. J Am Acad Child Adolesc Psychiatry 1998;37:484-87.
49. Satcher D. Bringing the public health approach to the problem of suicide. Suicide Life Threat Behav 1998;28:325-7.

B. References... Books and book chapters

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Presents information to school counselors, nurses, psychologists, administrators, teachers, and other school

personnel about intervention strategies in situations where suicide is a real possibility. Additional information here will show professionals in schools what to do about a student at risk for suicide until professional help arrives.

Poland, S. (1989). *Suicide intervention in the schools*. Guilford Press, New York, NY.
Contains many practical examples of how a school system can approach the topic of suicide intervention in the schools. The case examples provided are composites of suicidal students with whom the author has worked with.

B. References... Journal Articles, Briefs and Reports

Ackerman, G.L. (1993). A congressional view of youth suicide. *American Psychologist*, v48 (n2), 183-184.
Reviews the results of a national survey of adolescents about their knowledge of, and attitude toward, youth suicide. Also provides information about adolescents' explanations for self-destructive behavior. Given this information, recommendations for effective preventive interventions and policy decisions are offered.

Adams, C.M. (1996). Adolescent suicide: One school's response. *Journal of Secondary Gifted Education*, v7 (n3), 410-417.
Documents the responses of a state-supported residential high school for gifted students following the 1994 suicides of three students. The school's measures to develop a screening procedure, design a prevention program, disseminate information about adolescent suicide, and host a conference are outlined, as is a separate crisis management workshop.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual-IV*. *:*.
This publication provides diagnostic criteria for all mental disorders, including depression and otherchildhood/adolescent disorders.

Berman, A.L. & Jobes, D.A. (1995). Suicide prevention in adolescents (age 12-18). *Suicide & Life-Threatening Behavior*, v25 (n1), 143-154.
The epidemiology of adolescent suicide is summarized with particular emphasis on temporal trends by age and gender. "First generation" prevention programs are examined, followed by a description of selective, targeted, "second generation" prevention efforts, which are focused toward targets of individual predisposition, the social milieu, or proximal agents associated with high risk for suicidal behavior.

Blatt, S. J. (1995). The destructiveness of perfectionism: Implications for the treatment of depression. *American Psychologist, v49* (n12), 1003-1020.
Discusses perfectionism in high-achieving individuals and its relation to depression and suicide.

Boehm, K. E & Campbell, N.B. (1995). Suicide: A review of calls to an adolescent peer listening phone service. *Child Psychiatry and Human Development*, v26 (n1), 61-66.
Describes calls about suicide to a teen listening phone service over a period of 5.5 years. Of the 11,152 calls received, 441 of them were about suicide. Those concerned with suicide also discussed other serious issues such as self-esteem, family problems, substance use, and abuse and were less likely to be calling "just to talk."

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

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

Borowsky, I. W., et al. (1999, June). Suicide attempts among American Indian and Alaska Native youth. *Archives of Pediatrics and Adolescent Medicine*,573-580.
This article examines suicide attempts in a large sample (11,600 students) of 7th through 12th graders in reservation communities in 8 different states across the United States. Risk and protective factorsfor suicide attempts are discussed. (note: free copy available from Dr. Borowsky, Division of General Pediatrics and Adolescent Health, University of Minnesota, Box 571 FUMC, 420 Delaware St. SE, Minneapolis, MN 55455 or borow004@gold.tc.umn.edu.)

Center for Disease Control. (1995, April 28). Fatal and nonfatal suicide attempts among adolescents--Oregon, 1988-1993. *Morbidity and Mortality Weekly Report, v44*, (n16), 312-323.
Surveys suicide attempts in Oregon over a 5-year period and summarizes data including the characteristics of fatal and nonfatal suicide attempts, methods used, gender and age differences, and reasons for the attempt.

Center for Disease Control. (1998, March 20). Suicide among Black youth--United States, 1980-1995. *Morbidity and Mortality Weekly Report, v47* (n10), 193-196.
Examines trends in suicide among Black youth over a 15-year period. Reviews trends in demographic changes by age, ethnicity (as compared to white youth), gender, geographic location, and risk factors. .

Center for Disease Control (1998, April 10). Suicide prevention evaluation in a Western Athabaskan American Indian tribe--New Mexico, 1988-1997. *Morbidity and Mortality Weekly Report, v47*, (n13), 257-261.
Discusses and prevention and intervention program implemented into a Native American community in New Mexico. Examines suicidal behavior before and after program implementation.

Ciffon, J. (1993). Suicide prevention: A classroom presentation to adolescents. *Social Work*, v38 (n2), 197-203.
Subjected suicide prevention program for high school sophomores to statistical analysis of effectiveness. Results showed that disturbingly high proportion of adolescents had undesirable attitudes about suicide in baseline period. Program appeared to have caused significant shift from undesirable to desirable attitudinal responses in six of eight areas.

Collins, S. & Angen, M. (1997). Adolescents voice their needs: Implications for health promotion and suicide prevention. *Canadian Journal of Counseling*, v31 (n1), 53-66.
Investigated self-perceived need for health-related services, instruction, and environmental changes among 2,370 10^{th}-12^{th} graders in 3 Calgary senior high schools. Results are discussed.

Coy, D.R. (1995). The need for a school suicide prevention policy. *NASSP Bulletin*, v79 (n570), 1-9.
Discusses the need for school suicide prevention policy. Posits that administrators should adopt cautious and comprehensive policies, risk management, and prevention programs and that educators should recognize suicide warning signs.

Davidson, M.W. & Range, L.M. (1999). Are teachers of children and young adolescents responsive to suicide prevention training modules? Yes. *Death Studies*, v23 (n1), 61-71.
Examined whether teachers would be responsive to suicide prevention training, which might include teaching about suicide warning signs and offering specific suggestions such as using no-suicide agreements as a stop gap measure until students (and their families) can be seen by a counselor or other trained professional. Results are discussed.

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

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

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

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

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

Provides background information on school-based suicide prevention programs. The study describes a 3-stage identification process of identifying suicidal youth. All suicidal youth received a comprehensive suicide assessment and were then placed in one of three groups: 1) one semester of group intervention, 2) two semesters of group intervention, or 3) no intervention. Data suggest that all three groups showed decreases in suicidal behaviors, depression, hopelessness, stress, and anger. Furthermore, all three groups showed increased self-esteem and network social support. The researchers attribute this to the therapeutic effects of the comprehensive suicide assessment. Personal control only increased in the two treatment groups and not in the control group.

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

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

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

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

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

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

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

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

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

Examined the safety and effectiveness of an outpatient treatment program for suicidal children and adolescents

that used a clinical team approach and clinical team / family member gatherings to prevent future extreme reactions to stresses and developmental transitions. Evaluation of the program indicated significant long-term improvement.

Hennig, C.W., Crabtree, C.R. & Baum, D. (1998). Mental health CPR: Peer contracting as a response to potential suicide in adolescents. *Archives of Suicide Research*, v4 (n2), 169-187.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Kalafat, J. & Gagliano, C. (1996). The use of simulations to assess the impact of an adolescent suicide response curriculum. *Suicide & Life-Threatening Behavior*, v26 (n4), 359-364.
Employed simulations of encounters with suicidal peers to assess the impact of classroom suicide response lessons. Results provide evidence for the efficacy of such classes.

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

Kaplan, S.J., Pelcovitz, D., Salzinger, S., Mandel, F., et al. (1997). Adolescent physical abuse and suicide attempts. *Journal of the American Academy of Child & Adolescent Psychiatry*, v36 (n6), 799-808.
The rate of suicide attempts and the exposure to risk factors for suicide in a sample of 99 confirmed cases of physically abused adolescents was compared with those of a control community sample of 99 nonabused adolescents (aged 12-18 years). Results are discussed.

Kopper, B.A., Osman, A., Osman, J.R. & Hoffman, J. (1998). Clinical utility of the MMPI-A content scales and Harris-Lingoes subscales in the assessment of suicidal risk factors in psychiatric adolescents. *Journal of Clinical Psychology*, v54 (n2), 191-200.
This study of 143 inpatient adolescents (mean age 15.9 years) investigated the clinical utility of the MMPI-A in assessing suicidal risk factors by examining the unique contribution of the content scales and Harris-Lingoes subscales beyond what is provided by the basic clinical scales. Results are discussed.

Kotch, K. (1999). Childhood depression. *The Congressional Quarterly Researcher, v9*, (n26), 593-616.
This issue of the *CQ Researcher* examines the issues in childhood depression, including reviewing the role schools could play in the prevention and treatment of depression. Depression, as it relates to suicide, is also discussed.

Lester, D. (1992). State initiatives in addressing youth suicide: Evidence for their effectiveness. *Social Psychiatry and Psychiatric Epidemiology*, v27 (n2), 75-77.
Examined the efficacy of state government initiatives and school-based suicide prevention programs for preventing teen suicides.

Lewinsohn, P. M., & Clarke, G. N. (1999). Psychosocial treatments for adolescent depression. *Clinical Psychology Review, v19,* (n3), 329-342.
Reviews the research on cognitive-behavioral therapy (CBT) and provides an overview of techniques that are typically effective in treating adolescent depression. It also compares the merits of various treatment characteristics (e.g., number of sessions, group vs. individual therapy, age modifications, etc.).

Malley, P., et al. (1994). School-based adolescent suicide prevention and intervention programs: A survey. *School Counselor*, v24 (n2), 130-136.
Survey of school counselors revealed that schools with a written suicide policy incorporated more of the recommended components of suicide prevention programs than schools lacking written guidelines. Almost half of the schools did not use components that are necessary to ensure a systematic and comprehensive suicide prevention program.

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

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

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

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

McFarland, W.P.(1998). Gay, lesbian, and bisexual student suicides. *Professional school counseling*, 1(3), 26-29.

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

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

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

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

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

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

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

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

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

Orbach, I. & Bar-Joseph, H. (1993). The impact of a suicide prevention program for adolescents on suicidal tendencies, hopelessness, ego identity, and coping. *Suicide & Life-Threatening Behavior*, 23(2), 120-129.

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

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

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

Peach, L. & Reddick, T.L. (1991). Counselors can make a difference in preventing adolescent suicide. *School*

Counselor, v39 (n2), 107-110.

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

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

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

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

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

Range, L.M. (1993). Suicide prevention: Guidelines for schools. *Educational Psychology Review,* 5(2), 135-154.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Examines a group of 44 minority female suicide attempters. Compares depression and hopelessness of this group of suicide attempters to a similar group of psychiatrically disturbed nonattempters. Results suggest that hopelessness should not be used as the sole indicator of suicide risk.

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

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

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

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

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

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

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

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

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

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

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

Describes a very short-term, teacher-administered school suicide prevention program. The study evaluates the efficacy of the program in changing views/attitudes, coping behaviors, and suicide attempts. There was no convincing evidence for any program effect. Future directions are discussed in light of previous research.

Webb, L.D. & Metha, A. (1996). Suicide among American Indian youth: The role of the schools in prevention.

Journal of American Indian Education, v36 (n1), 22-32.

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

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

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

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

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

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

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

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

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

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

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

V. ADDITIONAL RESOURCES

C. Websites

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

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

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

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

American Psychological Association Help Center
http://www.apahelpcenter.org/featuredtopics/feature.php?id=38&ch=8
This brochure describes the "Warning Sings" project. To help youth proactively address the problem of violence, APA and MTV have teamed up to provide youth with information about identifying the warning signs of violent behavior and how to get help if they recognize these signs in themselves or their peers.

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

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

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

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

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

Internet & International Crisis Resources & Information
http://www.faqs.org/faqs/suicide/resources/
A one page listing of suicide resources. Descriptions are provided for each resource listed.

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

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

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

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

National Center for Injury Prevention and Control (NCIPC)
http://www.cdc.gov/ncipc/osp/data.htm
This site, also by NCIPC, provides access to national injury and mortality statistics, including deaths occurring as the result of suicide. In addition, suicide statistics can be examined by state. Another link provides comparative data on the leading causes of death for various age groups.

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

Program, and chapter information is also included. This is an informative site for the patient as well as their family members.

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

National Strategy for Suicide Prevention
http://www.mentalhealth.org/suicideprevention/
This is the official website for the National Strategy for Suicide Prevention. A collaborative project of SAMHSA, CDC, NIH, NRSA, and IHS. The website features information about the surgeon general's call to action to prevention suicide, the national strategy, as well as regularly updated news and resources related to suicide and suicide prevention.

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

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

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

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

Suicide Hotlines
www.suicidehotlines.com
This website provides a comprehensive nationwide overview of suicide hotlines by state.

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

thinking about committing suicide or knows someone that may be suicidal.

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

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

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

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

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

V. ADDITIONAL RESOURCES

D. Consultation Cadre Contacts

Professionals across the country volunteer to network with others to share what they know. Some cadre members run programs, many work directly with youngsters in a variety of settings and focus on a wide range of psychosocial problems. Others are ready to share their expertise on policy, funding, and major system concerns. The group encompasses professionals working in schools, agencies, community organizations, resource centers, clinics and health centers, teaching hospitals, universities, and so forth.

People ask how we screen cadre members. We don't! It's not our role to endorse anyone. We think it's wonderful that so many professionals want to help their colleagues, and our role is to facilitate the networking. If you are willing to offer informal consultation at no charge to colleagues trying to improve systems, programs, and services for addressing barriers to learning, let us know. Our list is growing each day; the following are those currently on file related to this topic. Note: the list is alphabetized by Region and State as an aid in finding a nearby resource.

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V. ADDITIONAL RESOURCES

E. Other Related Resources from our Center

(All available online at http://smhp.psych.ucla.edu)

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

I. Introductory Packets

We are developing overview packets on key topics. Each has overview discussions, descriptions of model programs (where appropriate), references to publications, access information to other relevant centers, agencies, organizations, advocacy groups, and Internet links, and a list of consultation cadre members ready to share expertise. Currently available are packets on:

A. System Concerns

1. Financial Strategies to Aid in Addressing Barriers to Learning

Designed as an aid in conceptualizing financing efforts, identifying sources, and understanding strategies related to needed reforms.

2. Evaluation and Accountability: Getting Credit for All You Do!

Emphasizes evaluation as a tool to improve quality and to document outcomes. Focuses on measuring impact on students, families and communities, and programs and systems.

3. Working Together: From School-Based Collaborative Teams to School-Community-Higher Education Connections

Discusses the processes and problems related to working together at school sites and in school-based centers. Outlines models of collaborative school-based teams and interprofessional education programs.

B. Program/Process Concerns

1. Violence Prevention and Safe Schools

Outlines selected violence prevention curricula and school programs and school-community partnerships for safe schools. Emphasizes both policy and practice.

2. Least Intervention Needed: Toward Appropriate *Inclusion* of Students with Special Needs

Highlights the principle of *least intervention needed* and its relationship to the concept of *least restrictive environment*. From this perspective, approaches for including students with disabilities in regular programs are described.

3. Parent and Home Involvement in Schools

Provides an overview of how home involvement is conceptualized and outlines current models and basic resources. Issues of special interest to under-served families are addressed.

4. Confidentiality and Informed Consent
Focuses on issues related to confidentiality and consent of minors in human services and interagency collaborations. Also includes sample consent forms.

5. Understanding and Minimizing Staff Burnout
Addresses various sources and issues of burnout and compassion fatigue among school staff and mental health professionals. Also identifies ways to reduce environmental stressors, increase personal capability, and enhance social support to prevent burnout.

6. Assessing to Address Barriers to Learning
Discusses basic principles, concepts, issues, and concerns related to assessment of various barriers to student learning. It also includes resource aids on procedures and instruments to measure psychosocial, as well as environmental barriers to learning.

7. Cultural Concerns in Addressing Barriers to Learning
Highlights concepts, issues and implications of multiculturalism/cultural competence in the delivery of educational and mental health services, as well as for staff development and system change. This packet also includes resource aids on how to better address cultural and racial diversity in serving children and adolescents.

C. Psychosocial Problems

1. Dropout Prevention
Highlights intervention recommendations and model programs, as well as discussing the motivational underpinnings of the problem.

2. Learning Problems and Learning Disabilities
Identifies learning disabilities as one highly circumscribed group of learning problems, and outlines approaches to address the full range of problems.

3. Teen Pregnancy Prevention and Support
Covers model programs and resources and offers an overview framework for devising policy and practice.

4. Attention Problems: Intervention and Resources
This packet serves as a starting point for increasing awareness of assessment and treatment of attention problems. Included are excerpts from a variety of sources, including government fact sheets and the classification scheme developed by the American Pediatric Association. "Symptoms" are discussed in terms of degree of severity and appropriate forms of intervention- ranging from environmental accommodations to behavior management to medication.

5. Anxiety, Fears, Phobias, and Related Problems: Intervention and Resources for School Aged Youth
This packet presents a discussion framed within the classification scheme developed by the American Pediatric Association. The variations in degree of problem are discussed with respect to intervention that range from environmental accommodations to behavioral strategies to medication.

6. Social and Interpersonal Problems Related to School Aged Youth
This packet synthesizes fundamental social and interpersonal areas of competence and related problems. The range of interventions discussed stress the importance of accommodations, as well as strategies designed to change the individual. References, resources, and cadre members are also listed.

7. Affect and Mood Problems Related to School Aged Youth
In providing an introduction to affect and mood problems, a discussion framed within the classification scheme developed by the American Pediatric Association is offered. Included is information on the symptoms and severity of a variety of affect and mood problems, as well as information on interventions -- ranging from environmental accommodations to behavior management to medication.

8. Conduct and Behavior Problems in School Aged Youth

In this introductory packet, the range of conduct and behavior problems are described using fact sheets and the classification scheme from the American Pediatric Association. Differences in intervention needed are discusses with respect to variations in the degree of problems manifested and include exploration of environmental accommodations, behavioral; strategies, and medication. Also provided is a set of references for further study and, as additional resources, agencies and websites are listed that focus on these concerns.

II. Resource Aid Packets

These are designed to complement our series of Introductory Packets. They are a form of *tool kit* for fairly circumscribed areas of practice. They contain materials to guide and assist with staff training and student/family interventions -- including overviews, outlines, checklists, instruments, and other resources that can be reproduced and used as information handouts and aids for training and practice.

A. Screening/Assessing Students: Indicators and Tools

Designed to provide some resources relevant to screening students experiencing problems. In particular, this packet includes a perspective for understanding the screening process and aids for initial problem identification and screening of several major psychosocial problems.

B. Responding to Crisis at a School

Provides a set of guides and handouts for use in crisis planning and as aids for training staff to respond effectively. Contains materials to guide the organization and initial training of a school-based crisis team, as well as materials for use in ongoing training and as information handouts for staff, students, and parents.

C. Addressing Barriers to Learning: A Set of Surveys to Map What a School Has and What It Needs

Surveys are provided covering six program areas and related system needs that constitute a comprehensive, integrated approach to addressing barriers and thus enabling learning. The six program areas are (1) classroom-focused enabling, (2) crisis assistance and prevention, (3) support for transitions, (4) home involvement in schooling, (5) student and family assistance programs and services, and (6) community outreach for involvement and support (including volunteers).

D. Students and Psychotropic Medication: The School's Role

Underscores the need to work with prescribers in ways that safeguard the student and the school. Contains aids related to safeguards and for providing the student, family, and staff with appropriate information on the effects and monitoring of various psychopharmacological drugs used to treat child and adolescent psycho-behavioral problems.

E. Substance Abuse

Offers some guides to provide schools with basic information on widely abused drugs and indicators of substance abuse. Includes some assessment tools and reference to prevention resources.

F. Clearinghouse *Catalogue*

Our Clearinghouse contains a variety of resources relevant to the topic of mental health in schools. This annotated catalogue classifies these materials, protocols, aids, program descriptions, reports, abstracts of articles, information on other centers, etc. under three main categories: policy and system concerns, program and process concerns, and specific psychosocial problems. (Updated regularly)

G. Consultation Cadre *Catalogue*

Provides information for accessing a large network of colleagues with relevant experiences related to addressing barriers to student learning and mental health in schools. These individuals have agreed to share their expertise without charging a fee. The catalogue includes professionals indicating expertise related to major system and policy concerns, a variety of program and process issues, and almost every type of psychosocial problem. (Updated regularly)

H. *Catalogue* of Internet Sites Relevant to Mental Health in Schools

Contains a compilation of internet resources and links related to addressing barriers to student learning and mental health in schools. (Updated regularly)

I. Organizations with Resources Relevant to Addressing Barriers to Learning: A *Catalogue* of Clearinghouses, Technical Assistance Centers, and Other Agencies

Categorizes and provides contact information on organizations focusing on children's mental health, education and schools, school-based and school-linked centers, and general concerns related to youth and other health related matters. (Updated regularly)

J. Where to Get Resource Materials to Address Barriers to Learning

Offers school staff and parents a listing of centers, organizations, groups, and publishers that provide resource materials such as publications, brochures, fact sheets, audiovisual & multimedia tools on different mental health problems and issues in school settings.

K. Where to Access Statistical Information Relevant to Addressing Barriers to Learning: An Annotated Reference List

Provides resources to updated statistical information on a broad range of topics on youth, mental health, education, etc.

III. Technical Aid Packets

These are designed to provide basic understanding of specific practices and tools.

A. *School-Based Client Consultation, Referral, and Management of Care*

Discusses why it is important to approach student clients as consumers and to think in terms of managing *care*, not *cases*. Outlines processes related to problem identification, triage, assessment and client consultation, referral, and management of care. Provides discussion of prereferral intervention and referral as a multifaceted intervention. Clarifies the nature of ongoing management of care and the necessity of establishing mechanisms to enhance systems of care. Examples of tools to aid in all these processes are included.

B. *School-Based Mutual Support Groups (For Parents, Staff, and Older Student)*

This aid focuses on steps and-tasks related to establishing mutual support groups in a school setting. A sequential approach is described that involves (1) working within the school to get started, (2) recruiting members, (3) training them on how to run their own meetings, and (4) offering off-site consultation as requested. The specific focus here is on parents; however, the procedures are readily adaptable for use with others, such as older students and staff.

C. *Volunteers to Help Teachers and School Address Barriers to Learning*

Outlines (a) the diverse ways schools can think about using volunteers and discusses how volunteers can be trained to assist designated youngsters who need support, (b) steps for implementing volunteer programs in schools, (c) recruitment and training procedures and (d) key points to consider in evaluating volunteer programs. The packet also includes resource aids and model programs.

D. *Welcoming and Involving New Students and Families*

Offers guidelines, strategies, and resource aids for planning, implementing, and evolving programs to enhance activities for welcoming and involving new students and families in schools. Programs include home involvement, social supports, and maintaining involvement.

E. *Guiding Parents in Helping Children Learn*

Specially designed for use by professionals who work with parents and other nonprofessionals, this aid consists of a "booklet" to help nonprofessionals understand what is involved in helping children learn. It also contains information about basic resources professionals can draw on to learn more about helping parents and other nonprofessionals enhance children's learning and performance. Finally, it includes additional resources such as guides and basic information parents can use to enhance children's learning outcome.

IV. Technical Assistance Samplers

These samplers provide basic information for accessing a variety of resources on *a specific topic* such as agencies, organizations, websites, individuals with expertise**,** relevant programs, and library resources.

A. *Evaluation and Accountability Related to Mental Health in Schools*

Includes information on diverse resources dealing with issues that arise in relation to evaluation and accountability for mental health services in schools (e.g., such topics as conceptual models, cost analysis**,** methodology, outcome measures, quality indicators, evaluation guidelines and standards).

B. *Thinking About and Accessing Policy Related to Addressing Barriers to Learning*

Information on various resources discussing policies and initiatives relevant to addressing barriers to learning (e.g., general perspectives, conceptual models and state initiatives, issues and implications pertinent to policy making for educational reforms, improving educational standards/learning outcomes).

C. *Behavioral Initiatives in Broad Perspective*

Covers information on a variety of resources focusing on behavioral initiatives to address barriers to learning (e.g., state documents, behavior and school discipline, behavioral assessments, model programs on behavioral initiatives across the country, school wide programs, behavioral initiative assessment instruments, assessing resources for school-wide approaches).

D. *School-Based Health Centers*

Includes information on a wide range of issues dealing with school-based health centers (e.g., general references, facts & statistics, funding, state & national documents, guides, reports, model programs across the country).

E. *Protective Factors (Resiliency)*

Contains a sample of diverse resources and links to other resources and information. Topics include: (1) Protective Factors and Resistance to Psychiatric Disorder; (2) Fostering Resiliency; and (3) Intervening in the School, Home, and Community. Approaches the topic of fostering resilience as an inside-out, deep structure process of changing our own belief systems to see resources and not problems in youth, their families, and their cultures. Fostering resilience also is seen as requiring a focus on policy.

F. *School Interventions to Prevent Youth Suicide*

Provides basic statistical info on the problem and gives overviews on the topics of assessing suicide risk, prevention activities, and aftermath assistance. Lists key references and major websites.

G. *Sampling of Outcome Findings from Interventions Relevant to Addressing Barriers to Learning*

In this results-oriented era, it is essential to be able to reference programs that report positive findings. This document provides information on outcomes from a sample of almost 200 programs. Instead of simply providing a "laundry list", the programs are grouped using an enabling component framework of six basic areas that address barriers to learning and enhance healthy development: (1) enhancing classroom-based efforts to enable learning, (2) providing prescribed student and family assistance, (3) responding to and preventing crises, (4) supporting transitions, (5) increasing home involvement in schooling, and (6) outreaching for greater community involvement and support – including use of volunteers.

H. *Using Technology to Address Barriers to Learning*

This sampler highlights a range of intervention activities that can benefit from advanced technological applications and some of the categories of tools that are available.

V. Guides to Practice -- Ideas into Practice for Comprehensive Integrated Approaches to Addressing Barriers

A. *Mental Health and School-Based Health Centers*

This revised guidebook is virtually a completely new aid. The introductory overview focuses on where the mental health facets of school-based health centers (SBHCs) fit into the work of schools. This is followed by three modules.

B. *What Schools Can Do to Welcome and Meet the Needs of All Students and Families*

This guidebook offers program ideas and resource aids that can help address some major barriers that interfere with student learning and performance.

C. *Common Psychosocial Problems of School Aged Youth: Developmental Variations, Problems, Disorders and Perspectives for Prevention and Treatment*

This five-part resource provides frameworks and strategies to guide schools as they encounter common psychosocial problems including five of the most common "syndromes" students manifest and schools agonize over. These are attention problems, conduct and behavior problems, anxiety problems, affect and mood problems, and social and interpersonal problems. It also explores ways to increase a school's capacity to prevent and ameliorate problems.

D. New Directions in Enhancing Educational Results: *Policymakers' Guide to Restructuring Student Support Resources to Address Barriers to Learning*

The purpose of this guidebook is to (a) clarify why policy makers should expand the focus of school reform to encompass a reframing and restructuring of education support programs and services and (b) offer some guidance on how to go about doing so. It is divided into two major sections. The first deals with the question: Why restructure support services? In addition to discussing the need, ideas for new directions are outlined. The emphasis is on reframing how schools' think about addressing barriers to learning with a view to systemic reforms aimed at establishing comprehensive, multifaced approaches. The second section discusses how to go about the process of restructuring so that such approaches are developed effectively. The guide also includes several appendices to expand on key matters and a section containing some tools to aid those who undertake the proposed reforms.

E. School-Community Partnerships: A Guide

This document was developed with three objectives in mind: to enhance understanding of the concept of school-community partnerships; to convey a sense of the state of the art in a way that would underscore directions for advancing the field; to provide some tools for those interested in developing and improving the ways schools and communities work together in the best interests of young people and their families. The entire document is meant to be a toolkit. The material contained here can be drawn upon to develop a variety of resource aids.

VI. Continuing Education Modules

A. *Addressing Barriers to Learning: New Directions for Mental Health in Schools*

Consists of three units to assist mental health practitioners in addressing psychosocial and mental health problems seen as barriers to students' learning and performance. Includes procedures and guidelines on issues such as initial problem identification, screening/assessment, client consultation & referral, triage, initial and ongoing case monitoring, mental health education, psychosocial guidance, support, counseling, consent, and confidentiality.

B. *Mental Health in Schools: New Roles for School Nurses*

The above three units (see item B) have been adapted specifically for school nurses. A subset of the nursing material will appear in video/manual self-study format produced by National Association of School Nurses with support of the Robert Wood Johnson Foundation and National Education Association.

C. *Classroom Focused Enabling*

Consists of guidelines, procedures, strategies, and tools designed to enhance classroom based efforts by increasing teacher effectiveness for preventing and managing problems in the classroom and helping address barriers to learning. Other units for this module are planned.

VII. Quick Training Aids

A brief set of resources to guide those providing an inservice session. Also useful as a form of quick self-tutorial. Most encompass: key talking points for a short training session, a brief overview of the topic, facts sheets, tools, a sampling of other related information and resources.

1. Assessing & Screening
2. Attention Problems in School
3. Behavior Problems at School
4. Bullying Prevention
5. Case Management in the School Context
6. Confidentiality
7. Addressing Barriers to Learning: Overview of the Curriculum for an Enabling (or Learning Supports) Component
8. Financing Strategies to Address Barriers to Learning
9. Re-engaging Students in Learning
10. School-Based Crisis Intervention
11. School Interventions to Prevent and Respond to Affect and Mood Problems
12. School Staff Burnout
13. Suicide Prevention
14. Violence Prevention

This Center Response is from our website at http://smhp.psych.ucla.edu To access the online version, visit our website, click "Search & QuickFind" on the left and then scroll down in the list of "Center Responses" to SUICIDE PREVENTION.

A Center Response:

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

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

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

Center Developed Resources and Tools

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

- **Technical Assistance Sampler on: School Interventions to Prevent Youth Suicide**
- **A Resource Aid Packet on Responding to Crisis at a School**
- **Screening/Assessing Students: Indicators and Tools**
- **An Introductory Packet on Assessing to Address Barriers to Learning**
- **Hotline Numbers**
- **An Introductory Packet on Affect and Mood Problems related to School Aged Youth**
- **Featured Newsletter article (Summer, '99): Youth Suicide/Depression/Violence**

Relevant Publications on the Internet

- **AACAP Fact Sheet: Teen Suicide**
- **American Academy of Pediatrics Some Things You Should Know About Preventing Teen Suicide**
- **APA Public Information on Teen Suicide**
- **Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings from the Adverse Childhood Experiences Study**
- **Common Misconceptions about Suicide**
- **Community Learning Network: Teen Suicide Theme Page**
- **Detecting Suicide Risk in a Pediatric Emergency Department: Development of a Brief Screening Tool**
- **Explaining Suicide to Children**
- **Frequently Asked Questions about Suicide (NIMH)**
- **Goals and Objectives of the National Suicide Prevention Strategy**
- **Health Teacher: Suicide Prevention**
- **Healthtouch: Suicide Facts**
- **Is Suicide Contagious? A Study of the Relation between Exposure to the Suicidal Behavior of Others and Nearly Lethal Suicide Attempts (PDF Document, 71K)**
- **Issues to Consider in Intervention Research with Persons at High Risk for Suicidality**
- **National Strategy for Suicide Prevention (U.S.)**
- **National Strategy for Suicide Prevention: Facts, Funding, Frameworks for Action**
- **The Office of Youth Affairs**
- **Pitfalls: What to Avoid**

- **Reducing Suicide: A National Imperative (2002) Institute of Medicine, National Academy Press**
- **Reporting on Suicide: Recommendations for the Media (PDF Document, 173K)**
- **Students' FAQs about Suicide**
- **Suicide Prevention**
- **Suicide Prevention in Schools: Courth Cases and Implications for Principals**
- **Suicide statistics in the US and San Francisco (1991). From San Francisco Suicide Prevention.**
- **Symptoms of Depression and Danger Signs for Suicide**
- **Temporal Variations in School-Associated Violent Deaths (PDF Document, 131K)**
- **Things to Watch Out for When Assessing Suicide Risk**
- **What to Do if Someone You Know Becomes Suicidal**
- **Youth Suicide National Center**
- **Youth Suicide Prevention Information**
- **Youth Suicide Prevention Program**
- **Youth Suicide Prevention Programs: A Resource Guide**
- **Preventing suicide: what will work and what will not**
- **Saving Kids from Suicide**

Selected Materials from our Clearinghouse

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

Relevant Publications That Can Be Obtained at Your Local Library

- **Best Practices in School Psychology III: Best Practices in Suicide Intervention**
  National Association of School Psychologists; 4340 East Highway, Suite 402, Bethesda, MD 20814; Phone: (301) 657-0270; Fax: (301) 657-0275.
- **Developing a comprehensive school suicide prevention program. (2001). K.A. King. *Journal of School Health, 71,* 132-137.**
- **Adolescent Mental Health: Prevention and Treatment Programs. By, A. E. Kazdin (1993). In: *American Psychologist,* Vol. 48(2): p.127-141.**
- **Adolescent Suicide Attempters: Response to Suicide Prevention Programs. By, D. Shaffer, V. Vieland, A. Garland, M. Rojas, M. Underwood & C. Busner (1990). In: *Journal of the American Medical Association,* Vol. 264(24): p. 3151-3155.**
- **Arguments for and against teaching suicide prevention in schools. By, P. Hazell & R. King (1996). In: *Australian and New Zealand Journal of Psychiatry,* 30: 633-642.**
- **The Impact of Curriculum-based Suicide Prevention Programs for Teenagers. By, D. Shaffer, A. Garland, V. Vieland, M. Underwood & C. Busner (1991). , 23(2), 120-129. *Journal of American Academy of Child and Adolescent Psychiatry*30, 4: 588-596.**
- **The Impact of a Suicide Prevention Program for Adolescents on Suicidal Tendencies, Hopelessness, Ego Identity, and Coping. By, I. Orbach & H. Bar-Joseph (1993). *Suicide and Life-Threatening Behavior,* 23(2), 120-129.**
- **A National Survey of School-Based, Adolescent Suicide Prevention Programs. By, A. Garland, D. Shaffer & B. Whittle (1989). *Journal of American Academy of Child and Adolescent Psychiatry*28, 6: 931-934.**
- **Suicide Awareness Programs in the Schools: Effects of Gender and Personal Experience. By, J.C. Overholser, A. H. Hemstreet, A. Spirito, & S. Vyse (1989). *Journal of American Academy of Child and Adolescent Psychiatry,* 28, 6: 925-930.**
- **Suicide Prevention in an Educational Context: Broad and Narrow Foci. By, J. Kalafat, M. J. Elias (1995). *Suicide and Life-Threatening Behavior,* 25(1): 123-133.**
- **A Systematic Overview of Adolescent Suicide Prevention Programs. By,J. Ploeg, D. Ciliska, M. Dobbins, S. Hayward, H.**

Thomas & J. Underwood (1996). ***Canadian Journal of Public Health*** **September-October: 319-324.**

Related Agencies and Websites

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

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

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

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

Shortcut Text	Internet Address
Quick Training Aid	http://smhp.psych.ucla.edu/qf/suicide_qt/
Technical Assistance Sampler on: School Interventions to Prevent Youth Suicide	http://smhp.psych.ucla.edu/techpak.htm#suicide
A Resource Aid Packet on Responding to Crisis at a School	http://smhp.psych.ucla.edu/resource.htm#crisis
Screening/Assessing Students: Indicators and Tools	http://smhp.psych.ucla.edu/resource.htm#screening
An Introductory Packet on Assessing to Address Barriers to Learning	http://smhp.psych.ucla.edu/intropak.htm#assessing
Hotline Numbers	http://smhp.psych.ucla.edu/hotline.htm
An Introductory Packet on Affect and Mood Problems related to School Aged Youth	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3013DOC9995
Featured Newsletter article (Summer, '99): Youth Suicide/Depression/Violence	http://smhp.psych.ucla.edu/dbsimple2.asp?primary=3002&number=9997
AACAP Fact Sheet: Teen Suicide	http://www.aacap.org/publications/factsfam/suicide.htm
American Academy of Pediatrics Some Things You Should Know About Preventing Teen Suicide	http://www.aap.org/advocacy/childhealthmonth/prevteensuicide.htm
APA Public Information on Teen Suicide	
Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings from the Adverse Childhood Experiences Study	Click Here
Common Misconceptions about Suicide	http://www.save.org/misconc.html
Community Learning Network: Teen Suicide Theme Page	http://www.cln.org/themes/suicide.html
Detecting Suicide Risk in a Pediatric Emergency Department: Development of a Brief Screening Tool	http://www.cln.org/themes/suicide.html
Explaining Suicide to Children	http://www.save.org/EXPLSUIC.HTM
Frequently Asked Questions about Suicide (NIMH)	http://www.nimh.nih.gov/suicideprevention/suicidefaq.cfm
Goals and Objectives of the National Suicide Prevention Strategy	http://www.findarticles.com/p/articles/mi_qa4120/is_200312/ai_n9314234
Health Teacher: Suicide Prevention	http://www.healthteacher.com/lessonguides/injuries/middle/inj5ms/index.asp
Healthtouch: Suicide Facts	http://www.healthtouch.com/bin/EContent_HT/showAllLfts.asp?lftname=NIMH023&cid=HT
Is Suicide Contagious? A Study of the Relation between Exposure to the Suicidal Behavior of Others and Nearly Lethal Suicide Attempts (PDF Document, 71K)	http://aje.oupjournals.org/cgi/reprint/154/2/120.pdf
Issues to Consider in Intervention Research with Persons at High Risk for	http://www.nimh.nih.gov/suicideresearch/highrisksuicide.cfm

Shortcut Text	Internet Address
Suicidality	
National Strategy for Suicide Prevention (U.S.)	http://www.mentalhealth.org/suicideprevention/
National Strategy for Suicide Prevention: Facts, Funding, Frameworks for Action	http://www.mentalhealth.samhsa.gov/suicideprevention/strategy.asp
The Office of Youth Affairs	http://www.youthaffairs.wa.gov.au/programs/suicide/help.html
Pitfalls: What to Avoid	http://www.sfsuicide.org/html/pitfalls.html
Reducing Suicide: A National Imperative (2002) Institute of Medicine, National Academy Press	http://www.iom.edu/report.asp?id=3843
Reporting on Suicide: Recommendations for the Media	http://www.afsp.org/education/recommendations/
Students' FAQs about Suicide	http://www.save.org/question.html
Suicide Prevention	http://www.suicideconsultant.com/
Suicide Prevention in Schools: Court Cases and Implications for Principals	http://www.findarticles.com/p/articles/mi_qa3696/is_200203/ai_n9080589
Suicide statistics in the US and San Francisco (1991).	http://www.sfsuicide.org/html/facts.html
Symptoms of Depression and Danger Signs for Suicide	http://www.save.org/symptoms.html
Temporal Variations in School-Associated Violent Deaths (PDF Document, 131K)	http://www.cdc.gov/mmwr/PDF/wk/mm5031.pdf
Things to Watch Out for When Assessing Suicide Risk	http://www.sfsuicide.org/html/plaid.html
What to Do if Someone You Know Becomes Suicidal	http://www.geocities.com/Wellesley/9691/whatdo.html
Youth Suicide National Center	
Youth Suicide Prevention Information	http://www.spyc.sanpedro.com/suicide.htm
Youth Suicide Prevention Program	http://yspp.org
Youth Suicide Prevention Programs: A Resource Guide	http://www.cdc.gov/ncipc/pub-res/youthsui.htm
Preventing suicide: what will work and what will not	http://www.mja.com.au/public/issues/jul20/rosenman/rosenman.html
Saving Kids from Suicide	http://www.nea.org/neatoday/0004/health.html
Youth Suicide Prevention Program, Los Angeles Unified School District	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC7
Evaluation of Suicide Risk Among Adolescents	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC17
A Measure of Adolescent Potential for Suicide (MAPS): Development and Preliminary Findings	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC40
Study on Suicide: Training Manual	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC19
Brief Cognitive-Behavioral Family	http://smhp.psych.ucla.edu/smhp.exe?

Shortcut Text	Internet Address
Therapy for Suicidal Adolescents	ACTION=POPUP&ITEM=3002DOC35
Adolescent Suicide Prevention: A Bibliography of Selected Resources	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC9
Asian-American / Pacific Islander Resource Guide: Suicide, the Hidden Problem	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC5
Crossroads: Coping with Crisis; Personal Wellness Handbook for The Youth Suicide Prevention Program	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC16
Helpline	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=2303DOC2
In His Brother's Footsteps: A Suicide Prevention Handbook for Teens (English and Spanish)	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC22
Interviewing the Suicidal/Depressed Child	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC15
Prevention and Containment of Suicide Clusters	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC3
Responding to Students At-Risk for Suicide	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC23
Youth Suicide Parent Information	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC6
Youth Suicide: Crisis Intervention and Management	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC26
American Academy of Child and Adolescent Psychiatry	http://www.aacap.org/
American Association of Suicidology (AAS)	http://www.suicidology.org/
American Foundation for Suicide Prevention (AFSP)	http://www.afsp.org/
Suicide Information and Education Center (SIEC)	http://www.suicideinfo.ca/
Center for Suicide Research and Prevention	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=02169
Hotline Numbers	http://suicidehotlines.com/
Keep Yourself Alive	http://auseinet.flinders.edu.au/suiprev/resources/kya.php
SA\VE: Suicide Awareness \ Voices of Education	http://www.save.org/
San Francisco Suicide Prevention Website	http://www.sfsuicide.org/index2.html
SPAN: Suicide Prevention Advocacy Network	http://www.spanusa.org/
B-SPAN: The Brown University Chapter of SPAN	http://www.brown.edu/Students/B-SPAN/
The Befrienders	http://www.befrienders.org/
The National Committee on Youth Suicide Prevention	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=02535
The Office of Youth Affairs	http://www.youthaffairs.wa.gov.au/programs/suicide/index.html
search	http://smhp.psych.ucla.edu/search.htm

UCLA Mental Health in Schools Center Training and Technical Assistance

From the Center's Clearinghouse...

Thank you for your interest and support of the Center for Mental Health in Schools. You have just downloaded one of the packets from our clearinghouse. Packets not yet available on-line can be obtained by calling the Center (310)825-3634.

We want your feedback! Please rate the material you downloaded:

How well did the material meet your needs? *Not at all* *Somewhat* *Very much*

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Not at all *Somewhat* *Very Much*

Given the purposes for which the material was designed, are there parts that you think should be changed? (Please feel free to share any thoughts you have about improving the material or substituting better material.)

We look forward to interacting with you and contributing to your efforts over the coming years. Should you want to discuss the center further, please feel free to call (310)825-3634 or e-mail us at smhp@ucla.edu

Send your responce to:
School Mental HealthProject,
UCLA Dept of Psychology
405 Hilgard Ave.
Los Angeles, CA 90095-1563

The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563 -- Phone: (310) 825-3634.

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U.S. Department of Health and Human Services HRSA Health Resources and Services Administration Maternal and Child Health Bureau

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