Youth Suicide Prevention School-Based Guide

Overview

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The Guide: Overview

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

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

The Guide

- Identifies and defines the elements of a comprehensive, school-based suicide prevention program.
- Examines the scientific literature to determine which of these elements are supported by research in reducing the incidence of suicide and suicidal behavior.
- Contains checklists and self-assessment instruments that may be completed by schools to evaluate the adequacy of their suicide prevention programs.
- Provides a guide to help school administrators and their partners add program elements that would result in more comprehensive programs and/or would replace unproven strategies with proven strategies.
- Was reviewed, in its original form, by national experts in suicide prevention, behavioral and physical health providers, and community-based school personnel, advocates, families, and youth.

Youth Suicide Prevention School-Based Guide ©

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

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

Youth Suicide

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

Consider these statistics that highlight youth suicide as an important issue:

- Suicide accounts for 12% of all adolescent deaths and ranks third as an overall cause of death in adolescents (1, 3).
- The youth suicide rate for 10-24 year olds rose 8% from 2003 to 2004, then showed a general decline through 2007 but the rate increased again in 2008 by 4.5%, the most current year data is available as of this publication (6).
- An estimated 100-200 non-fatal youth suicide attempts occur for each young person that dies by suicide (1).
- An average of one youth, under the age of 25, dies by suicide every 2 hours (4).
- More teenagers die by suicide than die from cancer, AIDS, birth defects, stroke, pneumonia, influenza and chronic lung disease combined (5).
- 90% of teenagers who die by suicide have a mental health diagnosis, usually depression, substance abuse, or both (7).

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

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

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

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

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

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

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

Schools need to understand not only the issues of suicide, but also the positive role they can play. However, given the multiple demands on school systems, districts, schools and school faculty and staff; they need up-to-date, accurate and user-friendly information, guidelines, and tools to assist them in their efforts. Suicide is a public health problem that requires

Youth Suicide Prevention School-Based Guide: Overview continued

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an evidence-based approach to prevention. The public health approach defines the problem, identifies risk factors and causes of the problem, develops interventions evaluated for effectiveness, and implements such interventions widely in a variety of communities (2). Wading through professional journals, examining the evidence, reviewing and evaluating the literature and then drawing conclusions, developing action plans and implementing strategies describes an often overwhelming course of action for educators, administrators, and school systems.

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

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References

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1. McIntosh, J.L. (for the American Association of Suicidology). (2010). *U.S.A. suicide 2007: Official final data.* Washington, DC: American Association of Suicidology, dated May 23, 2010. Retrieved from http://www.suicidology.org
2. U.S. Public Health Service. (1999). *The Surgeon General's Call to Action to Prevent Suicide.* Washington, DC.
3. Centers for Disease Control and Prevention: Web-based Injury and Statistics Query and Reporting System. (2010). *Leading causes of death reports.* Retrieved from http://webappa.cdc.gov/sasweb/ncipc/leadcaus10.html
4. Office of the Surgeon General, U.S. Dept. of Health and Human Services, Public Health Service. (2001). *National strategy for suicide prevention: Goals and objectives for action.* Rockville, MD.
5. National Center for Health Statistics (NCHS). (2000). Retrieved from http://www.cdc.gov/nchs/
6. Centers for Disease Control and Prevention: Web-based Injury and Statistics Query and Reporting System. (2011). *Fatal injury reports, National and Regional, 1999-2008.* Retrieved from http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html
7. Moscicki, E.K. (2001). Epidemiology of completed and attempted suicide: Toward a framework for prevention. *Clinical Neuroscience Research, 1,* 310-323.
8. U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Retrieved from http://www.surgeongeneral.gov/library/mentalhealth/home.html
9. Lester, D. (2000). *Suicide prevention: Resources for the millennium.* Ann Arbor, MI: Sheridan Books.
10. King, C.A. (1997). Suicidal behavior in adolescents. In R.W. Maris, M.M. Silverman, and S.S. Canetto (Eds.), *Review of Suicidology* (61–95). New York, NY: Guilford Press.

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Information Dissemination in Schools

Issue Brief 1

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Information Dissemination in Schools continued

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

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

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

References

Information Dissemination in Schools

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

References continued

Information Dissemination in Schools

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

Myths and Current Facts About Adolescent Suicide

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

Myths and Current Facts About Adolescent Suicide

continued

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

References

Myths and Current Facts About Adolescent Suicide

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

References continued

Myths and Current Facts About Adolescent Suicide

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

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

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

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True/False 1t

Information Dissemination in Schools

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The Facts about Adolescent Suicide

This document is a true and false test on adolescent suicide, which could be presented to staff as well as parents as a way of increasing their awareness and knowledge. By simply giving this true and false to staff and parents and allowing for some time to discuss questions and concerns, schools can effectively increase awareness about adolescent suicide and may help prevent an incident of suicide in their school.

True/False Test

True	False		
☐	☐	1.	Adolescent suicide has been increasing dramatically in the United States.
☐	☐	2.	Most teenagers will reveal that they are suicidal or have emotional problems for which they would like emotional help.
☐	☐	3.	Adolescents who talk about suicide do not attempt suicide or kill themselves.
☐	☐	4.	Educating teens about suicide leads to increased suicide attempts, since it provides them with ideas and methods about killing themselves.
☐	☐	5.	Talking about suicide in the classroom will promote suicidal ideas and suicidal behavior.
☐	☐	6.	Parents are often unaware of their child's suicidal behavior.
☐	☐	7.	The majority of adolescent suicides occur unexpectedly without warning signs.
☐	☐	8.	Most adolescents who attempt suicide fully intend to die.
☐	☐	9.	There is a significant difference between male and female adolescents regarding suicidal behavior.
☐	☐	10.	The most common method for adolescent suicide death is drug overdose.
☐	☐	11.	Because female adolescents die by suicide at a lower rate than male adolescents, their attempts should not be taken seriously.
☐	☐	12.	Not all adolescents who engage in suicidal behavior are mentally ill.
☐	☐	13.	Suicidal behavior is inherited.
☐	☐	14.	Adolescent suicide occurs only among poor adolescents.
☐	☐	15.	The only one who can help a suicidal adolescent is a counselor or a mental health professional.
☐	☐	16.	Adolescents cannot relate to a person who has experienced suicidal thoughts.
☐	☐	17.	If an adolescent wants to kill him/herself, there is nothing anyone can do to prevent its occurrence.

Answers to True/False Test

1. **Adolescent suicide has been increasing dramatically in the United States.** ***False.*** While one suicide is one too many, the youth suicide rate declined during the 1990s and early into this century. The child and adolescent suicide rate consistently declined for 14 years, deceasing from 9.48/100,000 in 1990 to 6.78/100,000 in 2003. The youth suicide rate for 10-24 year olds rose 8% from 2003 to 2004, then showed a general decline through 2007 (6.3%). The rate has increased again from 2007 to 2009 by 7.2%, the most current year data is available as of this publication (2). The 2009 suicide rate for 15–19 year olds stands at 7.75 per 100,000 and the 2009 suicide rate for 10–14 year olds is 1.30 per 100,000 (2).

2. **Most teenagers will reveal that they are suicidal or have emotional problems for which they would like emotional help.** ***True.*** Most teens will reveal that they are suicidal and although studies have shown that they are more willing to discuss suicidal thoughts with a peer than a school staff member, this disposition that most teens have towards expressing suicidal ideations could be used for screening adolescents through questionnaires and/or interviews (4).

3. **Adolescents who talk about suicide do not attempt suicide or kill themselves.** ***False.*** One of the most ominous warning signs of adolescent suicide is talking repeatedly about one's own death. Adolescents who make threats of suicide should be taken seriously and provided the help that they need. In this manner, suicide attempts can be averted and lives can be saved (3, 6).

4. **Educating teens about suicide leads to increased suicide attempts, since it provides them with ideas and methods about killing themselves.** ***False.*** When issues concerning suicide are taught in a sensitive, educational context they do not lead to, or cause, further suicidal behaviors. Since three-fourths (77%) of teenage students state that if they were contemplating suicide they would first turn to a friend for help, peer assistance programs have been implemented throughout the nation. These educational programs help students to identify peers at risk and help them receive the help they need. Such programs have been associated with increased student knowledge about suicide warning signs and how to contact a hotline or crisis center, as well as increased likelihood to refer other students at risk to school counselors and mental health professionals. Furthermore, directly asking an adolescent if he or she is thinking about suicide displays care and concern and may aid in clearly determining whether or not an adolescent is considering suicide. Research shows that when issues concerning suicide are taught in a sensitive and educational manner, students demonstrate significant gains in knowledge about the warning signs of suicide and develop more positive attitudes toward help- seeking behaviors with troubled teens (1, 7, 8, 11, 27).

5. **Talking about suicide in the classroom will promote suicidal ideas and suicidal behavior.** ***False.*** Talking about suicide in the classroom provides adolescents with an avenue to talk about their feelings, thereby enabling them to be more comfortable with expressing suicidal thoughts and increasing their chances of seeking help from a friend or school staff member. Additionally, recent research indicated that asking about suicidal behavioral does not plant the idea of suicide. Researchers found that students who were asked about suicidal ideation or behavior in a screening survey were no more likely to report thinking about suicide than students not exposed to these questions. Also, the research results seem to indicate that asking about suicidal ideation or behavior may have been helpful for at-risk students (i.e., those with depression symptoms or previous suicide attempts) (3, 27, 28).

6. **Parents are often unaware of their child's suicidal behavior.** ***True.*** One study has shown that as much as 86% of parents were unaware of their child's suicidal behavior. Another study found that parents were unaware of their children's depressive symptoms, as well as their alcohol use, both risk factors for youth suicidal behavior (1, 3, 30).

Answers to True/False Test continued

7. **The majority of adolescent suicides occur unexpectedly without warning signs.** ***False.*** Nine out of ten adolescents who die by suicide give clues to others before their suicide attempt. Warning signs for adolescent suicide include depressed mood, substance abuse, loss of interest in once pleasurable activities, decreased activity levels, decreased attention, distractability, isolation, withdrawing from others, sleep changes, appetite changes, morbid ideation, offering verbal cues (i.e., "I wish I were dead"), offering written cues (i.e., notes, poems), and giving possessions away. In addition, the following risk factors place an adolescent at increased risk for suicidal behavior: having a previous suicide attempt, having a recent relationship breakup, being impulsive, having low self-esteem, being homosexual, coming from an abusive home, having easy access to a firearm, having low grades, and being exposed to suicide or suicidal behavior by another person. Moreover, most suicidal adolescents attempt to communicate their suicidal thoughts to another in some manner. Not surprisingly, an effective way to prevent adolescent suicide is to learn to identify the warning signs that someone is at risk (4, 5, 9, 11, 15-18, 29-34).

8. **Most adolescents who attempt suicide fully intend to die.** ***False.*** Most suicidal adolescents do not want suicide to happen. Rather, they are torn between wanting to end their psychological pain through death and wanting to continue living, though only in a more hopeful environment. Such ambivalence is communicated to others through verbal statements and behavior changes in 80% of suicidal youths. (1, 10).

9. **There is a significant difference between male and female adolescents regarding suicidal behavior.** ***True.*** Adolescent females are significantly more likely than adolescent males to have thought about suicide and to have attempted suicide. More specifically, adolescent females are 1.5 to 2 times more likely than adolescent males to report experiencing suicidal ideation and 3 to 4 times more likely to attempt suicide. Adolescent males are 4 to 5.5 times more likely than adolescent females to complete a suicide attempt. While adolescent females die in one out of 25 suicide attempts, adolescent males kill themselves in one out of every three attempts (1, 3, 4, 7, 12).

10. **The most common method for adolescent suicide death is drug overdose.** ***False.*** In 2007, young people were much more likely to use firearms, suffocation, and poisoning than other methods of suicide, overall. However, while adolescents (ages 15-19) were more likely to use firearms than suffocation, children (ages 10-14) were dramatically more likely to use suffocation. Having a gun in the house increases an adolescent's risk of suicide. Regardless of whether a gun is locked up or not, its presence in the home is associated with a higher risk for adolescent suicide. This is true even after controlling for most psychiatric variables. Homes with guns are 4.8 times more likely to experience a suicide of a resident than homes without guns. In lieu of these findings, it should not be surprising that restricting access to handguns has been found to significantly decrease suicide rates among 15-24 year olds (1, 3, 12, 13, 15, 23, 24, 25).

11. **Because female adolescents die by suicide at a lower rate than male adolescents, their attempts should not be taken seriously.** ***False.*** One of the most powerful predictors of death by suicide is a prior suicide attempt. Adolescents who have attempted suicide are 8 times more likely than adolescents who have not attempted suicide to attempt suicide again. Between one-third to one-half of adolescents who kill themselves have a history of a previous suicide attempt. Therefore, all suicide attempts should be treated seriously, regardless of sex of the attempter (1, 3, 4, 12, 15, 16-21).

12. **Not all adolescents who engage in suicidal behavior are mentally ill.** ***True.*** The majority of adolescents have entertained thoughts about suicide at least once in their lives. There are cases of some adolescents attempting and dying by suicide who do not appear to have a diagnosable mental disorder. However, research studies regarding adolescents who die by suicide suggest that most (evidence suggests over 90%) have a diagnosable, although not always diagnosed, mental health disorder at the time of their death. Additionally, research suggests that identifying at-risk youth, by utilizing depression scales and psychopathology inventories, through screening and treating those individuals who test positive for mental illness can benefit from counseling by a trained professional (11, 14).

Answers to True/False Test continued

13. Suicidal behavior is inherited. ***False.*** There is no specific suicide gene that has ever been identified. Studies involving twins have found higher concordance rates for suicide in monozygotic twins than in dizygotic twins; meaning that an identical twin would be more likely than a fraternal twin to engage in suicidal behavior if his/her co-twin died by suicide. However, no study to date has examined the concordance for suicide in monozygotic twins separated at birth and raised apart, a requirement necessary to be met as a means to indicate inheritance of psychiatric illness. Such a study could assess the effects that parental rearing style and familial environment have on suicidal behavior. Interestingly enough, when compared to control subjects, adolescent suicide victims have been found to have had significantly less frequent and less satisfying communication with their parents (1, 12, 20, 21).

14. Adolescent suicide occurs only among poor adolescents. ***False.*** Adolescent suicide occurs in all socioeconomic groups. Socioeconomic variables have not been found to be reliable predictors of adolescent suicidal behavior. Instead of assessing adolescents' socioeconomic backgrounds, school professionals should assess their social and emotional characteristics (i.e., affect, mood, social involvement, etc.) to determine if they are at increased risk (1, 3, 15, 16, 21).

15. The only one who can help a suicidal adolescent is a counselor or a mental health professional. ***False.*** Most adolescents who are contemplating suicide are not presently seeing a mental health professional. Rather, most are likely to approach a family member, peer, or school professional for help. Displaying concern and care as well as ensuring that the adolescent is referred to a mental health professional are ways paraprofessionals can help (7).

16. Adolescents cannot relate to a person who has experienced suicidal thoughts. ***False.*** Data from the 2009 Youth Risk Behavior Surveillance Survey (YRBSS), which surveyed 16,220 high school students, found that more than one in ten students (13.8%) had seriously considered attempting suicide in the previous year. A population study of 5,000 teenagers from a rural community showed that 40% had entertained ideas of suicide at some point in their lives. Some researchers have estimated that it is more realistic that greater than half of all high school students have experienced thoughts of suicide (1, 14, 22).

17. If an adolescent wants to kill him/herself, there is nothing anyone can do to prevent its occurrence. ***False.*** One of the most important things an individual can do to prevent suicide is to identify the warning signs of suicide and recognize an adolescent at increased risk for suicide. School professionals should, therefore, be aware of these risk factors and know how to respond when a student threatens or attempts suicide. The existence of a school crisis intervention team may assist with this process (3, 11, 14, 26).

References

Information Dissemination in Schools

1. King, K.A. (1999). Fifteen prevalent myths about adolescent suicide. *Journal of School Health, 69*(4), 159–161.
2. Centers for Disease Control and Prevention: Web-based Injury and Statistics Query and Reporting System. (2012). *Leading causes of death reports.* Retrieved from http://webappa.cdc.gov/sasweb/ncipc/leadcaus10_us.html
3. Zenere, F.J., & Lazarus, P.J. (1997). The decline of youth suicidal behavior in an urban, multicultural public school system following the introduction of a suicide prevention and intervention program. *Suicide and Life-Threatening Behavior, 27*(4), 387–403.
4. Gould, M.S., & Kramer, R.A. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior, 31*, 6–31.
5. Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D., & Giles, W.H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the lifespan: Findings from the Adverse Childhood Experiences Study. *JAMA, 286*(24), 3089-3096.
6. Kirk, W.G. (1993). *Adolescent suicide: A school-based approach to assessment and intervention.* Champain, IL: Research Press.
7. Tierney, R., Ramsay, R., Tanney, B., & Lang, W. (1991). Comprehensive school suicide prevention programs. In A.A. Leenaars & S. Wenkstern (Eds.), *Suicide Prevention in Schools.* New York: Hemishere Publishing Corporation.
8. Kalafat, J., & Elias, M. (1994). An evaluation of a school-based suicide awareness intervention. *Suicide and Life-Threatening Behavior, 24*(3), 224–233.
9. Haas, A.P., Eliason, M., Mays, V.M., Mathym R.M., Cochran, S.D., D'Augelli, A.R, . . . Clayton, P.J. (2001). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of Homosexuality, 58*(1), 10-51.
10. King, K.A., Price, J.H., Telljohann, S.K., & Wahl, J. (1999). High school health teachers' knowledge of adolescent suicide. *American Journal of Health Studies, 15*(3), 156–163.
11. Gould, M., Greenberg, T., Velting, D., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. Journal of the *American Academy of Child and Adolescent Psychiatry, 42*(4), 386–405.
12. O'Carroll, P.W., Potter, L.B., & Mercy, J.A. (1994). Programs for the prevention of suicide among adolescents and young adults. *MMWR CDC Surveillance Summary 43* (RR-6). 1–7.
13. Shaffer, D., Garland, A., Vieland, V., Underwood, M., & Busner, C. (1991). The impact of curriculum-based suicide prevention programs for teenagers. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*(4), 588–596.
14. Garland, A.F., & Zigler, E. (1993). Adolescent suicide prevention: Current research and social policy implications. *American Psychologist, 48*(2), 169–182.
15. Borowsky, I.W., Ireland, M., & Resnick, M.D. (2001) Adolescent suicide attempts: Risks and protectors. *Pediatrics, 107*(3), 485–493.
16. Moscicki, E. (1999). Epidemiology of Suicide. In D.G. Jacobs (ed), *The Harvard Medical School Guide to Suicide Assessment and Intervention.* (pp. 40–51). San Francisco: Jossey-Bass Publishing.
17. Shaffer D., Gould, M., & Fisher, P. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry, 53,* 339–348.
18. Shaffer, D., Pfeffer, C.R., & Work Group on Quality Issues. (2001). Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. *Journal of American Academy of Child and Adolescent Psychiatry, 40*(1) supp, 24–51.
19. Zametkin, A.J. Alter, M.R., & Yemini, T. (2001). Suicide in teenagers: Assessment, management, and prevention. *Journal of American Medical Association, 286*(24). 3120–3125.

References

Information Dissemination in Schools

20. Lester, D. (2000). *Suicide prevention: Resources for the millennium.* Ann Arbor, MI: Sheridan Books.
21. Brent, D.A. (1995). Risk factors for adolescent suicide and suicidal behavior: Mental and substance abuse disorders, family environmental factors and life stress. *Suicide and Life-Threatening Behavior, 25,* 52–63.
22. Centers for Disease Control and Prevention. (June 4, 2010). Youth risk behavior surveillance-United States 2009. *Morbidity and Mortality Weekly Report: Surveillance Summaries, 59*(SS-5).
23. Centers for Disease Control and Prevention. (2007). Suicide trends among youths and young adults aged 10-24 years: United States 1990-2004. *Morbidity and Mortality Weekly Report, 56*(35), 905-908.
24. Dahlberg, L.L., Ikeda, R.M., & Kresnow, M. (2004). Guns in the home and risk of a violent death in the home: Findings from a national study. *American Journal of Epidemiology, 160*(10), 929-936. doi:10.1093/aje/kwh309
25. Brent, D.A., & Bridge, J.A. (2003). Firearms availability and suicide: Evidence, interventions, and future directions. *American Behavioral Scientist, 46*, 1192–1210. doi:10.1177/0002764202250662
26. Kalafat, J. (2003). School approaches to youth suicide prevention. *American Behavioral Scientist, 46*(9), 1211-1223.
27. Gould, M.S., Marrocco, F.A., Kleinman, M., Thomas, J.G., Mostkoff, K., Cote, J., & Davies, M. (2005). Evaluating iatrogenic risk of youth suicide screening programs: A randomized controlled trial. *JAMA, 293*(13), 1635–43.
28. Crawford, M.J., Thana, L., Methuen, C., Ghosh, P., Stanley, S.V., Ross, J, . . . Bajaj, P. (2011). Impact of screening for risk of suicide: Randomised controlled trial. *The British Journal of Psychiatry, 198,* 379-384. doi:10.1192/bjp.bp.110.083592
29. Hicks, B.B. (1990). *Youth suicide: A comprehensive manual for prevention and intervention.* Bloomington, IN: National Education Service.
30. Moskos, M., Olson, L., Halbern, S., Keller, T., & Gray, D. (2005). Utah youth suicide study: Psychological autopsy. *Suicide and Life-Threatening Behavior, 35*(5), 536-546.
30. Kaplan, S., Pelcovitz, D., Salzinger, S., Mandel, F., & Weiner, M. (1997). Adolescent physical abuse and suicide attempts. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(6), 799-809.
31. Maine Center for Disease Control and Prevention. (2007). *Maine Youth Suicide Prevention Implementation Plan.* Retrieved from http://www.state.me.us/suicide/myspp/program/plan.htm
32. U.S. Public Health Service. (1999). *The Surgeon General's Call to Action to Prevent Suicide.* Washington, DC. Retrieved from http://www.surgeongeneral.gov/library/calltoaction/
33. Russell, S. T., & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Public Health Association, 91*(8), 1276-1281.
34. Bridge, J.A., Goldstein, T.R., & Brent, D.A. (2006) Adolescent suicide and suicidal behavior. *Journal of Child Psychology and Psychiatry, 47*(3), 372-394.

Notes

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Notes

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Checklist 1

Information Dissemination in Schools

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Checklist 1

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

Yes	No	
☐	☐	Does your school currently have a suicide prevention program in place?
☐	☐	Are teacher and staff education and/or training one component of your school's suicide prevention program?
☐	☐	Does your school provide training sessions to all staff, including coaches, bus drivers, maintenance/janitorial staff, and cafeteria workers about adolescent suicide warning signs and risk factors, and what to do if approached by a student who may be at-risk for suicide?
☐	☐	Has your school decided on the most effective strategy(ies) to disseminate suicide prevention information about adolescent suicide warning signs and risk factors?
☐	☐	Has your school decided on the most effective strategy(ies) to disseminate suicide prevention information about faculty/staff response if approached by a student who may be at-risk for suicide?
☐	☐	If your school does provide training sessions, is there a designated trained individual or individuals who provide these training sessions and is there a targeted audience?

— continued next page

Checklist 1 continued

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

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School Climate

Issue Brief 2

The school's climate refers to both the physical and aesthetic qualities of the school, as well as the emotional and psychological qualities of the school. The emotional and psychological qualities of a school refer to the attitudes, beliefs, and feelings of the faculty, staff, and students (1).

The physical environment includes campus walkways and grounds, parking lots, school vehicles, cafeterias, bathrooms, gymnasiums, classrooms, and the equipment that is used in each of these places (2). Both qualities have a direct effect on the health, safety, performance, and the feeling of connectedness the staff and students have for their school.

Connectedness

Research has shown that students who feel connected to their school (e.g., felt teachers treated them fairly, felt close to people at school, felt like a part of their school) are less likely to experience suicidal thoughts and experience emotional distress (2, 4, 47). The National Longitudinal Study on Adolescent Health surveyed more than 90,000 students (grades 7–12) and found that students' feeling of connectedness was the number one protective factor against suicidal behavior (3). Students who feel connected to the school are also less likely to drink alcohol, carry weapons, or engage in other delinquent behavior (2). Research suggests that schools that wish to foster a feeling of connectedness in students should consider providing students with after school activities or clubs (4, 5), allowing students some involvement in decision making relating to issues that will affect them within their school (4, 63, 75), and creating small-sized student learning groups where students can discuss bias, prejudice, and the fair and equal treatment of all students in the school (75).

Participation

Research has shown that when students participate in decisions regarding their school and their community they tend to be healthier and more productive (4, 9, 10, 48). Assigning students roles in the school is an essential element for ensuring a healthy school climate (2, 4, 5, 10). A comprehensive 15,000-hour study of classroom strategies by the Surgeon General on Youth Violence found that academic achievement increased as the number of meaningful roles that the school assigned to students increased (45). It is important for schools to involve students in meaningful school roles and decisions in order to foster a sense of ownership in students. Students can play important roles in the school, acting as office helpers, classroom helpers, hallway monitors, school council members, or play a primary role in any number of student school committees such as a safe school planning committee. Students should be encouraged to participate in creating or revising their school's code of conduct, as well policies regarding the reporting of bullying (63, 74).

Youth Suicide Prevention School-Based Guide ©

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In the past, these jobs have been under-advertised to students who don't "excel." These jobs have been offered more as a reward to those who have succeeded in the past instead of as an opportunity for those who may have failed in the past and now feel discouraged or intimidated. Some suggest that these "underachievers" should be actively involved in such opportunities because these individuals may be the most at-risk for suicidal or violent behavior (2). Through their involvement with the school, these students (those potentially at-risk) may feel more connected to the school, which has been found to be an important protective factor for suicidal behaviors and ideations (2, 4, 39, 46, 47, 74).

Academic Success

Two of the main focal points for schools are academic success and supporting students so that they may achieve these high academic standards. Results of the 2009 Youth Risk Behavior Surveillance showed that students with high grades were less likely to make a suicide attempt (76), so it is critical that schools set academic goals for success and advancement (7) and provide encouragement to students when they meet or exceed these goals (2). A school may choose to use the media to put the names or faces of students who achieve their goals in print or on screen as well as displaying students' work in and around school (7). In order for students to achieve their academic potential and in order to decrease their likelihood of suicidal behaviors or other violent behaviors, students must feel safe and supported.

Safety

There are several strategies that schools can implement in order to make students' learning environment the safest possible and most productive. Lack of physical and/or emotional safety is likely to result in unconstructive educational outcomes such as poor academic performance or truancy. Research has shown that students who feel victimized by other students or staff have an elevated risk of suicidal ideations and behaviors (12, 13, 20). It is critical that schools set high expectations on all staff to behave respectfully and kindly to others, as adolescents tend to watch and mimic the behaviors they observe in adults (2, 22). Teachers should fashion a classroom where students feel respected, supported, and feel comfortable approaching an adult when confronted with problems (2, 4, 7, 46, 48, 74). Research shows that a positive relationship with an adult, not necessarily with a teacher, is one of the most critical factors in preventing student violence, suicide, and bullying, as students need to feel comfortable enough to share potentially dangerous information (5, 10, 46, 48).

Research has also found that adolescents are most likely to know in advance about a potentially dangerous and violent situation, particularly suicidal behavior or thoughts from peers (35, 49-51).

For this reason, it is important for schools to create ways for students to feel comfortable enough about providing information to an adult when confronted with a potentially dangerous situation. Students should be provided a list of adults in school that they may contact if they feel unsafe or if they have knowledge about a potentially dangerous situation, and the difference between "ratting out someone" and reporting a situation should be clearly distinguished (74). Students are more likely to feel connected to their school if they believe that they are being treated fairly, feel safe, and believe that teachers are supportive (8, 74).

Bullying: Special Safety Concern

Bullying is negative or abusive behavior, repeated over a period of time, and in which there is an imbalance of strength or power between or among the parties involved (14, 15). Bullying occurs more frequently in a school setting than away from school (65), so it is essential that schools provide training to their staff to identify harassing behavior and how to effectively intervene (2, 6, 21). This malicious behavior can be physical, verbal, or relational, and can occur face-to-face, or electronically (cyber-bullying) (60, 61, 62). Students at-risk for being bullied include those that "don't fit in" (including those with learning and physical disabilities)(16, 17, 63, 64), those perceived as gay, lesbian, bisexual, or transgender (6,18,19, 20), those who are socially isolated or lack social skills (59), and those that differ from the majority of their classmates in regards to race, religion, or ethnicity (2). Recent research found that 20 percent of surveyed adolescents had been bullied, had bullied others, or both, within the previous two months (62). Boys tend to physically and verbally bully more than girls (59, 62), while girls are more likely to be involved in cyber- and relational bullying, such as spreading rumors or socially excluding a peer (62, 68).

A unique category of bullying, cyber-bullying, happens through electronic media, such as the computer or cell phones. Research has found that as many as one in three 10 to 15 year

olds had experienced at least one incident of cyber-bullying or harassment within the previous year (61). Whether cyber-bullying occurs in or away from school, consequences of being victimized electronically tend to manifest at school, so it is imperative that schools be prepared to handle the unique issues surrounding cyber-bullying (61, 62, 69). Research has shown that the majority of cyber-bullying takes place through instant messages, aggressive emails, and text messages over the phone, and that as many as half of cyber-bullying victims do not personally know their aggressor (61, 68). The Centers for Disease Control and Prevention (69) suggest a combination of preventative measures to keep children safe from cyber-bullying, including software designed to block certain websites, educational campaigns for students and parents about cyber-safety, and regular communication between children and adults about their experiences with electronics and technology.

A number of highly publicized cases in the media have suggested a direct relationship between bullying and suicide. This is not the case. However, there may be an indirect relationship as children who bully others, are victims of bullying, or who are bully-victims (those who bully and are also victims of bullying) are at increased risk of symptoms of anxiety, depression, loneliness, and decreased self-esteem (60, 65, 70, 71) which are all risk factors for suicidal thoughts and behavior in children. Research has shown that students who feel victimized by other students, whether face-to-face or over the internet or telephone, have an elevated risk of suicidal ideations and behaviors (12, 20, 61, 65, 76). Both bullies and victims have been shown to have increased internalizing problems, decreased interpersonal skills, and an increased risk for depression (65, 70, 72). Research has also shown that bully-victims, exhibit the poorest psychosocial development of these three groups (60, 73).

There are a number of strategies that school officials can implement in order to prevent bullying situations, as well as diffuse them as they are occurring. Research shows that schools' approaches to bullying prevention and intervention include:

- Creating Clear Policies
  - » Students should understand that bullying will not be tolerated. It is critical that teachers and school staff consistently enforce the rules and give praise when they are followed (66).
- Providing Adequate Supervision
  - » Pay special attention to times and spaces where bullying may occur, especially bathrooms, hallways, in between classes, and recess (63). If a school identifies a "hot spot" for bullying, staff should find creative ways to increase their presence there (78).
  - » All school personnel, not just teachers, should know how to identify and respond to bullying (63, 74, 78, 79). This includes bus drivers, cafeteria workers, and coaches (74).
- Involving Parents
  - » Youth with high parental involvement and support in their lives are less likely to be bullied and bully others (25, 60, 62). Researchers suggest educating and informing parents specifically about cyber-bullying and internet harassment, particularly as technology rapidly evolves (62, 66, 67, 68).
  - » Children may not be sharing their bullying experiences at home, so it may be necessary to arrange a meeting with parents or guardians to discuss a child's bullying and/or victimization (66, 79).
- Utilize Technology
  - » Be sure to keep up with the same technology that students are using. Not only are social media sites, such as Twitter and Facebook, and cell phones places where cyber-bullying is taking place, but these are avenues through which youth may be expressing suicidal thoughts.
  - » The Suicide Prevention Resource Center (80) recommends that both bullying and suicide prevention programs be able to address this unique area.
- Teaching Bullying Prevention
  - » Because of the connection between childhood bullying and mental health problems, it is critical that schools implement an anti-bullying prevention and intervention program (66, 70, 72, 76).
  - » Research has shown that lessons, policies, and prevention efforts regarding bullying should begin when children are in elementary school (70, 76), possibly as young as 5 years old (72), and that all the children in a school will benefit from bully-prevention education, not just the "troubled" or "challenging" ones (63). Programs that are administered to the entire school have been shown to be more effective than lessons or lectures that are given in a single class, or at a school assembly, as school-wide programs tend to work towards changing the environment and attitude of the school community (77, 78).

» The following programs, while not a complete list, contain components that address bullying and school violence. They are considered evidence-based, or promising practices, because they have met specific criteria for effectiveness:

- The Olweus Bullying Prevention Program http://www.clemson.edu/olweus/
- Safe School Ambassadors http://www.community-matters.org/safe-school-ambassadors/
- Positive Behavioral Interventions and Supports (PBIS) http://www.pbis.org/
- Promoting Alternative Thinking Strategies (PATHS) http://www.channing-bete.com/prevention-programs/paths/paths.html
- The Incredible Years: Parent, Teacher, and Child Training Series http://www.incredibleyears.com/
- Peace Works http://peaceeducation.org/
- Resolving Conflict Creatively & Partners in Learning http://esrnational.org/

When bullying does occur, there are several specific interventions to enact in order to diffuse the situation quickly and safely, as well as some strategies that have been shown not to be helpful. The following information was synthesized from The Olweus Bullying Prevention Program, a best-practice anti-bullying school-based program (79), The U.S. Department of Health and Human Services anti-bullying program, Stop Bullying Now! (78), and Eyes on Bullying (63), a multi-media anti-bullying toolkit for parents and educators.

- The critical first step is breaking up the bullying situation immediately. This is not only for the children's safety, but also sends the message that this behavior is unacceptable.
- Talk to the children involved separately in order to find out the circumstances regarding the incident due to the power imbalance inherent in bullying situations, and they should never be left alone to "work it out."
- It is also important for a school staff member to discuss the incident with bystanders, and any children that sought help should be shown appreciation.
- School staff members who intervene should allow themselves some time to consider the incident and the history of the students involved before deciding on a course of action. Interveners need to be careful not to respond aggressively or make snap judgments.
- Some interventions that have been shown not to be effective are group treatments for bullies (as they tend to reinforce bullying behavior) and peer mediation (as having to face their bullying may further traumatize a child).
- Once the situation has been diffused, it is important that school staff follow-up with the bully (or bullies) and victim, again separately, so the bullying will, ideally, end. However, bully prevention should be thought of, and treated, as a continuous process.

Training

Research has found that teachers make effective observers about students' mental health issues (24, 26) and although they should not diagnose and treat adolescents who may be suicidal, they should certainly be taught how to recognize and refer students who may be at-risk for engaging in suicidal thoughts or behaviors, which research has found to be an essential component of any suicide prevention program (37, 43, 51-58). Research suggests that training be done at the beginning of the school year and that teachers be given periodic opportunities to discuss students who may be displaying worrisome behavior (7). School counselors can present suicide prevention training to staff and faculty that should highlight school (and/or school district) policy and procedures for referring potentially suicidal youth (81, 82).

Just as teachers should be provided with training and education, students should be taught about how to interact with peers and adults, particularly about how to solve interpersonal conflicts in a nonviolent fashion (5). A safe school is one that helps students develop appropriate problem-solving and conflict resolution strategies. Pro-social behavioral skills training that focuses on problem solving, coping, and conflict resolution strategies have shown positive results on distress coping skills (38, 74). Additionally, staff and teacher training should contain specific bullying prevention and cultural competence components (74). These training programs have also been shown to reduce attempted suicides and death by suicide in adolescents (37) and may be one of the most effective ways to prevent adolescent suicide (36). Empirical evaluations of programs that have focused on such pro-social behavioral strategies have found an increase or enhancement of factors that protect adolescents from suicide while reducing the risk factors for suicide in these adolescents (40, 41, 42, 46, 48).

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

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

1. Choose a prevention program and curricula that are grounded in theory or that have scientific evidence of effectiveness.
2. Implement unintentional injury and violence prevention curricula consistent with national and state standards for health education.
3. Use active learning strategies, interactive teaching methods, and proactive classroom management to encourage student involvement in learning about violence prevention.
4. Provide adequate staffing and resources, including budget, facilities, staff development, and class time to provide violence prevention education to all students.

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

Discipline

Just as educating students about socially appropriate ways to deal with difficult situations is an important component of a positive school climate, the disciplining of students may be just as important because discipline is one process by which appropriate behaviors are taught (2). Disciplinary policies must be explicitly stated, use language that is easy to understand, applied fairly, and above all be applied consistently (2, 7, 10), in order to avoid creating an environment of favoritism and bias. Research has found that the best approach to disciplining students is a proactive and positive approach used by all staff and faculty (2, 5, 7). Such an approach focuses on such things as intervening before an argument escalates to a physical fight, identifying and intervening when faced with a bullying situation, teaching problem-solving skills, teaching conflict resolution strategies, and teaching socially appropriate behaviors (2, 5). Research also suggests that disciplinary approaches avoid emphasizing punishment (5, 7). Humiliating, harassing, scolding, nagging, physically aversive punishment, and other behavior-corrections that disrupt the flow of instruction should be prohibited (2, 63). Research has found that when these correction methods are used, behavioral problems in adolescents increase (44).

Physical Environment

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

well as other problems, such as violence and bullying, which have been shown to be risk factors for suicidal behaviors and thoughts (12, 13, 20, 70, 76).

Security

One of the most obvious aspects of the school environment, which a school should certainly address, is ensuring that the school is free from weapons. One study found that those students who were frequently cyber-bullied were more likely to attempt to bring a weapon to school (61). Security cameras and metal detectors have been used effectively in order to keep weapons off school property (33, 34). How a school chooses to prevent weapons on school grounds will vary, however, all schools should comply with the Gun Free Schools Act of 1994 which requires educational agencies that receive federal funding to expel any student who brings a firearm to school for at least one year and that any student who does so should be referred to the criminal justice system. Research suggests that schools should work with parents and community agencies in order to supervise students and reduce the likelihood that they will bring a weapon to school; this may also reduce the likelihood that students will have access to a weapon (1, 2, 4, 5, 6, 32). Schools may also find it helpful to use parents and community agencies in order to broaden the web for identifying students at-risk for suicidal behaviors, thoughts, and for those who may be at-risk for other violent behavior. An essential part of any safe school is a well-established system of community links and parental involvement (1-7, 10, 21, 24, 32). For more on the necessity of community and family links please refer to *Issue Brief 8: Community Partnerships*. Other physical characteristics that a school may wish to address besides firearm/weapon control includes the following:

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

Research suggests that schools should conduct comprehensive safety assessments at least once a year (30) and that more frequent assessments may be necessary for certain areas of the school such as playgrounds (31). For more information about a safe physical environment, schools should refer to and comply with OSHA regulations for safety. The Centers for Disease Control and Prevention's NIOSH branch has compiled a checklist that provides information about OSHA regulations in schools, available at http://www.cdc.gov/niosh/docs/2004-101/. Schools may also wish to utilize California's Department of Education guide, available at http://www.cde.ca.gov/ls/ss/, which provides reasons why and specific methods for examining the aforementioned physical characteristics.

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

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

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

Three examples of school climate programs include Halfmoon Bay "Growing Pains" project, The School Transition Environment Program (STEP), and the Alberta Safe and Caring Schools Initiative. For more on safe school programs refer to the US Department of Education. Additionally, Safe School Ambassadors is a program that engages socially-influential students to intervene with their peers to prevent and stop bullying and is supported by research findings from an evaluation involving several university researchers (83). Positive Behavioral Interventions and Supports (PBIS) is an evidence-based, data-driven framework with numerous, published research studies supporting reduced disciplinary incidents, increased school's sense of safety, and improved academic outcomes (11, 23, 52).

References

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1. Henderson, A., & Rowe, D.E. (1998). A healthy school environment. In Marx, E., Wooley, S.F., Northrop, D. (Eds.). *Health is Academic: A Guide to Coordinated School Health Programs.* New York, NY: Teachers College Press.
2. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), (2001). School health guidelines to prevent unintentional injuries and violence. *Morbidity and Mortality Weekly Report, 50*, RR-22.
3. Resnick, M.D., Bearman, P.S., Blum, R.W., Bauman, K.E., Harris, K.M., Jones, J…Udrey, R. (1997). Protecting adolescents from harm, findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association, 278,* 823–832.
4. King, K.A. (2001). Developing a comprehensive school suicide prevention program. *The Journal of School Health, 71*(4), 132–137.
5. Dwyer, K., & Osher, D. (2000). *Safeguarding our children: An action guide.* Washington, DC: US Department of Education and Justice, American Institutes for Research.
6. *The Oregon Plan for Youth Suicide Prevention.* (2000). Oregon Department of Human Services. Retrieved, from http://public.health.oregon.gov/PreventionWellness/SafeLiving/Suicideprevention/Pages/index.aspx
7. California Department of Education. (2011). *Safe Schools.* Retrieved from http://www.cde.ca.gov/ls/ss/
8. Samdal, O., Nutbeam, D., Wold, B., & Dannas, L. (1998). Achieving health and educational goals through schools-A study of the importance of the school climate and the students' satisfaction with school. *Health Educational Research, 13,* 383–397.
9. Rudd, R.E., & Walsh, D.C. (1993). Schools as healthful environments: Prerequisite to comprehensive school health? *Preventative Medicine, 22,* 499–506.
10. Maine Center for Disease Control and Prevention. (2007). *Maine Youth Suicide Prevention Implementation Plan.* Retrieved from http://www.state.me.us/suicide/myspp/program/plan.htm.

References continued

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11. Muscott, H., Mann, E., & LeBrun, M. (2008). Positive behavioral interventions and supports in New Hampshire: Effects of large-scale implementation of schoolwide positive behavior support on student discipline and academic achievement. *Journal of Positive Behavior Intervention, 10*(3), 190-205. doi:10.1177/1098300708316258

12. Center for Health Statistics (2000). A potential for violent injury. *Oregon Health Trends, 56.* Health Division, Oregon Department of Human Services. Portland, Oregon.

13. Lewinsohn, P., Rohde, P., & Seeley, J. (1993). Psychosocial characteristics of adolescents with a history of suicide attempt. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*(1), 60–68.

14 Olweus, D. (1997). Bully/victim problems in school: Knowledge base and an effective intervention program. *Irish Journal of Psychology, 18,* 170–190.

15. Hoover, J.H., & Oliver, R. (1996). *The Bullying Prevention Handbook: A Guide for Principals, Teachers, and Counselors.* Bloomingon, IN: National Education Service.

16. Hoover, J.H., Oliver, R., & Thompson, K.A. (1993). Perceived victimization by school bullies: New research and future direction. *Journal of Humanistic Educational Development, 32,*130–136.

17. Hoover, J.H., Oliver, R.L., & Hazler, R.J. (1992). Bullying: Perceptions of adolescent victims in the mid-western USA. *School Psychology International, 13,* 5–16.

18. Human Rights Watch (2001). *Hatred in the hallways: Violence and discrimination against lesbian, gay, bisexual, and trans-gendered students in U.S. schools.* New York, NY: Human Rights Watch

19. Russell, S.T., Franz, B.T., & Driscoll, A.K. (2001). Same-sex romantic attraction and experiences of violence in adolescence. *American Journal of Public Health, 91,* 903–906.

20. Bontempo, D.E., & D'Augelli, A.R. (2002). Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. *Journal of Adolescent Health, 30*(5), 364–374.

21. Commonwealth of Virginia Board of Education. (2003). *Suicide Prevention Guidelines.* Retrieved from http://youthviolence.edschool.virginia.edu/prevention/pdf/Suicide%20Prevention%20Guidelines%20for%20Virginia%20schools.pdf.

22. Battistich, B., Schaps, E., Watson, M., & Solomon, D. (1996). Prevention effects of the Child Development Project: Early findings from an ongoing multi-site demonstration trial. *Journal of Adolescent Research, 11,* 12–35.

23. Bohanon, H., Fenning, P., Carney, K.L., Minnis-Kim, M.J., Anderson-Harriss, S., Moroz, K.B, . . . Pigott, T.D. (2006). Schoolwide application of positive behavior support in an urban high school: A case study. *Journal of Positive Behavior Interventions, 8*(3), 131-145. doi:10.1177/109830070060080030201

24. Loeber, R., Green, S.M., & Lahey, B.B. (1990). Mental health professionals' perception of the utility of children, mothers, and teachers as informants on childhood psychopathology. *Journal of Clinical and Child Psychology, 19,* 136–143.

25. Baldry, A.C., & Farrington, D. P. (2005). Protective factors as moderators of risk factors in adolescence bullying. *Social Psychology of Education, 8*(3), 263-284.

26. Sanford, M.N., Offord, D.R., Boyle, M.H., Peace, A., & Racine, Y.A. (1992). Ontario child health study: Social and school impairments in children aged 6-16 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 31,* 60–67.

27. Slavin, R. (1990). *Cooperative Learning: Theory, Research, and Practice.* Englewood Cliffs, NJ: Prentice Hall.

28. Hathaway, W.E. (1988). Educational facilities: Neutral with respect to learning and human performance? *CEFP Journal, 26,* 8–12.

29. Hoy, W.K., Tarter, C.J., & Bliss, J.R. (1990). Organizational climate, school health, and effectiveness: A comparative analysis. *Educational Administrative Quarterly, 26,* 260–279.

30. Children's Safety Network at Education Development Center, Massachusetts Occupational Health Surveillance Program. (1995). *Protecting Working Teens: A Public Health Resource Guide.* Newton, MA: Education Development Center, Inc.

References continued

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31. Di Scala, C., Gallagher, S.S., & Schneps, S.E. (1997). Causes and outcomes of pediatric injuries occurring at school. *Journal of School Health, 79,* 69–75.

32. Gardiner, H., & Gaida, B. (2002) *Suicide prevention services: Literature review final report.* Alberta Mental Health Board, Research and Evaluation Unit. Calgary, AB.

33. Hawkins, J.D., Farrington, D.P., & Catalano, R.F. (1998). Reducing violence through the schools. In: D.S. Elliot, B.A. Hamburg, K.R. Williams, (Eds.) *Violence in American Schools: A New Perspective.* New York, NY: Cambridge University Press, 188–216.

34. Mercy, J.A., & Rosenberg, M.L. (1998). Preventing firearm violence in and around schools. In: D.S. Elliot, B.A. Hamburg, & K.R. Williams, (Eds.) *Violence in American Schools: A New Perspective.* New York, NY: Cambridge University Press, 159–187.

35. Gallup, G. (1991). *The Gallup Survey on Teenage Suicide.* Princeton, NJ: George H. Gallup International Institute.

36. Cole, D.A. (1989). Psychopathology of adolescent suicide: Hopelessness, coping beliefs, and depression. *Journal of Abnormal Psychology, 98,* 248–255.

37. Zenere, F.J., & Lazarus, P. J. (1997). The decline of youth suicidal behavior in an urban, multicultural public school system, following the introduction of a suicide prevention and intervention program. *Suicide and Life-Threatening Behavior, 27*(4), 387–403.

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

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

40. 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.

41. Thompson, E.A., Eggert, L.L., Randell, B.P., & Pike, K.C. (2001). Evaluation of indicated suicide risk prevention approaches for potential high school dropouts. *American Journal of Public Health, 91,* 742–752.

42. Randell, B.P., Eggert, L.L., & Pike, K.C. (2001). Immediate post intervention effects of two brief youth suicide prevention interventions. *Suicide and Life Threatening Behavior, 31,* 41-61.

43. Gould, M., Greenberg, T., Velting, D., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(4), 386–405.

44. Embry, D. (2001). *The next generation multi-problem prevention: A comprehensive sciencebased practical approach.* Presentation at California Association for Behavior Analysis (CALABA). Redondo Beach, CA, February 2001.

45. *Youth violence: A report of the Surgeon General.* Descriptions of specific programs that meet standards for model and promising categories (Appendix 5-B). Appendix 5-B also includes a section on ineffective programs. Retrieved from http://www.surgeongeneral.gov/library/youthviolence/chapter5/appendix5b.html

46. U.S. Public Health Service. (1999). *The Surgeon General's Call to Action to Prevent Suicide.* Washington, DC.

47. Borowsky, I.W., Ireland, M., & Resnick, M.D. (2001). Adolescent suicide attempts: Risks and protectors. *Pediatrics, 107*(3), 485–493.

48. World Health Organization. (2000). *Preventing suicide: A resource for teacher's and other school staff.* Mental and Behavioral Disorders, Department of Mental Health, Geneva.

49. Hazell, P., & King, R. (1996). Arguments for and against teaching suicide prevention in schools. *Australian and New Zealand Journal of Psychiatry, 30,* 633–642.

50. Kalafat, J., & Elias, M. (1994). An evaluation of a school-based suicide awareness intervention. *Suicide and Life-Threatening Behavior, 24*(3), 224–233.

References continued

School Climate

51. Mazza, J.J. (1997). School-base suicide prevention programs: Are they effective? *The School Psychology Review, 26*(3), 382–96.

52. Horner, R.H., Sugai, G., Smolkowski, K., Eber, L., Nakasato, J., Todd, A.W., & Esperanza, J. (2009). A randomized, wait-list controlled effectiveness trial assessing school-wide positive behavior support in elementary schools. *Journal of Positive Behavior Interventions, 11*(3). 133-144. doi:10.1177/1098300709332067

53. Garland, A.F., & Zigler, E. (1993). Adolescent suicide prevention: Current research and social policy implications. *American Psychologist, 48*(2), 169–182.

54. Hayden, D.C., & Lauer, P. (2000). Prevalence of suicide programs in schools and roadblocks to implementation. *Suicide and Life-Threatening Behavior, 30*(3), 239–251.

55. O'Carroll, P.W., Potter, L.B., & Mercy, J.A. (1994). *Programs for the prevention of suicide among adolescents and young adults.* MMWR, 43, 9 (RR-6), 1–7. Atlanta: US Department of Health and Human Services, Public Health Service, CDC.

56. Kalafat, J., & Brown, C.H. (2001). *Suicide prevention and intervention: Summary of a workshop.* The National Academy of Sciences, Retrieved from http://www.nap.edu/catalog.php?record_id=10226

57. Kalafat, J. (2003). School approaches to youth suicide prevention. *American Behavioral Scientist, 46*(9), 1211-1223.

58. Berman, A.L., & Jobes, D.A. (1995). Suicide prevention in adolescents (ages 12–18). *Suicide and Life-Threatening Behavior, 25,* 143–154.

59. Nansel, T.R., Overpeck, M., Pilla, R.S., Ruan, W.J., Simons-Morton, B., & Scheidt, P. (2001). Bullying behaviors among US youth: Prevalence and association with psychosocial adjustment. *Journal of the American Medical Association, 285,* 2094–2100.

60. Wang, J., Nansel, T.R., & Iannotti, R.J. (2010). Cyber and traditional bullying: Differential association with depression. *Journal of Adolescent Health, 48*(4), 415-417.

61. Wang, J., Iannotti, R.J., & Nansel, T.R. (2009). School bullying among adolescents in the United States: Physical, verbal, relational, and cyber. *Journal of Adolescent Health, 45*(4), 368-375.

62. Ybarra, M.L., Diener-West, M., & Leaf, P.J. (2007). Examining the overlap in internet harassment and school bullying: Implications for school intervention. *Journal of Adolescent Health, 41*(6 Suppl 1), S42-50.

63. Storey, K., Slaby, R., Adler, M., Minotti, J., & Katz, R. (2007). *Eyes on bullying...what can you do?: A toolkit to prevent bullying in children's lives.* Education Development Center, Inc. Retrieved from http://www.eyesonbullying.org/pdfs/toolkit.pdf

64. Flynt, S.W., & Morton, R.C. (2004). Bullying and children with disabilities. *Journal of Instructional Psychology, 31*(4), 330-335.

65. Klomek, A.B., Marrocco, F., Kleinman, M., Schonfeld, I.S., & Gould, M.S. (2007). Bullying, depression, and suicidality in adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(1), 40-49.

66. Olweus, D. (2003). *Bullying is not a fact of life.* U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Retrieved from http://www.mentalhealth.samhsa.gov

67. Berson, I.R., Berson, M.J., & Ferron, J.M. (2002). Emerging risks of violence in the digital age: Lessons for educators from an online study of adolescent girls in the United States. *Journal of School Violence, 1*(2), 51-71.

68. Kowalski, R.M., & Limber, S.P. (2007). Electronic bullying among middle school students. *Journal of Adolescent Health, 41*(6 Suppl 1), S22-30.

69. Hertz, M.F., & David-Ferdon, C. (2008). *Electronic Media and Youth Violence: A CDC Issue Brief for Educators and Caregivers.* Atlanta(GA): Centers for Disease Control. Retrieved from http://www.cdc.gov/violenceprevention/pub/EA-brief.html

70. Klomek, A.B., Sourander, A., Kumpulainen, K., Piha, J., Tamminem, Moilen, I…Gould, M.S. (2008). Childhood bullying as a risk for later depression and suicidal ideation among Finnish males. *Journal of Affective Disorders, 109,* 47-55.

71. Marsh, H., Parada, R., Craven, R., & Finder, L. (2004). In the looking glass: A reciprocal effects model elucidating the complex nature bullying, psychological determinants, and the central role of self-concept. In C.E. Sanders & G.D. Phye (Eds.), *Bullying: Implications for the Classroom* (63-109). San Diego, CA: Elsevier.

References continued

School Climate

72. Arsenault, L., Walsh, E., Trzesniewski, K., Newcombe, R., Caspi, A., & Moffitt, T.E. (2006). Bullying victimization uniquely contributes to adjustment problems in young children: A nationally representative cohort study. *Pediatrics, 118*(1), 130-138.

73. Nansel, T.R., Craig, W., Overpeck, M.D., Saluja, G., Ruan, J., & The Health Behaviour in School-aged Children Bullying Analyses Working Group. (2004). Cross-national consistency in the relationship between bullying behaviors and psychosocial adjustment. *Archives of Pediatric and Adolescent Medicine, 158,* 730-736.

74. Feinberg, T. (2003). Bullying prevention and intervention. *Principal Leadership, 36*(1), 4-5.

75. Centers for Disease Control and Prevention. (2009). *School Connectedness: Strategies for Increasing Protective Factors Among Youth.* Atlanta, GA: U.S. Department of Health and Human Services.

76. Klomek, A.B., Sourander, A., Neimela, S., Kumpulainen, K., Pila, J., Tamminen, T, … Gould, M.S. (2009). Childhood bullying behaviors as a risk for suicide attempts and completed suicides: A population-based birth cohort study. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(3), 254-261.

77. Vreeman, R.C., & Carroll, A.E. (2007). A systematic review of school-based interventions to prevent bullying. *Archives of Pediatric and Adolescent Medicine, 161,* 78-88.

78. U.S. Department of Health and Human Services. *Stop Bullying Now!* http://www.stopbullyingnow.hrsa.gov/index.html

79. Olweus, D. (1993). *Bullying at School: What We Know and What We Can Do.* Malden, MA: Blackwell

80. Suicide Prevention Resource Center. (2011). *Suicide and Bullying (Issue Brief)*. Newton, MA: Education Development Center, Inc., Retrieved from http://www.sprc.org/library/Suicide_Bullying_Issue_Brief.pdf

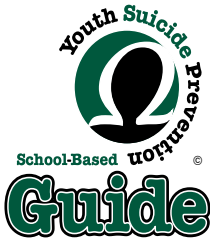
81. Gibbons, M. M., & Studer, J. R. (2008). Suicide awareness training for faculty and staff: A training model for school counselors. *Professional School Counseling, 11*(4), 272–276. doi:10.5330/PSC.n.2010-11.272

82. Popenhagen, M. P., & Qualley, R. M. (1998). Adolescent suicide: Detection, intervention, and prevention. *Professional School Counseling, 1*, 30–35.

83. White, A., Raczynski, K., Pack, C., & Wang, A. (2011). Evaluation report: The safe School Ambassadors® program: A student led approach to reducing mistreatment and bullying in schools. Texas State University: *Community Matters.*

Notes

School Climate



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Checklist 2

Youth Suicide Prevention School-Based Guide ©

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School Climate

Checklist 2

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

Yes	No	
☐	☐	Does your school provide extracurricular opportunities for students such as after school clubs, activities, and student organization meetings?
☐	☐	If Yes, are these clubs/activities open and advertised to all students, regardless of academic achievement or disciplinary issues?
☐	☐	Are youth involved in decisions related to school issues that impact them?
☐	☐	Does your school discuss safety issues openly?
☐	☐	Does your school provide clean and safe school buildings and grounds?
☐	☐	Does your school ensure high academic standards?
☐	☐	Does your school provide regular meetings in which staff and faculty are given the opportunity to discuss students who may be displaying worrisome behavior?
☐	☐	Does your school have established policies that define harassment, bullying, and cyber-bullying?
☐	☐	Does your school provide curricula to students focusing on harassment, bullying, tolerance, and problem-solving skills?

— continued next page

Checklist 2 continued

Yes	No	
☐	☐	Are there meaningful school-related roles available to all students?
☐	☐	Does your school have a system in place to refer students suspected of abuse/neglect?
☐	☐	Does your school have established link to the community for assessment and referral of students in crisis?
☐	☐	Does your school provide training to staff to help them recognize harassment, bullying, and warning signs of students who don't feel safe?
☐	☐	Are there policies that state explicitly how to deal with a student who bullies and/or harasses other students?
☐	☐	Does your school treat students equally and enforce disciplinary, harassment, and civil right's policies consistently?
☐	☐	Are there specific safety procedures in place to support the personal safety of students, faculty, and staff?
☐	☐	Does your school provide adequate supervision to students in spaces and times when bullying is likely to occur (recess, when on computers, in between classes, etc.)?
☐	☐	Is there a specific procedure in place regarding how to properly break up a bullying situation?
☐	☐	Does your school conduct regular safety and hazard assessments?
☐	☐	Does your school ensure that the school environment, including buses and bathrooms, is free from weapons?
☐	☐	Does your school stress to staff the importance of a positive relationship with students and how such a relationship can prevent dangerous situations from occurring?
☐	☐	Does your school treat all students with respect, care, and support?

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Risk Factors
Risk and Protective Factors, and Warning Signs

Issue Brief
3a

Suicide is the result of an extremely complex interaction involving a number of factors that all contribute to the expression of suicidal behaviors. This Issue Brief discusses how knowledge of risk factors, protective factors, and warning signs plays a key role in youth suicide prevention. Risk factors are characteristics that make it more likely that someone will consider, attempt, or die by suicide. Protective factors are those that make it less likely that someone will consider, attempt, or die by suicide. Warning signs are behaviors and characteristics that someone may harm him or herself in the near future.

There are numerous risk factors for suicide, any one of which may be present or absent in an adolescent at-risk for suicide. Researchers have identified a number of factors associated with a higher risk for youth suicide, as well as protective factors that may reduce the likelihood of youth suicidal behavior. Given the amount of time children and adolescents spend in school, it is imperative that school faculty and staff are educated about youth suicide risk factors, warning signs, and protective factors of suicidal behavior (3, 15).

Suicide does not lend itself easily to an identifiable period of symptoms that occur before the disease; however, research does show that suicidal youth tend to give evidence about their distress both verbally and through changing behavior (5, 14). Being able to recognize these clues and knowing the risk factors associated with adolescent suicide may help school staff prevent a student at-risk for suicide from attempting and/or dying by suicide. The importance of risk and protective factors can vary by age, gender, and ethnicity (13).

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

Risk Factors (for non-fatal suicide attempts and deaths by Suicide)

Risk factors are characteristics that increase the possibility that an individual will attempt to end his or her life, although it is important to note that risk factors are not necessarily causes of self-injury or death (17). Risk factors can be thought of as indicators to a child's potential for self-harm, and much research has gone into identifying specific risk factors for youth (4, 15, 17, 18). Research has shown that the following are risk factors for suicide attempts and death by suicide in adolescents: previous suicide attempt (2, 4, 6, 7, 9, 10, 15, 20); mood disorder (particularly depression) or psychopathology (2, 4, 7, 8, 9, 10, 15, 20, 35); substance abuse disorder (2, 4, 7, 8, 9, 10, 20, 35); family history of

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suicidal behavior or mental illness (2, 4, 8, 10, 20); relationship, social, work, or financial loss (3, 4, 8, 10, 20); access to lethal agents (such as firearms or medications) (3, 4, 8, 10, 20, 33); contagion or exposure to individuals who have attempted or died by suicide with exposure through media, television, and direct contact (8, 10, 11); history of physical or sexual abuse (6, 7, 10, 23); conduct disorder (7, 10, 20, 35); juvenile delinquency (7, 10); gay, lesbian, or bisexual sexual orientation, or identification as transgendered(2, 4, 8, 10, 16, 24); stressful life events (7, 10); chronic physical illness (2, 4, 8, 20); impulsive or aggressive tendencies (3, 4, 20); being homeless/runaway (7, 10, 20); and school problems (2).

The impact of some risk factors can be reduced by interventions such as providing treatment for depression or substance abuse, and removing access to firearms (3, 20, 33). Those risk factors that cannot be changed (such as a previous suicide attempt) can alert others to the heightened risk of suicide during periods of the recurrence of a mental or substance abuse disorder, or following a significant stressful life event (11). The following list of risk factors that have been found to be associated with adolescent suicide is intended for use by school staff in order to help identify a student who may be at-risk for attempting or dying by suicide.

Protective Factors

Measures that enhance resilience or protective factors are as essential for preventing suicide as reducing the factors that increase risk for suicide. Resilience refers to the process by which individuals build their coping skills, gain competencies, and increase their resistance to stress (36).

Protective factors are characteristics believed to reduce the likelihood that someone will harm or kill him/herself by counterbalancing risk factors, and vary according to age, gender, ethnicity, and religion (11, 17). Leading researchers in the field of youth suicide have noted that much research still needs to be conducted regarding specific protective factors for children and teens (4) although the following have shown to be protective factors for preventing youth suicide: parental/ family support and connectedness (2, 4, 7, 11, 12, 20, 34), good social/coping skills (11, 12), religious/cultural beliefs (2, 4, 11, 12), good relationships with other school youth/best friends (7, 12), reduced access to means (10, 11), support from relevant adults/ teachers/professionals (7, 11, 12), help-seeking behavior/advice seeking (12), impulse control (7), adaptive problem solving/ conflict resolution abilities (11), social integration/ opportunities to participate (7, 12), positive sense of worth/confidence (7, 12), stable living environment (7), access to and care for mental/ physical/substance disorders (11), responsibility for others/pets (7), and their perceived connectedness to school (2). Additionally, involvement on sports teams (high school and community teams) is associated with reduced suicide ideation and non-fatal suicide attempts (27, 29, 30), reduced hopelessness and self-reported

Risk Factors

- Previous suicide attempt
- Physical abuse
- Sexual abuse
- Feelings of hopelessness or isolation
- Psychopathology (especially mood disorders)
- Parental psychopathology
- Substance abuse disorder (especially with comorbid mental health disorder)
- Conduct disorders or disruptive behaviors
- Juvenile delinquency
- School problems
- Exposure to suicidal behavior of friends or acquaintances, or in the media
- Chronic physical illness
- Being homeless/or having run away from home
- Aggressive-impulsive behaviors
- Life stressors such as interpersonal losses (relationship, social, work) and legal or disciplinary problems
- Access to firearms or other means

Demographic Risk Factors

- Being male (for death by suicide)
- Being female (for suicide attempt)
- Homosexual or bisexual orientation, or trans-gendered identity
- Family history of suicidal behavior

Protective Factors

- Family cohesion (family with mutual involvement, shared interests, and emotional support)
- Good coping skills
- Support from teachers and other relevant adults
- Perceived connectedness to the school
- Positive relationships with other school youth
- Reduced access to means for suicidal behavior
- Help-seeking behavior/advice seeking
- Impulse control
- Problem solving/conflict resolution abilities
- Social integration/opportunities to participate
- Sense of worth/confidence
- Stable living environment
- Access to and delivery of effective care for mental/physical/ substance disorders
- Responsibilities for others/pets
- Religious or cultural beliefs that discourage self-harm
- Sports team participation

plans of suicide (28), and decreased risks for depression (30). Higher involvement (usually 3 or more teams per year) often showed more pronounced protection (28, 30, 32). However, one study revealed male high school athletes who made non-fatal suicide attempts reported serious injury more often than non-athlete counterparts (31, 32). The following checklist presents these protective factors in an easy-to-read format.

Warning Signs

While risk factors suggest long-term risk (i.e., a year to lifetime), warning signs are the earliest detectable signals that someone may harm themselves in the near-term (i.e., within minutes, hours, days, or months) (19). If risk factors can be compared to "clues," then warning signs might be thought of as "red flags." Emotional ups and downs are inherent in adolescence, and it can be hard to determine what behavior is normal and what may be harmful, therefore research has been done on suicide warning signs specifically for youth (1, 19). Again, it must be noted that these factors and warning signs do not provide a definitive method for determining if a student is or is not suicidal, but rather present a method to help identify potentially suicidal adolescents.

In 1997 the American Academy of Child & Adolescent Psychiatry adopted a list of symptoms and warning signs specifically for adolescents who may try to kill themselves, which was updated in May 2008 (14). The Suicide Prevention Resource Center [SPRC] has also compiled a list of youth-specific suicide warning signs (26). Three state suicide prevention program guideline manuals also offer youth suicide warning signs: Maine Youth Suicide Prevention Program (7), Washington State's Youth Suicide Prevention Program (YSPP) (21), and the Virginia Guidelines for Suicide Prevention manual (22). Additionally, researchers in Utah conducted 49 psychological autopsies of adolescents and young adults who died by suicide in the mid-1990s in an effort to examine risk factors and warning signs of the descendents (25). Warning signs for youth suicidal behavior from these resources are combined and appear in this section.

One key to preventing suicide in children and teens is to know these warning signs and know what to do when faced with a student who presents them so that they may get the help they need. Some of these signs are similar to those for depression, a risk factor for suicidal behavior (15, 20). The following lists present warning signs that have been found to be associated with adolescent suicide.

Warning Signs

- ***Actually talking about suicide or a plan****
- ***Seeking out ways to harm or kill oneself****
- ***Saying other things like: "I'm going to kill myself," "I wish I were dead," or "I shouldn't have been born"****
- Withdrawal from friends and family
- Change in eating and sleeping habits
- Loss of interest in pleasurable activities
- Frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- Loss of interest in things one cares about
- Preoccupation with death
- Exhibiting impulsivity such as violent actions, rebellious behavior, or running away
- Complaining of being a bad person or feeling "rotten inside"
- Making statements about hopelessness, helplessness, worthlessness, or being "beyond help"
- Marked personality change and serious mood changes
- Giving verbal hints with statements such as: "I won't be a problem for you much longer," "Nothing matters," "It's no use," and "I won't see you again"
- Becoming suddenly cheerful after a period of depression-this may mean that the student has already made the decision to escape all problems by ending his/her life
- Giving away favorite possessions
- Difficulty concentrating and a decline in quality of school work

* ***These signs and behaviors indicate an individual needs immediate professional attention or 9-1-1 should be called (19).***

References

Risk Factors: Risk and Protective Factors, and Warning Signs

1. Van Orden, K., Witte, T., Selby, E., Bender, T., & Joiner, T. (2008). Suicidal behavior in youth. In J. R. Z. Abela, & B. L. Hankin (Eds.), *Handbook of depression in children and adolescents* (pp. 441-465). New York: Guilford Press.
2. Borowsky, I.W., Ireland, M., & Resnick, M.D. (2001) Adolescent suicide attempts: Risks and protectors. *Pediatrics, 107*(3), 485–493.
3. Gould, M.S., & Kramer, R.A. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior, 31*(Suppl), 6-31.
4. Gould, M., Greenberg, T., Velting, D., & Shaffer, D. (2003). Youth Suicide Risk and Preventive Interventions: A Review of the Past 10 Years. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(4), 386-405.
5. Taliaferro, L. A., & Borowsky, I. W. (2011). Physician education: A promising strategy to prevent adolescent suicide. *Academic Medicine, 86*(3), 342-347.
6. Kaplan, S., Pelcovitz, D., Salzinger, S., Mandel, F., & Weiner, M. (1997). Adolescent physical abuse and suicide attempts. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(6), 799-809.
7. Maine Center for Disease Control and Prevention. (2007). *Maine Youth Suicide Prevention Implementation Plan.* Retrieved from http://www.state.me.us/suicide/myspp/program/plan.htm
8. Moscicki, E. (1999). Epidemiology of suicide. In DG Jacobs (Ed), *The Harvard Medical School Guide to Suicide Assessment and Intervention.* San Francisco: Jossey-Bass Publishing, 40–51.

References continued

9. Shaffer D., Gould, M., & Fisher, P. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry, 53,* 339–348.
10. Shaffer, D., Pfeffer, C.R., & Work Group on Quality Issues. (2001). Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*(1) supp, 24–51.
11. U.S. Public Health Service. (1999). *The Surgeon General's Call to Action to Prevent Suicide.* Washington, DC. Retrieved from http://www.surgeongeneral.gov/library/calltoaction/
12. World Health Organization. (2000). *Preventing Suicide: A Resource for Teacher's and Other School Staff.* Mental and Behavioral Disorders, Department of Mental Health, Geneva.
13. Centers for Disease Control and Prevention. (2010). *Suicide: Risk and protective factors.* Retrieved from http://www.cdc.gov/ViolencePrevention/suicide/riskprotectivefactors.html
14. American Academy of Pediatrics. (2008). Teen suicide. *Facts for Families, No. 10.* Retrieved from http://www.aacap.org/galleries/FactsForFamilies/10_teen_suicide.pdf
15. Miller, D.N., & Eckert, T.L. (2009). Youth suicidal behavior: An introduction and overview. *School Psychology Review, 38*(2), 153-167.
16. Russell, S. T., & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Public Health Association, 91*(8), 1276-1281.
17. Silverman, M. M. (2008). Suicide assessment, intervention and prevention. *The doctor will see you now.* Retrieved from http://www.thedoctorwillseeyounow.com/content/depression/art1955.html
18. Mazza, J. J., Fleming, C. B., Abbott, R. D., Haggerty, K. P., & Catalano, R. F. (2008). Identifying trajectories of adolescents' depressive phenomena: An examination of early risk factors. *Journal of Youth and Adolescence, 39*(6), 579-593.
19. Rudd, M. D., Berman, A. L., Joiner, T. E., Nock, M. K., Silverman, M. M., Mandrusiak, M., . . . Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior, 36*(3), 255-262.
20. Bridge, J.A., Goldstein, T.R., & Brent, D.A. (2006) Adolescent suicide and suicidal behavior. *Journal of Child Psychology and Psychiatry, 47*(3), 372-394.
21. Washington State Youth Suicide Prevention Program. *Know the Warning Signs.* Retrieved from http://www.yspp.org/about_suicide/warning_signs.htm
22. Commonwealth of Virginia Board of Education. (2003). *Suicide Prevention Guidelines.* Retrieved from http://youthviolence.edschool.virginia.edu/prevention/pdf/Suicide%20Prevention%20Guidelines%20for%20Virginia%20schools.pdf
23. Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the lifespan: Findings from the Adverse Childhood Experiences Study. *JAMA, 286*(24), 3089-3096.
24. Haas, A.P., Eliason, M., Mays, V.M., Mathym R.M., Cochran, S.D., D'Augelli, A.R. . . Clayton, P.J. (2001). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of Homosexuality, 58*(1), 10-51.
25. Moskos, M., Olson, L., Halbern, S., Keller, T., & Gray, D. (2005). Utah youth suicide study: Psychological autopsy. *Suicide and Life-Threatening Behavior, 35*(5), 536-546.
26. Suicide Prevention Resource Center (2010). *Featured Resources: Teens.* Retrieved from http://www.sprc.org/featured_resources/customized/teens.asp#warningsigns
27. Taliaferro, L.A., Rienzo, B.A., & Donovan, D.A. (2010). Relationships between youth sport participation and selected health risk behaviors from 1999 to 2007. *Journal of School Health, 80*(8), 399-410. doi:10.1111/j.1746-1561.2010.00520.x
28. Taliaferro, L.A., Rienzo, B.A., Miller, M.D., Pigg, R.M., & Dodd, V.J. (2008). High school youth and suicide risk: Exploring protection afforded through physical activity and sport participation. *Journal of School Health, 78*(10), 545-553. doi:10.1111/j.1746-1561.2008.00342.x
29. Harrison, P.A., & Narayan, G. (2003). Difference in behavior, psychological factors, and environmental factors associated with participation in school sports and other activities in adolescence. *Journal of School Health, 73*(3), 113-120. doi:10.1111/j.1746-1561.2003.tb03585.x
30. Babiss, L.A., & Gangwisch, J.E. (2009). Sports participation as a protective factor against depression and suicidal ideation in adolescents as mediated by self-esteem and social support. *Journal of Developmental and Behavioral Pediatrics, 30*(5), 376-384. doi:10.1097/DBP.0b013e3181b33659
31. Sabo, D., Melnick, M.J., Miller, K.E., Farrell, M.P., & Barnes, G.M. (2002). Athletic participation and the health risks of adolescent males: A national study. *International Journal of Men's Health, 1*(2), 173-194. doi:10.3149/jmh.0102.173
32. Sabo, D., Miller, K.E., Melnick, M.J., Farrell, M.P., & Barnes, G.M. (2005). High school athletic participation and adolescent suicide: A nationwide US study. *International Review for the Sociology of Sport, 40*(5), 5-23. doi:10.1177/1012690205052160
33. Grossman, D.C., Mueller, B.A., Reidy, C., Dowd, M.D., Villaveces, A. . . Harruff, R. (2005). Gun storage practices and risk factors of youth suicide and unintentional firearms injuries. *Journal of the American Medical Association, 293*(6), 707-714.
34. Flouri, E., & Buchanan, A. (2002). The protective role of parental involvement in adolescent suicide. *Crisis, 23*(1), 17-22.
35. Fleischmann, A., Bertolote, J., M., Belfer, M., & Beautrais, A. (2005). Completed suicide and psychiatric diagnosis in young people: A critical examination of the evidence. *American Journal of Orthopsychiatry, 75*(4), 676-683.
36. Friesen, B. J. (2005) *Frequently asked questions about resilience and recovery.* Portland, OR: Research & Training Center on Family Support and Children's Mental Health, Portland State University.

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Risk Factors
How Can a School Identify a student at Risk for Suicide?

Issue Brief
3b

Every school will be faced with different challenges when attempting to implement suicide prevention programs. The resources available will vary between schools and the ability of a school to address suicide will depend upon resources such as time and funding. However, it is essential that every school provide some type of prevention program and students experiencing suicidal thoughts or behaviors are recognized in order to get them help. One of the most important and essential components of a program is how to identify students who are at risk for suicidal thoughts and behaviors. Although much research regarding interventions is limited by a number of challenges (e.g., non-randomization of interventions, substitute variables for outcome measures, small sample sizes, brief time periods of study) (67), promising programs do exist. Research has generally focused on three primary ways for identifying an adolescent potentially at-risk for suicide:

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

Suicide Awareness Curriculum

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

Research has shown that a curriculum approach intended to raise awareness about suicide can lead to a significant improvement in students' knowledge gain (2, 5, 6, 9, 10, 12, 62, 68, 69, 70), particularly about how to seek help for oneself and for others, and that students exposed to suicide curriculum improve in their attitudes about suicide (2, 9, 10, 13, 56, 62, 68-71), that is, they hold more accurate and positive attitudes concerning suicide, such as suicide is not a normal reaction to an overwhelming amount of stress. When curriculum concerning suicide are taught in a gradual, sensitive, and educational manner, students have shown gains in knowledge, positive attitudes, and a reduction in suicidal feelings (2, 10, 12, 40, 69, 70).

Youth Suicide Prevention School-Based Guide ©

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

Importance of Curriculum Length

Some literature suggests that a curriculum approach should not be recommended until more investigation regarding potential benefits and risks is conducted (72). Additionally, research shows that the exposure dose or length of time the curriculum is administered is extremely important. Studies have shown that a curriculum approach may potentially not have any impact on students or may even produce harmful effects on students (9, 14, 57). These studies found that a limited number of students who had previously attempted suicide and were exposed to a curriculum were more likely to view these programs as unsettling and may see suicide as a possible solution to overwhelming problems.

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

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

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

Third, these studies that have found harmful effects utilized a brief (2-4 hour), single session that emphasized a stress model for suicide, which states that suicide is a reaction to an extreme amount of stress. Research has shown that a brief, single session has been found to be ineffective (30, 60).

Therefore, if schools wish to use a curriculum approach in order to address suicide and identify students who may be at-risk for suicide, they must avoid using a single-session approach that focuses on suicide as a reaction to extreme stresses. Schools must address suicide in a more prolonged approach, refraining from saturating students with a single, 2-4 hour class, which may overwhelm students and which studies have found to be potentially harmful for students who have previously attempted suicide (9, 14, 57).

Studies have shown that a more appropriate method when utilizing a curriculum approach is one that presents suicide curriculum to students in a more prolonged fashion (e.g., multiple sessions). Research has shown that curriculum length of anywhere from three classes (40–45 minutes each) to a semester-long class are effective at significantly reducing suicidal ideations, hopelessness, and depression in adolescents (2).

These classes have also shown to significantly increase knowledge about peers at-risk for suicide, increasing positive attitudes toward help seeking, and increasing the likelihood of intervening with troubled peers (6).

Program Examples

Examples of school-based suicide prevention programs that have been found to be effective and have utilized a prolonged curriculum approach include Bergen County, New Jersey (2), and Dade County, Florida (35, 77).

These programs have also incorporated curriculum that focused suicide prevention awareness into existing programs that deal with issues such as substance abuse, tobacco restriction, problem solving, help seeking, and decision making. Because such programs have focused on risk factors, such as substance abuse and protective factors, such as help seeking, they may provide a more comprehensive approach to suicide awareness curriculum.

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

Programs that have utilized this approach in conjunction with other approaches (gatekeeper training) and have been evaluated and disseminated include SAFE: Teen (previously named Adolescent Suicide Awareness Program) (22, 78) and Lifelines (2, 30), which was combined into Lifelines/ASAP (30)

and recently produced as Lifelines by Hazelden Foundation (73). Other programs that have utilized a similar approach for preventing adolescent suicide include programs in Miami, Florida (35, 77) and Washington State (23).

Mental Health Approach

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

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

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

Suicide Awareness Curriculum Conclusions

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

- Avoid using a brief (2–4 hour) single-session, approach in assembly presentations or classes.
- Use a more prolonged approach (i.e., multiple sessions) when using curriculum delivered to students.
- Avoid a curriculum approach that emphasizes suicide as a reaction to stress.
- Avoid curriculum that includes media depictions of suicidal behavior.
- Avoid presentations by youth who have previously made a suicidal attempt because participants may identify with presenter and copycat his/her suicidal behavior.
- Consider implementing suicide awareness curriculum within the context of established classes such as a health class or a life-management skills class.
- Consider incorporating problem-solving skills, coping skills, and self-esteem building skills into the curriculum.
- Provide students with a list of crisis intervention services and resources that are available in the community.
- Have established policies and procedures on how to deal with a suicidal adolescent.
- Have established community links that may provide assistance in a suicidal crisis.
- Have faculty and staff who know what to do if a student expresses concern about a potentially suicidal peer or expresses suicidal thoughts themselves.

Gatekeeper Training

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

Gatekeeper training is universally advocated and supported by research as an essential and effective component to a suicide prevention program (4, 24, 26-29, 30, 33 - 36). Research suggests that gatekeeper training can produce positive effects on an educator's knowledge, attitude, and referral practices (11, 24, 36-39, 44, 75, 82).

Gatekeeper training has also been found to increase an educator's confidence that they have the ability to recognize a student potentially at risk for suicide by more than four times that of teachers who don't receive training (40). Research has found that more than 25% of all teachers sampled in a study reported that they had been approached by suicidal teens (61). In the past, gatekeeper training focused primarily on educators and administrators, however recent research suggests that it is more beneficial to train all school staff (e.g., coaches,

cafeteria workers, bus drivers, nurses) about adolescent suicide, particularly on how to identify, intervene, and refer students potentially at-risk for suicide (25, 27, 37, 38).

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

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

In-service training programs have been shown to be an effective method of gatekeeper training and were a major component of a study that had a positive impact on student's suicidal behavior (35). Principals have expressed that in-service training programs are an acceptable method for educating faculty and staff (33, 42) as did school superintendents (8).

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

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

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

- Maine's Youth Suicide Prevention Program.
- Colorado's Safe Communities-Safe Schools Program.
- Washington's Youth Suicide Prevention Program (YSPP).
- Safe: Teen [previously known as Adolescent Suicide Awareness Program (ASAP)].
- Suicide Prevention Unit-Los Angeles Unified School District.

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

Gatekeeper Training Conclusions

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

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

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

Screening

Screening refers to a method of identifying adolescents potentially at-risk for suicide through the use of self-reports and individual interviews. Generally, screening consists of asking students directly about whether they are experiencing symptoms associated with depression, currently or previously had suicidal ideations or behaviors, and whether they possess risk factors for suicide (46).

Many researchers suggest that school-based suicide prevention programs can be quite effective when they are targeted to a particular high-risk group of students who have been identified through direct assessment (47, 48). Government reports support screening as an early mental health detection and intervention method (7) and at least one call was issued specifically encouraging social workers to become more involved in screening in schools to help reduce youth suicide attempts and deaths (81).

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

Although research seems to indicate that screening programs are effective ways of identifying students who may be at-risk for suicide, there are some concerns about using screening to identify students at risk. Since suicidality fluctuates in adolescents (29), repeated screening must be done to measure the changes in suicidality and to avoid missing a student who is not suicidal at one time but becomes suicidal over time (28, 29, 36). Screening may also identify as much as 10% of the adolescent at school as being at risk, creating a costly need to follow-up with those identified as at risk for suicide or needing additional help (26, 79). In order to reduce identifying all at-risk youth in the school at one time and perhaps challenging the school and local resources, schools may decide to screen in waves. Schools could decide to screen by grade level (e.g., 9th graders in October, 10th graders in November) or by some other mechanism to screen identified parts of the student body until the entire school is screened.

The US Preventive Services Task Force reviewed the research and currently recommends adolescent screening (12 to 18 years of age) for major depressive disorder (MDD), a risk factor for youth suicidal behavior, in a primary care setting provided adequate safeguard are in place. Safeguards include the ability to provide an accurate diagnosis, access to therapy (cognitive-behavioral or interpersonal), and follow-up (74).

In order for schools to initiate a screening session they must have cooperation and consent from parents. While both active and passive methods of permission are legal, your school should weigh the benefits and risks when determining how consent is obtained. Because of its higher participation rates, researchers commonly use passive consent methods (83-85) as active parental consent runs as low as 50% (29, 84). Disadvantages to passive permission include opposition from parents or groups who may object to the screening (83, 84). Some researchers, however, view the potential public health benefits of screening a larger population as outweighing the potential risks (84). Screening implementation research suggests it is important to have adequate school staff to respond to students identified as at risk (79), utilizing community linkages, and creating community partnerships for screening and youth support (80).

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

1. **The Suicidal Ideation Questionnaire**, which has been used in a two-stage screening and assessment process (47) and has thus far been shown to be efficacious (43). The questionnaire is then followed by the Suicidal Behavioral Interview, which should be done by an experienced professional.
2. **The Suicidal Risk Screen** (50), which has been used in a three-stage screening process for identifying, among high school dropouts, youths that require referral to prevention or treatment programs for potentially suicidal teens.
3. **The Columbia Teen Screen** (54), which has been used in a three-stage screening process for students at-risk of suicidal behavior.
4. **Signs of Suicide** (SOS), which has been implemented in numerous US schools and includes both an educational and screening component (76).

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

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

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

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

Despite the method used to identify a student at-risk for suicidal behavior, schools should ensure that faculty and staff are aware of school policies and procedures so when a student is identified, school representatives are knowledgeable about next steps and who to notify. Policies should include timely parent or caregiver notification provided this does not exacerbate the situation (55). In these rare cases, child protective services would typically be alerted.

Screening Conclusions

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

- Use a questionnaire or other screening instrument that research has shown to be effective and valid such as the four presented previously.
- Weigh the benefits vs. risk of both passive and active forms of parental consent.
- Get parent's consent before presenting students with the screening instrument (if active consent).
- Have established referral systems in place so that when a student screens positive for suicidal potential he or she can be given the help they need as soon as possible.
- Communicate to staff and parents that empirical research has found that screening will *not* create suicidal ideations and behaviors in teens who are not suicidal. Screening will not implant suicidal thought in those non-suicidal before exposure to the screening.
- Staff and practitioners should be made aware that screening is not perfectly precise for determining whether a student will express suicidal thoughts or behaviors.
- Ensure every school psychologist and counselor should be aware of valid suicidal screening tools.
- Conduct repeated screenings, possibly once or twice every school year.

References

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

1. Hazell, P., & King, R. (1996). Arguments for and against teaching suicide prevention in schools. *Australian and New Zealand Journal of Psychiatry, 30,* 633–642.
2. Kalafat, J., & Elias, M. (1994). An evaluation of a school-based suicide awareness intervention. *Suicide and Life-Threatening Behavior, 24*(3), 224–233.
3. Gallap, G. (1991). *The Gallup survey on teenage suicide.* Princeton, NJ: George H. Gallup International Institute.
4. Mazza, J.J. (1997). School-base suicide prevention programs: Are they effective? *The School Psychology Review, 26*(3), 382–396.
5. Silbert, K.L., & Berry, G.L. (1991). Psychological effects of a suicide prevention unit on adolescents' levels of stress, anxiety, and hopelessness: Implications for counseling psychologists. *Counseling Psychology 4,* 45–58.
6. Eggert, L. L., Thompson, E.A., Herting, J.R., & Nicholas, L.J. (1995). Reducing suicidal potential among high-risk: Tests of school-based prevention program. *Suicide and Life-Threatening Behavior, 25,* 276–296.
7. President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America (Pub. No. SMA 03-3832).* Rockville, MD: Author. Retrieved from http://govinfo.library.unt.edu/mentalhealthcommission/reports/reports.htm
8. Scherff, A.R., Eckert, T., & Miller, D.N. (2005). Youth suicide prevention: A survey of public school superintendents' acceptability of school-based programs. *Suicide and Life-Threatening Behavior 35*(2), 154–169.
9. Shaffer, D., Garland, A., Vieland, V., Underwood, M., & Busner, C. (1991). The impact of curriculum-based suicide prevention programs for teenagers. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*(4), 588–596.
10. Ciffone, J. (1993). Suicide prevention: A classroom presentation to adolescents. *Social Work, 38,* 197–203.
11. Issac, M., Elias, B., Katz, L.Y., Belik, S., Deane, F.P., Enns, M.W, . . . Sareen, J. (2009). Gatekeeper training as a preventative intervention for suicide: A systematic review. Canadian *Journal of Psychiatry-Revue Canadienne de Psychiatrie, 54*(4), 260-268. Retrieved from http://ro.uow.edu.au/hbspapers/229
12. Orbach, I., & Bar-Joseph, H. (1993). The impact of a suicide prevention program for adolescents on suicidal tendencies, hopelessness, ego identity, and coping. *Suicidal and Life-Threatening Behavior, 23*(2), 120–129.
13. 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. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*(5), 811–815.
14. Shaffer, D., Vieland, V., Garland, A., Rojas, M., Underwood, M., & Busner, C. (1990). Adolescent suicide attempters: Response to suicide-prevention programs. *Journal of American Medical Association, 264*(24), 3151–3155.
15. Miller, D.N., & Dupaul, G.J. (1996). School-based prevention of adolescent suicide: Issues, obstacles and recommendations for practice. *Journal of Emotional and Behavioral Disorders, 4*(4), 221–230.
16. Elias, M.J., Gara, M.A., Schuyler, T.F., Branden-Muller, L.R., & Sayette, M.A. (1991). The promotions of social competence: Longitudinal study of a preventive school-based program. *American Journal of Orthopsychiatry, 61,* 409–417.
17. Hawkins, J.D., Catalano, R.F., Kosterman, R., Abbottt, R., & Hill, D.G. (1999). Preventing adolescent risk behaviors by strengthening protection during childhood. *Archives of Pediatric Adolescent Behavior, 153,* 226–234.
18. Lonczak, H.S., Abbott, R.D., Hawkins, J.D., Kosterman, R., & Catalano, R.F. (2002). Effects of the Seattle Social Development Project on sexual behavior, pregnancy, birth, and sexually transmitted disease outcomes by age 21 years. *Archives of Pediatric Adolescent Medicine, 156,* 438–447.
19. Perry, C.L., Williams, C.L., Komro, K.A., Veblen-Mortenson, S., Forster, J.L., Bernstein-Lachter, R, . . . McGovern, P. (2000). Project Northland High School Interventions: Community action to reduce adolescent alcohol use. *Health Education & Behavior, 27,* 29–49. doi:10.1177/109019810002700105
20. Evans, W., Smith, M., Hill, G., Albers, E., & Nuefeld, J. (1996). Rural adolescent views of risk and protective factors associated with suicide. *Crisis Intervention, 3,* 1-12.

References continued

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

21. Mcbride, C.M., Curry, S.J., Cheadle, A., Anderman, C., Wagner, E.H., Diehr, P., & Psaty, B. (1995). School-level application of a social bonding model of adolescent risk-taking behavior. *Journal of School Health, 65,* 63–68.
22. Ryerson, D. (1990). Suicide awareness education in schools: The development of a core program and subsequent modifications for special populations or institutions. *Death Studies, 14,* 371–390.
23. Eastgard, S. (2000). *Youth suicide prevention program toolkit.* Seattle, WA: Youth Suicide Prevention Program.
24. Garland, A.F., & Zigler, E. (1993). Adolescent suicide prevention: Current research and social policy implications. *American Psychologist, 48*(2), 169–182.
25. Kalafat, J., & Elias, M. (1995). Suicide prevention in an educations context: broad and narrow foci. *Suicide and Life-Threatening Behavior, 25,* 123–133.
26. Hayden, D.C., & Lauer, P. (2000). Prevalence of suicide programs in schools and roadblocks to implementation. *Suicide and Life-Threatening Behavior, 30*(3), 239–251.
27. Parental Division of the American Association of Suicidology. (1999). *Guidelines for school-based suicide prevention programs.* Retrieved from www.suicidology.org/associations/1045/files/School%20guidelines.pdf
28. O'Carroll, P.W., Potter, L.B., & Mercy, J.A. (1994). Programs for the prevention of suicide among adolescents and young adults. *MMWR, 43*(9) (RR-6), 1–7. Atlanta: US Department of Health and Human Services, Public Health Service, CDC.
29. Kalafat, J., & Brown, C.H. (2001). *Suicide prevention and intervention: Summary of a workshop.* The National Academy of Sciences, Retrieved from www.nap.edu/openbook/0309076242/html/4.html
30. Kalafat, J. (2003). School approaches to youth suicide prevention. *American Behavioral Scientist, 46*(9), 1211–1223.
31. King, K.A., Price, J.H., Telljohann, S.K., & Whal, J. (1999). High school health teachers' knowledge of adolescent suicide. *American Journal of Health Studies, 15*(3), 156–163.
32. King, K. (1999). High school suicide postvention: Recommendations for an effective program. *American Journal of Health Studies, 15*(4), 217–222.
33. Gould, M., Greenberg, T., Velting, D., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(4), 386–405.
34. Davidson, L., & Marshall, M. (2003). *School-based suicide prevention: A guide for the students, families, and communities they serve.* American Association of Suicidology: The Task Force for Child Survival and Development.
35. Zenere, F.J., & Lazarus, P. J. (1997). The decline of youth suicidal behavior in an urban, multicultural public school system following the introduction of a suicide prevention and intervention program. *Suicide and Life-Threatening Behavior, 27*(4), 387–403.
36. Berman, A.L., & Jobes, D.A. (1995). Suicide prevention in adolescents (ages 12-18). *Suicide and Life-Threatening Behavior, 25,* 143–154.
37. King, D.A., & Smith, J. (2000). Project SOAR: A training programs to increase school counselors' knowledge and confidence regarding suicide prevention and intervention. *Journal of School Health, 70,* 402–407.
38. Mackesy-Amiti, M.E., Fendrich, M., Libby, S., Goldenberg, D., & Grossman, J. (1996). Assessment of knowledge gains in proactive training for postvention. *Suicide and Life-Threatening Behavior, 26,* 161–174.
39. Tierney, R.J. (1994). Suicide intervention training evaluations: A preliminary report. *Crisis, 15,* 69–76.
40. King, K. (2001). Developing a comprehensive school suicide prevention program. *The Journal of School Health, 71*(4), 132–137.
41. Kalafat, J., & Ryerson, D.M. (1999). The implementation and institutionalization of a school-based youth suicide prevention program. *The Journal of Primary Prevention, 19*(3), 157–175.
42. Miller, D.N., Eckert, T.L., Dupaul, G.J., & White, G.P. (1999). Adolescent suicide prevention: Acceptability of school-based programs among secondary school principals. *Suicide and Life-Threatening Behavior, 29,* 72–85.

References continued

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

43. Eckert, T.L., Miller, D.N., & Dupaul, G.J. (2003). Adolescent suicide prevention: School psychologists' acceptability of school-based programs. *The School Psychological Review, 32*(1), 57–76.
44. Tompkins, T.L., Witt, J., & Abraibesh, N. (2009). Does a gatekeeper suicide prevention program work in a school setting? Evaluating training outcome and moderators of effectiveness. *Suicide and Life-Threatening Behavior, 39*(6), 671-681.
45. Berman, A.L., & Jobes, D.A. (1991). *Adolescent suicide: assessment and intervention*. Washington, DC: American Psychological Association.
46. Shaffer, D., & Craft, L. (1999). Methods of adolescent suicide prevention. *Journal of Clinical Psychiatry, 60*(Supp2), 70–74.
47. Reynolds, W.M. (1991). A school-based procedure for the identification of adolescents at risk for suicidal behaviors. *Family and Community Health, 14,* 64–75.
48. Reynolds, W.M., & Mazza, J.J. (1994). Suicide and suicidal behaviors in children and adolescents. In W.M. Reynolds & H.F. Johnston (Eds.), *Handbook of depression in children and adolescents* (pp. 525–580). New York: Plenum.
49. Shaffer, D., & Craft, L. (1999). Methods of adolescent suicide prevention. *Journal of Clinical Psychiatry, 60,* 70–74.
50. Thompson, E.A., & Eggert, L.L. (1999). Using the suicide risk screen to identify suicidal adolescents among potential high school dropouts. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 1506–1514.
51. Eggert, L.L., Thompson, E.A., Randell, B.P., & McCauley, E. (1995). *Youth suicide prevention plan for Washington State,* Olympia, WA: Washington State Department of Health.
52. Garrison, C.A., McKeown, R.E., Valois, R.F., & Cincent, M.L. (1993). Aggression, substance use, and suicidal behaviors in high school students. *American Journal of Public Health, 83,* 179–184.
53. Hayden, D.C., & Lizasuain, S.L. (1998 April). *Screening for suicide: An evaluation.* Paper presented at the American Association of Suicidology, Bethesda, MD.
54. National Registry of Evidence-based Programs and Practices. (2007). *TeenScreen.* Retrieved from http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=150
55. Poland, S., & Lieberman, R. (2002). Best practices in suicide intervention. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology – IV* (pp. 1151–1165). Bethesda, MD: The National Association of School Psychologists.
56. Battaglia, J., Coverdale, J.H., & Bushong, C.P. (1990). Evaluation of mental illness awareness week program in public schools. *American Journal of Psychiatry, 147,* 324–329.
57. 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. *Journal of the American Academy of Child and Adolescent Psychiatry, 30,* 811–815.
58. Brent, D. A., Perper, J. A., Moritz, G., Allman, C.J., Friend, A., Roth, C., Schweers, J., Balach, L., & Baugher, M. (1993). Psychiatric risk factors for adolescent suicide: A case control study. *Journal of the American Academy of Child and Adolescent Psychiatry, 32,* 521–529.
59. Lewinsohn, P.M., Rohde, Pl, & Seeley, J.R. (1993). Psychosocial characteristics of adolescents with a history of a suicide attempt. *Journal of the American Academy of Child and Adolescent Psychiatry, 32,* 60–68.
60. Silverman, M.M., & Felner, R.D. (1995). Suicide prevention programs: Issues of design, implementation, feasibility and developmental appropriateness. *Suicide and Life-Threatening Behavior, 25*(1), 92–104.
61. Leane, W., & Shute, R. (1998). Youth suicide: The knowledge and attitudes of Australian teachers and clergy. *Suicide and Life-Threatening Behavior, 28,* 165–173.
62. Sandoval, J., & Brock, S.E. (1996). The school psychologist's role in suicide prevention. *School Psychology Quarterly, 11,* 169–185.
63. Kalafat, J. (1997). Prevention of youth suicide. In R.P. Weisssberg, T.P. Gullotta, R.L. Hampton, B.A. Ryan, & G.R. Adams (Eds.), *Enhancing children's wellness* (Vol. 8, pp. 175–213). Thousand Oaks, CA: Sage.

References continued

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

64. Sheridan, S.M., & Gutkin, T.B. (2000). The ecology of school psychology: Examining and changing our paradigm for the 21st century. *School Psychology Review, 29,* 485-502.
65. Gould, M.S., & Kramer, R.A. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior, 31,* 6–31.
66. Goldston, D.B. (2000). *Assessment of suicidal behaviors and risk among children and adolescents.* Wake Forest University School of Medicine.
67. Kutcher, S.P., & Szumilas, M. (2008). Youth suicide prevention, *Canadian Medical Association Journal, 178*(3), 282-285.
68. Cusimano, M.D., & Sameem, M. (2010). The effectiveness of middle and high school-based suicide prevention programmes for adolescents: A systematic review. *Injury Prevention, 17,* 43-39. doi:10.1136/ip.2009.025502
69. Aseltine, R., & DeMartino, R. (2004). An outcome evaluation of the SOS suicide prevention program. *American Journal of Public Health, 94,* 446-451.
70. Aseltine, R., James, A., Schilling, E.A., & Glanovsky, J. (2007). Evaluating the SOS suicide prevention program: A replication and extension, *BMC Public Health, 7,* 161-167. doi:10.1186/1471-2458-7-161
71. Ciffone, J. (2007). Suicide prevention: An analysis and replication of a curriculum-based high school program. *Social Work, 52,* 41-49.
72. Beautrais, A., Fergusson, D., Coggan, C., Collings, C., Doughty, C., Ellis, P, . . . Surgenor, L. (2007). Effective strategies for suicide prevention in New Zealand: A review of the evidence. *Journal of the New Zealand Medical Association, 120,* (1251). Retrieved from http://journal.nzma.org.nz/journal/120-1251/2459/
73. Underwood, M., Kalafat, J., & the Maine Youth Suicide Prevention Program, lead by the Maine CDC. (2009). *Lifelines: A suicide prevention program.* Center City, Minnesota: Hazelden Foundation.
74. US Preventive Services Task Force. (2009). Screening and treatment for major depressive disorder in children and adolescents: US Preventive Services Task Force recommendation statement. *Pediatrics, 123*(4), 1223-1228.
75. Reis, C., & Cornell, D. (2008). An evaluation of suicide gatekeeper training for school counselors and teachers. *Professional School Counseling, 11*(6), 386-394.
76. Screening for Mental Health. (2011). *SOS Signs of Suicide Program: FAQs.* Retrieved from http://mentalhealthscreening.org/programs/youth-prevention-programs/sos/faqs.aspx#7
77. Zenere, F.J., & Lazarus, P.J. (2009). The sustained reduction of youth suicidal behavior in an urban, multicultural school district. *School Psychology Review, 38*(2), 189–199.
78. Wanner, D.M. (2007). *The Impact of a Comprehensive Suicide Prevention Program on Knowledge, Attitudes, Awareness, and Response to Suicidal Youths.* School of Professional Psychology. Paper 148. Retrieved from http://commons.pacificu.edu/spp/148
79. Hallfors, D., Brochish, P.H., Cho, H., & Steckler, A. (2006). Feasibility of screening adolescents for suicide risk in "real-world" high school settings. *American Journal of Public Health, 96*(2), 282-238.
80. Knox, K.L., Conwell, Y., & Caine, E.D. (2004). If suicide is a public health problem, what are we doing to prevent it? *American Journal of Public Health, 94,* 37-45.
81. Peebles-Wilkins, W. (2006). Evidence-based suicide prevention [Editorial]. *Children & Schools, 28*(4), 195–196.
82. Wyman, P.A., Brown, C.H., Inman, J., Cross, W., Schmeelk-Cone, K., Guo, J, . . . Pena, J.B. (2008). Randomized trial of a gatekeeper program for suicide prevention: 1-year impact on secondary school staff. *Journal of Consulting and Clinical Psychology, 76*(1), 104-115.
83. Jason, L.A., Pokorny, S., & Katz, R. (2001). Passive versus active consent: A case study in school settings. *Journal in Community Psychology, 29*(1), 53-68.
84. Chartier, M., Vander Stoep, A., McCauley, E., Herting, J.R., Tracy, M., & Lymp, J. (2008). Passive versus active parental permission: Implications for the ability of school-based depression screening to reach youth at risk. *Journal of School Health, 78*(3), 157-165.
85. Scott, M.A., Wilcox, H.C., Schonfeld, I.S., Davies, M., Turner, J.B., & Shaffer, D. (2009). School-bsed screening to identify at-risk students not already known to school professionals: The Columbia Suicide Screen. *American Journal of Public Health, 99*(2), 334-339.

Notes

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Administrative Issues

Issue Brief 4

Why a School-Based Suicide Prevention Program?

As the third leading cause of death among 15–19 year olds in the United States in 2009 (1), adolescent suicide is a serious and preventable tragedy, which has the potential to affect a large number of families and communities across the country. In 1999, the United States Surgeon General declared suicide, particularly adolescent suicide, a serious public health concern and initiated a call to action for every state to address the issue of adolescent suicide (3). Research has found that schools provide an ideal and strategic setting for preventing adolescent suicide (4). Because law and school education codes include the mandate to not only educate, but to protect students (7, 78, 79), it seems only reasonable and prudent to implement, maintain, and evaluate prevention programs in schools, the places where adolescents spend more than one-third of their day.

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

Youth Suicide Prevention School-Based Guide ©

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Implementation

Research on school districts has found that one of the major questions about implementing prevention/intervention programs was on how to begin a school-based suicide prevention program (16). Although each school and school district should initiate a suicide prevention program that will "fit" well within the culture of their school and will be dictated by the resources available, research suggests that meetings with district leaders, school principals, educators, and potentially a parent group could help facilitate "reconnaissance and relationship development" (11). The meeting may involve a discussion about the prevention program ahead of time with various members of the group in order to determine what resources, barriers, and concerns each may have about implementing a prevention program (12).

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

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

Developing Policies and Procedures

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

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

Although each school should adopt a policy that "fits" appropriately with the culture and emotion of their school, research (6, 12, 18, 25, 30) has suggested that schools may want to be aware of the following propositions for what policies may wish to address:

- Formally state that the school considers suicide prevention a priority.
- Formally state and express to others what prevention efforts a school will utilize to address adolescent suicide (curriculum, gatekeeper training, screening, peer groups). See *Issue Brief 5: Suicide Prevention Guidelines* for more information.
- Maintain a crisis management handbook, which should provide information about suicidal behavior, risk factors, protective factors, suicide contagion (imitation), and prevention guidelines.

- Describe what staff, faculty, or students should do if they suspect that a student may be potentially at risk for suicidal ideations and/or behavior (this will entail education on referral practices).
- Describe how to respond to a student overtly expressing suicidal ideations and/or behaviors.
- Describe and recognize a school crisis response team.
- Detail the roles and responsibilities of each crisis response team member.
- Describe criteria for assessing the lethality of a student potentially at risk for suicidal behavior.
- Describe how a school and its staff members will respond to a suicidal crisis (attempt at school or death by suicide).
- Describe how a school will evaluate the program.
- Should be clear and detailed.
- Should be consistently defined at the school, district, and county level.

Policies are only effective if they are disseminated and recognized as important (2, 8, 12, 14, 41, 74). It is essential that once policies are established and are agreed upon by administrators, staff, and community professionals (counselors, psychiatrists) as comprehensive and empirically sound methods for addressing the issue of suicide, that these policies are provided to all faculty and staff, preferably through a mandatory in-service suicide awareness and prevention training (5, 71, 77). It is also recommended that policies regarding any action taken when confronted with a potentially suicidal student should be written in conjunction with and reviewed by an attorney (66, 71). It is also important that school staff be explicitly informed about who in the school and/or the community they may contact when dealing with a potentially suicidal student.

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

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

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

Program Support and Maintenance

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

Supportive and informed teachers have been found to make good informants concerning student mental health, provide support for one another, are able to reach a high level of mastery of a complex prevention program, and are likely to obtain skills and materials from suicide prevention programs that are transferable to other elements of their repertoires (12, 31–33). Research has found that when schools communicate and involve parents with school activities and programs, parents are more likely to cooperate with the school and help the school maintain these programs (34, 35, 50). When schools involve and gain support from parents, students feel more competent and less confused because by working with parents, schools ensure that students receive consistent messages (36).

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

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

In order for a school and/or school district to ensure that a school-based prevention program will be effectively adopted and maintained, research suggests that schools gain support from parents, administrators, educators, and various community members and that these persons are aware of the prevalence and risk of suicide in their community (12, 14, 16, 18, 25, 27, 29, 30, 34, 35, 52, 54, 74). These persons should also understand how myths, or fictitious beliefs lacking scientific merit, might undermine a community's ability to help a troubled adolescent. For more information on myths behind suicide please refer to *Issue Brief 1: Information Dissemination.* Also included in the Guide is a True and False Test for Myths and Evidence-based Facts about adolescent suicide.

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

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

Crisis Response Team

In order for a school to effectively intervene with a student potentially at risk for suicidal behavior, schools must develop, train, and support a school crisis response team long before a crisis occurs (6, 10, 13, 15, 19, 25, 49, 75, 76). It is critical that schools respond to potentially suicidal students and crisis situations carefully and thoughtfully in order to diminish the threat of the immediate situation, and also to create a quick recovery and return to normalcy for the school community (2).

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

Administrative Issues continued

The crisis response plan should also designate a crisis team leader and backup leader, who should have support from the administration and should be given the authority to coordinate team member assignments while keeping an open channel with school administrators (6, 49, 50). Should a crisis overwhelm a school's ability to intervene, the crisis team leader may find it necessary to recommend the use of a school-district team.

For more on crisis response teams please refer to *Issue Brief 6b: Crisis Intervention and Crisis Response Teams*.

Evaluating Programs

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

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

If a school's efforts have been demonstrated to be effective at preventing adolescent suicide then without explicit documented strategies of their specific prevention strategies and policies, there is no way to replicate effective designs. Although many suggest that evaluating the impact of suicide prevention strategies is essential and such methods may be appropriately placed in the crisis response plan, little empirical research has been done to critically evaluate the impact of such strategies (2, 12, 18, 25, 42, 51, 54). That is not to say that such evaluations have not been done. Some examples, which only represent evaluations that have been published, disseminated to enough persons to validate results, and have been maintained over an extended period of time to reduce effects of time trends, have all demonstrated positive effects such as a reduction in youth suicide rates (12, 18, 55) or a reduction in suicidal ideation and less favorable attitudes towards suicide (56–59).

Other research, which focused evaluation on a single-session, 3–4 hour curriculum showed that a small restricted group of students, those who had attempted suicide, expressed more maladaptive coping skills and increased levels of hopelessness following the classes (60, 61). The authors of these studies, however subsequently stated that such single session, limited in duration, classes should be avoided. This idea is consistent with other research that classes can have a positive effect on attitudes, knowledge, and referral practices, but only when offered for multiple sessions rather than one, 3–4 hour session. Additionally, such a long period of time, (3–4 hours) could have influenced how well received these classes were in this small group. For more information on these studies, and on curriculum in general please refer to *Issue Brief 5: Prevention Guidelines*.

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

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

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

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

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

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

Duty, Responsibility, and Liability

An important issue for schools and one that many administrators, teachers, and school board members consider to be of paramount importance is the issue of liability. Whether a school district will be held liable and/or responsible for a student's death will depend on whether the legal claim is based on negligence or a constitutional claim based on due process (65, 79). Negligence is defined by courts as the failure to use such care as a reasonable person would use under similar circumstances, and can consist of either doing something or failing to do something, that a reasonably prudent person would do or not do (66, 79). Legal duty is a responsibility to follow legal standards of reasonable conduct where there is apparent risk (79). Negligence in schools is established when a legal duty is owed to the student (by teacher or school), the duty was breached, that an actual loss or damage was suffered by the student as a result, and there was a sufficient causal connection between the breach and the student's injury or death (65, 67). Usually the first two elements are vital and the first step is proving that a legal duty existed, in which case proving if the teacher or school had a duty to protect the student from suicidal behavior. If duty can be proven, then the case proceeds to prove the remaining elements.

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

- The school must provide supervisory care to students at the same level as a concerned parent (68, 79). That is, when children are in school, the school stands in loco parentis, or in the place of a parent (68, 79).
- Failure to prevent suicide because of a lack of action when a school administrator, educator, or faculty member has knowledge that a student is a potential risk for suicide may be found liable (77).
- Failure to notify a parent when faculty or staff have reason to believe that a student is at an increased risk for suicidal behavior has led to a school district being found liable in the states of Florida and Maryland (69, 79).
- Educators may be found liable if they violate a statute that is intended to protect a student potentially at risk for suicide. An example of this violation would be releasing confidential information about a student, which may contribute to that student engaging in suicidal behavior. Under the Family Educational and Privacy Rights Act of 1974 (FERPA), educators must protect the privacy

of student records such as grades, health information, counselor's reports, teacher observations, and disciplinary actions to name a few (80). There are however, exceptions to maintaining confidentiality including if a student is believed to be experiencing a suicidal crisis or has expressed suicidal thoughts, then confidentiality should be breached in order to protect the student (80). Students should be told that in order to ensure that they get the appropriate care it is essential that someone who may be in a better position to help should be contacted (77, 80).

Overall, school districts, administrators, educators, and staff may be held liable for a student's suicidal behavior when there is knowledge that a student could potentially harm himself and when action is not taken to prevent such a tragedy (79). Research evaluating information on school liability suggests that it is wise for districts to develop programs to train (or retrain) their personnel at a minimum and may wish to train students to detect suicidal behavior and provide them with information on where to get help (66). Some also suggest that involving parents, developing prevention policies, and disseminating this information to staff and parents are also necessary components to any effective program (66, 70).

It is critical that school faculty and staff are not only aware of their policy regarding students who express suicidal thoughts and/or behaviors, but also that such school policies are followed. Legal experts recommend that in-service policy training for school staff and faculty regarding suicide prevention and warning signs, confidentiality, intervention, and postvention be mandatory (5, 71, 77). It is also recommended that this policy should be written in conjunction with and reviewed by an attorney (66, 71).

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

Faculty and staff of Florida's schools should be aware of Florida's Mental Health Act, commonly known as the Baker Act, which was enacted in 1971 and that allows for involuntary examination based on evidence of mental illness AND harm to self, harm to others and/or self neglect (73). Put simply, this act recognizes that some persons with mental illness, including children and adolescents, may need to be voluntarily admitted to a mental health facility for evaluation and short-term treatment. Under the emergency statute, an adolescent may be admitted involuntarily "if there is reason to believe he is mentally ill and that without care and treatment, he is likely to suffer from substantial harm" (73).

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

1. Refused voluntary admission or is unable to determine for him/herself whether such admission is necessary.
2. Without care he or she is likely to suffer neglect or refuse to care for him/herself; such that this neglect poses a real and present threat of substantial harm to his/her well being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services.

The adolescent may also be taken involuntarily if it is more likely than not that in the future he/she will inflict serious, unjustified bodily harm on another person, as evidenced by behavior causing, attempting, or threatening such harm, including at least one incident thereof within 20 days prior to the examination (73). Involuntary exams may be initiated by mental health professionals, law enforcement officials, and judges, and may last up to 72 hours. The exams may occur in the 105 Department of Children and Families designated Baker Act receiving facilities (locations can be found at http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml).

Every state will differ in its rules, regulations, policies, and procedures for responding to an individual potentially at risk for harming him- or herself, harming another, or not having the ability or the capability to care for him- or herself. Regardless of how a state chooses to define and respond to people who may be at risk for harming themselves or others, it is important that your school and its staff have

Administrative Issues continued

some knowledge about legislation in order to make school personnel feel more secure about issues, such as liability and for the important reason that by being aware of such legislation may help educators more effectively respond to an adolescent at risk for suicidal behavior.

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

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

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

References

Administrative Issues

1. Centers for Disease Control and Prevention: Web-based Injury and Statistics Query and Reporting System. (2012). *Leading causes of death reports.* Retrieved from http://webappa.cdc.gov/sasweb/ncipc/leadcaus10_us.html
2. Cornell, D.G., & Sheras, P.L. (1998). Common errors in school crisis response: Learning from our mistakes. *Psychology in the Schools, 35*(3), 297-307.
3. United States Public Health Service. (1999). *The Surgeon General's Call to Action to Prevent Suicide.* Washington D.C. Retrieved from http://www.surgeongeneral.gov/library/calltoaction/calltoaction.pdf
4. Malley, P.B., Kush, F., & Bogo, R.J. (1994). School-based adolescent suicide prevention and intervention programs: A survey. *School Counselor, 42,* 130-136.
5. Gamble, E. (2000). A student commits suicide: What would-could your school do? *School Law Bulletin, 31*(2), 29-33.
6. Klicker, R.L. (2000). *A student dies, a school mourns: Dealing with death and loss in the school community.* Philadelphia, PA: Taylor & Francis.
7. Portner, J. (1994). Florida suit blames school officials in pupil's suicide. *Education Week,* (April 20).
8. King, K.A., Price, J.H., Telljohann, S.K., & Wahl, J. (1999). High school health teachers' knowledge of adolescent suicide. *American Journal of Health Studies, 15*(3), 156-163.
9. Gould, M., Greenberg, T., Velting, D., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(4), 386-405.
10. U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (1992). *Youth suicide prevention programs: A resource guide.* Retrieved from http://aepo-xdvwww. epo.cdc.gov/wonder/prevguide
11. Weissberg, R.P., Caplan, M., & Sivo, P.J. (1989). A new conceptual framework for establishing school-based social competence promotion programs. In L.A. Bond & B.E. Compas (Eds.), *Primary preventions and promotions in the schools* (pp. 255-296). Newbury Park, CA: Sage.
12. Kalafat, J., & Ryerson, D.M. (1999). The implementation and institutionalization of a school-based youth suicide prevention program. *The Journal of Primary Prevention, 19*(3), 157-175.

References continued

Administrative Issues

13. King, K. (1999). High school suicide postvention: Recommendations for an effective program. *American Journal of Health Studies, 15*(4), 217-222.
14. Garland, A.F., & Zigler, E. (1993). Adolescent suicide prevention: Current research and social policy implications. *American Psychologist, 48*(2), 169-182.
15. Hicks, B.B. (1990). *Youth suicide: A comprehensive manual for prevention and intervention.* Bloomington, IN: National Education Service.
16. Hayden, D.C., & Lauer, P. (2000). Prevalence of suicide programs in schools and roadblocks to implementation. *Suicide and Life-Threatening Behavior, 30*(3), 239-251.
17. Davidson, L., & Marshall, M. (2003). *School-based suicide prevention: A guide for the students, families, and communities they serve.* American Association of Suicidology: The Task Force for Child Survival and Development.
18. Zenere, F.J., & Lazarus, P. J. (1997). The decline of youth suicidal behavior in an urban, multicultural public school system following the introduction of a suicide prevention and intervention program. *Suicide and Life-Threatening Behavior, 27*(4), 387-403.
19. The Maine Youth Suicide Prevention Program. (2009). *Youth suicide prevention intervention and postvention guidelines: A resource for school personnel.* Maine Children's Cabinet.
20. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). (2001). School health guidelines to prevent unintentional injuries and violence. *Morbidity and Mortality Weekly Report, 50,* RR-22.
21. Gardiner, H., & Gaida, B. (2002). *Suicide prevention services: Literature review final report.* Alberta Mental Health Board, Research and Evaluation Unit. Calgary, AB.
22. Kalafat, J. (1997). Prevention of youth suicide. In R.P. Weissberg, T.P. Gullotta, R.L. Hampton, B.A. Ryan, & G.R. Adams (Eds.), *Enhancing Children's Wellness* (pp. 175-213). Thousand Oaks, CA: Sage.
23. Tierney, R., Ramsay, R., Tanney, B., & Lang, W. (1990). Comprehensive school suicide prevention programs, In A. Leenaars & S. Wenckstern (Eds.), *Suicide prevention in schools* (pp. 83-98). New York: Hemisphere.
24. Goldsmith, S.K. (2001). *Suicide prevention and intervention: Summary of a workshop.* Board of Neuroscience and Behavioral Health, Institute of Medicine. Washington, DC: National Academy Press.
25. King, K. (2001). Developing a comprehensive school suicide prevention program. *The Journal of School Health, 71*(4), 132-137.
26. Cellota, B., Jacobs, G., Keys, S.G., & Cannon, G.A. (1989). *A model prevention program.* In D. Cappuzzi & L. Golden (Eds.), Preventing adolescent suicide. Muncie, IN: Accelerated Development.
27. Kalafat, J., & Underwood, M. (1989). *Lifelines: A school-based adolescent suicide response program.* Dubuque, Iowa: Kendall/Hunt.
28. Huberman, A.M., & Miles, M.B. (1984). *Innovation up close: How school improvement works.* New York: Plenum.
29. Miller, D.N., & Dupaul, G.J. (1996). School-based prevention of adolescent suicide: Issues, obstacles and recommendations for practice. *Journal of Emotional and Behavioral Disorders, 4*(4), 221-230.
30. Kalafat, J. (2003). School approaches to youth suicide prevention. *American Behavioral Scientist, 46*(9), 1211-1223.
31. Roeser, R.W., & Midgley, C. (1997). Teachers' views of issues involving student's mental health. *Elementary School Journal, 98,* 115-133.
32. Loeber, R., Green, S.M., & Lahey, B.B. (1990). Mental health professionals' perception of the utility of children, mothers, and teachers as informants on childhood psychopathology. *Journal of Clinical and Child Psychology, 19,* 136-143.
33. Ollendick, T.H., Greeene, R.W., Werst, M.D., & Oswald, D.P. (1990). The predictive validly of teacher nominations: A five-year follow-up of at risk youth. *Journal of Abnormal Child Psychology, 18,* 699-713.
34. Carlyon, P., Carlyon, W., & McCarthy, A.R. (1998). Family and community involvement in school health. In E. Marx, S.F. Wooley, & D. Northrop (Eds.), *Health is academic: A guide to coordinated school health programs* (pp. 67-95). New York, NY: Teachers College Press.

References continued

Administrative Issues

35. Marx, E., & Northrop, D. (1995). *Educating for health: A guide for implementing a comprehensive approach to school health education.* Newton, MA: Education Development Center.
36. Hawkins, J.D., Catalano, R.F., & Miller, J.Y. (1992). Risk and protective factors in adolescence and early adulthood. *APA Bulletin, 112,* 64-105.
37. Ross, J.G., Luepker, R.V., Nelson, G.D., Saavedra, P., & Hubbard, B.M. (1991). Teenage health teaching modules: Impact of teacher training on implementation and student outcomes. *Journal of School Health, 61,* 31-34.
38. Smith, D.W., McCormick, L.K., Steckler, A.B., & McLeroy, K.R. (1993). Teachers' use of health curricula: Implementation of Growing Healthy, Project SMART, and the Teenage Health Teaching Modules. *Journal of School Health, 63,* 349-354.
39. Burak, L.J. (1994). Examination and prediction of elementary school teachers' intentions to teach HIV/AIDS education. *AIDS Education and Prevention, 6,* 310-321.
40. Silverman, M.M., & Felner, R.D. (1995). Suicide prevention programs: Issues of design, implementation, feasibility and developmental appropriateness. *Suicide and Life-Threatening Behavior, 25*(1), 92-104.
41. Mazza, J.J. (1997). School-based suicide prevention programs: Are they effective? *The School Psychology Review, 26*(3), 382-96.
42. Dyck, R.J. (1990). System-entry issues in school suicide preventions education programs. In A. Leenaars & S. Wenckstrn (Eds.), *Suicide prevention in schools* (pp. 41-50). New York: Hemisphere.
43. Reynolds, W.M., & Mazza, J.J. (1994). Suicide and suicidal behavior in children and adolescents. In W.M. Reynolds & H.F. Johnston (Eds.), *Handbook of depression in children and adolescents* (pp. 525-580). New York: Plenum.
44. King, K.A. (1999). Fifteen prevalent myths about adolescent suicide. *Journal of School Health, 69*(4), 159-161.
45. Centers for Disease Control and Prevention. (1995). Suicide among children, adolescents, and young adults. *Morbidity and Mortality Weekly Report, 44*(15), 289-291.
46. Vidal, J. (1986). Establishing a suicide prevention program. *National Association of Secondary School Principals Bulletin,* October, 68-72.
47. McKee, P.W., Jones, R.W., & Barbe, R.H. (1993). *Suicide and the school: A practical guide to suicide prevention.* Horsham, PA: LRP Publications.
48. Center for Mental Health in Schools at UCLA. (2000). *A resource aid packet on responding to a crisis at a school.* Los Angeles, CA: Author.
49. Underwood, M.M., & Dunne-Maxim, K. (1997). *Managing sudden traumatic loss in the schools: New Jersey adolescent suicide prevention project* (revised edition). Piscataway, New Jersey: University of Medicine and Dentistry of New Jersey-University Behavioral Healthcare.
50. Maine, S., Shute, R., & Martin, G. (2001). Educating parents about youth suicide: Knowledge, response to suicidal statements, attitudes, and intention to help. *Suicide and Life-Threatening Behavior, 31*(3), 320-332.
51. Mulder, A.M., Methorst, G.J., & Diekstra, R.F.W. (1989). Prevention of suicidal behavior in adolescents: The role and training of teachers. *Crisis, 10*(1), 36-51.
52. Kalafat, J. (1994). On initiating school-based suicide response programs. *Special Services in the Schools, 8*(2), 21-31.
53. Commins, W.W., & Elias, M.J. (1991). Institutionalization of mental health programs in organizational contexts: The case of elementary schools. *Journal of Community Psychology, 19,* 207-220.
54. O'Carroll, P.W., Potter, L.B., & Mercy, J.A. (1994). Programs for the prevention of suicide among adolescents and young adults. *Morbidity and Mortality Weekly Report, 43 9* (RR-6); 1-7. Atlanta: US Department of Health and Human Services, Public Health Service, CDC.
55. Kalafat, J. (2000). Issues in the evaluation of youth suicide prevention initiatives. In T. Joiner & M.D. Rudd (Eds.), *Suicide science: Expanding the boundaries* (pp. 241-249). Boston: Kluwer Academic.
56. Eggert, L. L., Thompson, E.A., Herting, J.R., & Nicholas, L.J. (1995). Reducing suicidal potential among high-risk: Tests of school-based prevention program. *Suicide and Life-Threatening Behavior, 25*(2), 276-296.
57. Randell, B.P., Eggert, L.L., & Pike, K.C. (2001). Immediate post intervention effects of two brief youth suicide prevention interventions. *Suicide and Life-Threatening Behavior, 31,* 41-61.

References continued

Administrative Issues

58. Thompson, E.A., Eggert, L.L., Randell, B.P., & Pike, K.C. (2001). Evaluation of indicated suicide risk prevention approaches for potential high school dropouts. *American Journal of Public Health, 91,* 742-752.
59. Zenere, F.J., & Lazarus, P.J. (2009). The sustained reduction of youth suicidal behavior in an urban, multicultural school district. *School Psychology Review, 38*(2), 189–199.
60. Shaffer, D., Garland, A., Vieland, V., Underwood, M., & Busner, C. (1991). The impact of curriculum-based suicide prevention programs for teenagers. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*(4), 588-596.
61. Shaffer, D., Vieland, V., Garland, A., Rojas, M., Underwood, M., & Busner, C. (1990). Adolescent suicide attempters: Response to suicide-prevention programs. *Journal of American Medical Association, 264*(24), 3151-3155.
62. Nation, M., Crusto, C., Wandersman, A., Kumpfer, K.L., Seybolt, D., Morrissey-Kane, E., & Davino, K. (2003). What works in prevention: Principles of effective prevention programs. *The American Psychologist, 58*(6/7), 449-456.
63. Weissburg, R.P., Kumpfer, K.L., & Seligman, M.E.P. (2003). Prevention that works best for children and youth: An introduction. *The American Psychologist, 58*(6/7), 425-432.
64. Biglan, A., Mrazek, P.J., Carnine, D., & Flay, B.R. (2003). Integration of research and practice in the prevention of youth problem behaviors. *The American Psychologist, 58*(6/7), 433-440.
65. Taylor, K.R. (2001). Student suicide: Could you be held liable? *Principal Leadership, 2*(1), 74-78.
66. Milsom, A. (2002). Suicide prevention in schools: Court cases and implications for principals. *Bulletin, 86,* 630.
67. Fischer, L., & Sorenson, G.P. (1996). *School law for counselors, psychologists, and social workers.* New York: Longman.
68. Ballard v. Polly, 387 F. Supp. 895 (1975).
69. Wyke v. Polk County School Board, 129 F. 3d 560 (1997).
70. Coy, D.R. (1995). The need for a school suicide prevention policy. *NASSP Bulletin, 79*(570), 1-9.
71. Capuzzi, D. (1994). *Suicide prevention in the schools: Guidelines for middle and high school settings.* Alexandria, VA: American Counseling Association.
72. Poland, S. (1989). *Suicide intervention in the schools.* New York, NY: Guilford Publications Inc.
73. Mental Health Program Office & Department of Mental Health Law & Policy (2010). *2011 Baker Act user reference guide: The Florida Mental Health Act.* Tallahassee, FL: Department of Children and Families, Mental Health Program Office; Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute.
74. Centers for Disease Control (1992). *Youth suicide prevention programs: A resource guide.* Atlanta, GA: Centers for Disease Control.
75. Oregon Department of Human Services. (2000). *The Oregon Plan for Youth Suicide Prevention.* Retrieved from www.ohd.hr.state.or.us/cdpe/yspinfo.htm
76. Goldenberg, D., Grossman, J., Pokorny, S., & Mazur, C. (1996). *Creating a safe environment: Training gatekeepers.* Presentation at the 29th Annual Conference of the American Association of Suicidology, St. Louis, MO.
77. Capuzzi, D. (2002). Legal and ethical challenges in counseling suicidal students. *Professional School Counseling, 6*(1), 36-46.
78. Capuzzi, D., & Gross, D. (2004). *Youth at risk: A prevention resource for counselors, teachers, and parents.* Alexandria, VA: American Counseling Association.
79. Cafaro, C.S. (2000). Student suicides and school system liability. *School Law Bulletin, 31*(2), 17-28.
80. Glosoff, H.L., & Pate, R.H. (2002) Privacy and confidentiality in school counseling. *Professional School Counseling, 6*(1), 20-47.

Notes

Administrative Issues

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Checklist 4

Administrative Issues

Youth Suicide Prevention School-Based Guide ©

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CFS Community SOLUTIONS
All Children & Youth—Every Community

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Checklist 4

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

Yes	No	
☐	☐	Does your school provide information to staff and faculty about the impact and prevalence of adolescent suicide?
☐	☐	Does your school have policies and procedures in place concerning suicide issues?
☐	☐	Does your school have support from superintendents, principals, and teachers for a suicide prevention program?
☐	☐	Does your school have established links to the community that may offer help and assistance when a school is confronted with a student potentially at risk for suicidal behavior?
☐	☐	Does your school have an established crisis response plan?
☐	☐	Does your school's crisis response plan detail what actions to take (interventions) if a student does threaten, attempt, or dies by suicide?
☐	☐	Do all staff members and faculty know how your school will respond to a suicidal crisis situation?

— continued next page

Checklist 4 continued

Yes	No	
☐	☐	Does your school educate and inform all staff members on who they should contact in the community or in the school should a student express or demonstrate any signs of suicidal behavior (verbal threats, written warnings, or overt suicidal behaviors)?
☐	☐	Does your school have an established crisis response team?
☐	☐	Does your school's crisis response team have administrative support?
☐	☐	Does your school's crisis response team meet with one another and with other staff members on a regular and consistent basis?
☐	☐	Does your school's staff, faculty, and administrators know about the challenges and potential roadblocks for implementing and maintaining a school-based suicide prevention program?
☐	☐	Do your crisis response team members know who to contact if a crisis exhausts your school's ability to handle the problem?
☐	☐	Does your school provide parents with a list of community resources or agencies that they may contact should they suspect that their son/daughter is considering suicide or has expressed suicidal thoughts or behaviors?
☐	☐	Does your school actively communicate with parents, informing them about risk factors and the importance of disposing of or restricting access to lethal means (such as firearms)?
☐	☐	Does your school inform parents about what the school is doing to prevent or address the issue of suicide?
☐	☐	Does your school provide a way to measure or evaluate the impact and maintenance of your suicide prevention program?
☐	☐	Are your school's administration and staff aware of legislation concerning liability as it relates to suicidal behavior in students?
☐	☐	Are your school's administration and staff aware that while students are in school, the school must act in loco parentis, or as reasonably as a concerned parent?

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Suicide Prevention Guidelines

Issue Brief 5

Suicide was the third leading cause of death among 15–19 year olds in the United States in 2009 (1). A typical US high school classroom includes one boy and two girls who have attempted suicide in the past year (2). Adolescents spend one-third of their day in school, the institution that has the largest responsibility for educating and socializing youth (3). For this reason, schools provide an ideal setting for suicide prevention strategies for adolescents (4). School education codes include the mandate not only to educate but to protect students (5). It seems that schools not only have a moral obligation to address adolescent suicide, but a potentially legal one as well. School districts have and can be sued for inadequate suicide-prevention programs (5, 6, 7).

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

Policies and Procedures

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

Every school should create suicide prevention policies that fit appropriately with the culture of the school community, but research has suggested that school-based suicide prevention policies and procedures include: formally stating that suicide prevention is a school priority, describe the steps that should be taken if staff or faculty suspect a student is at risk for suicidal behavior, and describe a school crisis response team (9, 14, 19).

In order to send the message that suicide prevention policies are a school priority, once they are agreed upon by administrators, staff, and community professionals as comprehensive and evidence-based, the policy should then be provided to all school faculty and staff, possibly through a mandatory in-service training (14, 20, 23).

Youth Suicide Prevention School-Based Guide ©

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Gatekeeper Training

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

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

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

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

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

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

Educating Parents and Community Members

An interrelated prevention guideline and technique is training parents and community members about suicide prevention. Developing partnerships with family-run and youth-run organizations can be an effective strategy to reaching and engaging families and youth in suicide prevention activities. Additionally, research has found that when schools communicate and involve parents with school activities and programs, parents are more likely to cooperate with the school and help the school maintain these programs (37, 38). Parents are sometimes not sure how to be involved in their children's school, so it is often up to school personnel to facilitate and foster a positive home/school relationship (108). Some suggestions for how to better involve families in school-based suicide prevention efforts include: placing suicide awareness issues on PTA agendas, use terms such as "partnership" and "teaming" to empower families about suicide prevention, disseminate literature and notices in families' first languages, and schedule meetings and conferences around families' busy schedules (102-104).

Although it may be beyond the scope of responsibility for schools to actually train parents and community members in the same way school staff members are trained (3), schools should make sure that there are established relationships between the school and crisis service providers such as the police, clergy, mental health agencies, and outpatient agencies (3, 8, 10, 14, 28). These links will help school staff make effective referrals for at-risk students. Schools should also provide information to parents and collaborating community organizations about warning signs, risk factors, protective factors, community resources, and what to do during and following a suicidal crisis (3, 10). Research has found that parents who attended a brief educational session about youth suicidal issues increased their intention to assist children and teens that may be facing a suicidal crisis, were able to choose more appropriate responses to suicide statements, and had more rejecting attitudes of suicide compared to a control group (109). An important point to make concerning parent education is that research suggests that an essential aspect of any prevention strategy and one that is often overlooked is restricting access to potentially lethal weapons (3, 7, 20, 24, 25, 28, 40, 49). Restricting access to means of suicide, especially firearms, has been shown to be an effective method for decreasing the likelihood of adolescent suicide (7, 15, 22, 23, 41). Despite evidence from numerous studies that suggest that restriction of access to lethal means is an effective prevention component for suicide, as well as interpersonal violence among youth, when the Department of Health and Human Services reviewed suicide prevention programs in the United States, there were none that included a component for addressing restricting access to means for suicide (28). Means restriction could possibly be the most under-appreciated method for preventing suicide.

If a school staff member suspects that a child is at high risk for self harm or suicidal behavior, the school mental health professional and the student's parents or guardians should be notified immediately (105, 106, 107). If there is disagreement between school staff and the parents about the child's risk for suicide or self-injury, the school should confer with administration and legal counsel in order to make sure that best practices are implemented when navigating legal and ethical considerations (107).

Student Curriculum Addressing Suicide

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

Suicide Prevention Guidelines continued

Several studies have found that curriculum approaches may have no effect on students or may be potentially dangerous for certain students (51– 53). These studies found that certain students showed less desirable attitudes about suicide after class, were less likely to seek help, were less likely to refer a friend or recommend the class to other students, and were more likely after the class to view suicide as a reasonable response to intense stress (52, 53). Although these results are alarming, some important comments must be made in reference to these studies. First, the studies were conducted by the same researchers. Second, the authors stated that their curriculum approach focused on destigmatizing suicide, which is most commonly done by expressing to adolescents that suicide is commonly a reaction to extreme stress (53, 54). Research has shown, and the authors of these previously mentioned studies also acknowledge, that curriculum which presents suicide as a reaction to the common stressors of adolescence is not only ineffective, but may be harmful because it normalizes the behavior and reduces protective taboos, thereby making suicide more acceptable (7, 20, 23, 55, 56). Third, these studies primarily used one-time curriculum approaches: the classes were given only one time and lasted anywhere from 2–4 hours. Research has suggested that such single-session approaches not be used and could be potentially harmful to students (3, 23, 57). Fourth, these results were found primarily in isolated groups, such as students who had previously attempted, who as a group we would expect to express such negative reactions. These results were further restricted to males (primarily black males). For a more critical review of some of the problems associated with these studies please see Tierney and Lang (99).

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

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

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

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

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

Schools that wish to use suicide curriculum as a preventive method should utilize a method that has been shown to be effective and should utilize this approach, not in isolation, but in conjunction with other preventative strategies such as gatekeeper training, screening, establishing community links, and skills training. Schools, however, should not avoid using this approach due to a fear that talking about suicide and

teaching students about suicide will only provide students with ideas and methods for suicidal behaviors, because this is simply not true (Please refer to *Issue Brief 1: Information Dissemination*, and for the True and False Myth Test for more information).

Although there are numerous suicide education programs that have been used and used effectively, this guide will provide only five: Washington's Youth Suicide Prevention Program (YSPP), Safe: Teen (Suicide Awareness for Everyone) (formerly known as the Adolescent Suicide Awareness Program [ASAP]), (22) Lifelines (2, 30, 120), Miami, Florida (35), Adolescent Suicide Awareness Program (ASAP), and Reconnecting Youth (64).

Teaching Adaptive Skills to Students

A safe school is one that helps students develop appropriate problem-solving and conflict resolution strategies. It is critical that suicide prevention curriculum focus on helping students develop proper social, coping, and help-seeking skills, as well as problem-solving strategies, because research has shown that students who are potentially at risk for suicidal thoughts and behaviors have deficits in these areas (67, 68). Research has found that when students are taught such skills it may provide a sort of protective factor against suicidal behavior (22). Evaluation studies that have examined the effectiveness of skills training programs seem to indicate reductions in deaths by suicide and attempted suicide (9) and improvements in attitudes and emotions (62, 69). Empirical evaluations of programs that have focused on skills training strategies have also found an increase or enhancement of factors that protect adolescents from suicide while reducing the risk factors for suicide in these adolescents (64, 70-72).

Helping youth develop healthy adaptive skills is an important step in preventing and mitigating the effects of bullying as well. Approximately 20 percent of adolescents report that they had been bullied, had bullied others, or both, within the previous two months (39). Research has shown that students who feel victimized by other students, whether face-to-face or over the Internet or telephone, have an elevated risk of suicidal ideations and behaviors (45, 111, 112, 114).

Pro-social behavioral skills training should focus on problem solving, coping, and conflict resolution strategies (48). Students should be taught about how to interact with peers and adults, particularly about how to solve interpersonal conflicts in a nonviolent fashion (73). Additionally, staff and teacher training should contain specific bullying prevention and cultural competence components (74). These training programs have also been shown to reduce depression, hopelessness, substance abuse, attempted suicides, and death by suicide in adolescents (9, 22, 67).

Strengthening social skills has also been found to have a positive effect on cognitive development and learning in adolescents (74). Suicide prevention programs that attempt to teach problem solving skills, coping skills, social skills, and help-seeking skills may not only potentially prevent suicidal behaviors from occurring, but may also help prevent unintentional injuries and violence in schools (75-80). These skills are necessary, not just to prevent adverse events in adolescents, but also to promote the development of a well-balanced and productive adult. These skills can be taught by focusing on social skills and problem-solving skills directly through lessons or indirectly by incorporating these skills into existing classes such as a health class, driver's education class, physical education class, or reading class (73).

Programs that have utilized social skills training include the Resolving Conflict Creatively Program (RCCP) (121), which is one of the longest and largest-running programs for conflict resolution in the country, and the Promoting Alternative Thinking Strategies (PATH) curriculum (122). Both of these programs are evidence-based programs and have been found to have a positive impact on students, however, these are only two of the many that are available for use in schools. Collaborative for Academic, Social, and Emotional Learning (CASEL) is an organization that has found a positive effect on decision-making abilities and coping skills through education to improve social and emotional competence. For more information about this program please refer to www.casel.org. Although The Guide does provide examples of programs that schools may wish to use as a reference for their own program, The Guide does not endorse any one program over another. A school should adopt a problem-solving program that fits their school culture and their resource availability.

Suicide Prevention Guidelines continued

Peer Support Groups

Research suggests that students who are potentially at risk for suicidal behaviors are more likely to confide in and feel comfortable with peers rather than adults (20, 24, 50, 65, 66). Some suggest that not only should the school train students to recognize potentially suicidal peers, but should also provide an opportunity for vulnerable students to meet with other students in a comfortable group climate (12, 28, 49, 81). The rationale behind these support groups is that they help youths at risk develop peer relationships and more appropriate coping skills, thereby reducing feelings of isolation, antisocial behavior, substance abuse, and other early risk factors while enhancing important protective factors (49, 82). Research has found results that suggest that these programs can increase a student's knowledge about suicide and increase the likelihood that students at risk will get help from school counselors (83, 84). Although research does suggest that these programs can be effective at preventing suicide, schools may wish to use these programs in conjunction with screening programs in order to identify students at risk. They should not be used as a substitute for professional counseling or therapy (12, 28, 82).

Screening

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

Screening tools typically consist of asking students directly about whether they are experiencing symptoms associated with depression, currently or previously had suicidal ideations or behaviors, and whether they possess risk factors for suicide (54). Research demonstrates that asking about suicide will not plant the idea (123).

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

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

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

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

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

Suicide Prevention Guidelines continued

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

Five Examples of Widely Used Screening Tools:

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

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

Postvention (Strategies for Responding to a Suicidal Crisis)

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

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

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

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

Crisis Centers and Hotlines

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

1. Reach an important and usually under served population (28).
2. Help those students that use them (94).
3. Have been associated with decreases in suicide rates among white females under 25, the most frequent users of hotlines (49).
4. Are endorsed by youth as a more acceptable resource than mental health centers (50).

5. Can serve as "drop in" centers, providing immediate intervention as well as acting as referral agents to mental health services in the community (25).

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

Additionally, emerging technologies such as email, Skype, social networks, and text messaging are sites where public health needs are beginning to be met, including suicide prevention. With over 75% of adolescents using text messaging as a main method of communication (115), several states are implementing text services into existing suicide and crisis hotlines (116). While there is currently little research on the effectiveness of text-based suicide prevention hotlines, the use of texting has been shown to be successful with smoking cessation and weight loss (117, 118).

School Climate

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

Fostering a feeling of connectedness between the students and the school, providing an opportunity for students to become involved in school activities, and ensuring an overall safe environment for students are just some of the essential components of a safe and positive school climate, which has the potential to have a dramatic impact on adolescent suicide (10, 11, 14, 62, 73, 81, 97, 98). Some ways that school staff can help students become and remain connected to the school is to allow them to play important roles in the school. For example, they could be given roles such as office helpers, classroom helpers, hallway monitors, school council members, or play a primary role in any number of student school committees such as a safe school planning committee (10, 14). Students should also be encouraged to contribute to the creation or revision of their school's code of conduct, as well as policies regarding the reporting of bullying (113). All students should be able to be involved in these activities, not just those with the best grades or who participate in other school activities. Research suggest that those students who do not get the best grades or other achievements should be actively involved in these activities because they may be the most at-risk for suicidal or violent behavior and their involvement with the school may make them feel more connected, which has been found to be an important protective factor for suicidal behaviors and ideations (11, 14).

It is crucial that both students and school personnel feel safe while on the school campus. Schools should set high expectations on all staff and students to behave respectfully and kindly to other and teachers should create classroom environments where students feel respected, supported, and feel comfortable approaching an adult when confronted with problems (11, 14, 48). Importantly, bullying among students should be taken very seriously, as research has shown that students who feel victimized by other students or staff have an elevated risk of suicidal ideations and behaviors (46, 47, 110).

When choosing curriculum regarding school safety and pro-social skills, ensure that the program is based in research and is consistent with national and state standards for health education (11). Utilize a variety of teaching techniques, such as interactive learning and student involvement when teaching about violence prevention, and be sure to include all students in the curriculum (as opposed to just "troubled youth") (11). Examples of school-based safety curricula include Resolving Conflict Creatively Program (RCCP) and Promoting Alternative Thinking Strategies (PATH) (121, 122).

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

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

Suicide Prevention Guideline TIPS

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

References

Suicide Prevention Guidelines

1. Centers for Disease Control and Prevention: Web-based Injury and Statistics Query and Reporting System. (2012). *Leading causes of death reports.* Retrieved from http://webappa.cdc.gov/sasweb/ncipc/leadcaus10_us.html
2. King, C.A. (1997). Suicidal behavior in adolescence. In R.W. Maris, M.M. Silverman, & S.S. Canetto (Eds.), *Review of Suicidology* (pp. 61-95). New York, NY: Guilford Press.
3. Kalafat, J. (2003). School approaches to youth suicide prevention. *American Behavioral Scientist, 46*(9), 1211–1223.
4. Malley, P.B., Kush, F., & Bogo, R.J. (1994). School-based adolescent suicide prevention and intervention programs: A survey. *School Counselor, 42,* 130–136.
5. Portner, J. (1994). Florida suit blames school officials in pupil's suicide. *Education Week,* (April 20).
6. Slenkovich, J. (1986). School districts can be sued for inadequate suicide intervention programs. *The School's Advocate,* June, 1–3.
7. Miller, D.N., & Dupaul, G.J. (1996). School-based prevention of adolescent suicide: Issues, obstacles and recommendations for practice. *Journal of Emotional and Behavioral Disorders, 4*(4), 221–230.
8. Davidson, L., & Marshall, M. (2003). *School-based suicide prevention: A guide for the students, families, and communities they serve.* American Association of Suicidology: The Task Force for Child Survival and Development.
9. Zenere, F.J., & Lazarus, P. J. (2009). The Sustained Reduction of Youth Suicidal Behavior in an Urban, Multicultural School District. *School Psychology Review, 38*(2), 189-199.
10. The Maine Youth Suicide Prevention Program. (2009). *Youth suicide prevention intervention and postvention guidelines: A resource for school personnel.* Maine Children's Cabinet. Retrieved from http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf
11. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). (2001). School health guidelines to prevent unintentional injuries and violence. *Morbidity and Mortality Weekly Report, 50,* RR-22.
12. Gardiner, H., & Gaida, B. (2002) *Suicide prevention services: Literature review final report.* Alberta Mental Health Board, Research and Evaluation Unit. Calgary, AB.
13. King, K. (1999). High school suicide postvention: Recommendations for an effective program. *American Journal of Health Studies, 15*(4), 217–222).
14. King, K. (2001). Developing a comprehensive school suicide prevention program. *The Journal of School Health, 71*(4), 132–137.
15. Kalafat, J., & Ryerson, D.M. (1999). The implementation and institutionalization of a school-based youth suicide prevention program. *The Journal of Primary Prevention, 19*(3), 157–175.
16. Kalafat, J. (1997). Prevention of youth suicide. In R.P. Weissberg, T.P. Gullotta, R.L. Hampton, B.A., Ryan, & G.R. Adams (Eds.), *Enhancing children's wellness* (pp. 175–213). Thousand Oaks, CA: Sage.
17. Hayden, D.C., & Lauer, P. (2000). Prevalence of suicide programs in schools and roadblocks to implementation. *Suicide and Life-Threatening Behavior, 30*(3), 239–251.
18. Tierney, R., Ramsay, R., Tanney, B., & Lang, W. (1990). Comprehensive school suicide prevention programs, In A. Leenaars & S. Wenckstern (Eds.), *Suicide prevention in schools* (pp. 83-98). New York: Hemisphere.
19. Minnesota Department of Health, Family Health Division (2000). *Report to the Minnesota Legislature: Suicide prevention plan.* St. Paul, MN.
20. Mazza, J.J. (1997). School-based suicide prevention programs: Are they effective? *The School Psychology Review, 26*(3), 382–396.
21. Berman, A.L., & Jobes, D.A. (1995). Suicide prevention in adolescents (ages 12-18). *Suicide and Life-Threatening Behavior, 25,* 143–154.
22. Gould, M., Greenberg, T., Velting, D., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(4), 386–405.
23. Garland, A.F., & Zigler, E. (1993). Adolescent suicide prevention: Current research and social policy implications. *American Psychologist, 48*(2), 169–182.
24. Parental Division of the American Association of Suicidology. (1999). *Guidelines for school-based suicide prevention programs.* Retrieved from www.suicidology.org/associations/ 1045/files/School%20guidelines.pdf
25. O'Carroll, P.W., Potter, L.B., & Mercy, J.A. (1994). Programs for the prevention of suicide among adolescents and young adults. *Morbidity and Mortality Weekly Report, 43* (9 RR-6); 1–7. Atlanta: US Department of Health and Human Services, Public Health Service, CDC.

References continued

Suicide Prevention Guidelines

26. Kalafat, J., & Brown, C.H. (2001). *Suicide prevention and intervention: Summary of a workshop.* The National Academy of Sciences, Retrieved from www.nap.edu/openbook/0309076242/html/4.html
27. Tierney, R.J. (1994). Suicide intervention training evaluation: A preliminary report. *Crisis, 15*(2), 69–76.
28. Joiner, T., Kalafat, J., Draper, J., Stokes, H., Knudson, M. … McKeon, R. (2007). Establishing standards for the assessment of suicide risk among callers to the National Suicide Prevention Lifeline. *Suicide and Life-threatening Behavior, 37*(3), 353-366.
29. Goldsmith, S.K. (2001). *Suicide prevention and intervention: Summary of a workshop.* Board of Neuroscience and Behavioral Health, Institute of Medicine. Washington, DC: National Academy Press.
30. King, K.A., Price, J.H., Telljohann, S.K., & Whal, J. (1999). High school health teachers' knowledge of adolescent suicide. *American Journal of Health Studies, 15*(3), 156–163.
31. King, K.A., Price, J.H., Telljouhann, S.K., & Wahl, J. (1999). High school health teachers' perceived self-efficacy in identifying students at risk for suicide. *Journal of School Health, 69*(5), 202–207.
32. Leane, W., & Shute, R. (1998). Youth suicide: The knowledge and attitudes of Australian teachers and clergy. *Suicide and Life-Threatening Behavior, 28,* 165-173.
33. Mackesy-Amiti, M.E., Fendrich, M., Libby, S., Goldenberg, D., & Grossman, J. (1996). Assessment of knowledge gains in proactive training for postvention. *Suicide and Life-Threatening Behavior, 26,* 161–174.
34. Shaffer, D., Garland, A., & Whittle, R. (1988). An evaluation of three youth suicide prevention programs in New Jersey. *Adolescent Suicide Prevention Project. Final Project Report,* Trenton, NJ: New Jersey Department of Human services: Governor's Advisory Council on Youth Suicide Prevention.
35. Miller, D.N., Eckert, T.L., Dupaul, G.J., & White, G.P. (1999). Adolescent suicide prevention: Acceptability of school-based programs among secondary school principals. *Suicide and Life-Threatening Behavior, 29,* 72–85.
36. Institute of Medicine. (2002). *Reducing suicide: A national imperative.* Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide, Board of Neuroscience and Behavioral Health: Washington, DC: The National Academies Press.
37. Carlyon, P., Carlyon, W., & McCarthy, A.R. (1998). Family and community involvement in school health. In E. Marx, S.F. Wooley, & D. Northrop (Eds.), *Health is academic: A guide to coordinated school health programs* (pp. 67-95). New York, NY: Teachers College Press.
38. Marx, E., & Northrop, D. (1995). *Educating for health: A guide for implementing a comprehensive approach to school health education.* Newton, MA: Education Development Center.
39. Ybarra, M.L., Diener-West, M., & Leaf, P.J. (2007). Examining the overlap in Internet harassment and school bullying: Implications for school intervention. *Journal of Adolescent Health, 41*(6 Suppl 1), S42-50.
40. Poland, S. (1995). Suicide intervention. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology-II* (pp. 259-274). Washington, DC: National Association of School Psychologists.
41. Berman, A.L., & Jobes, D.A. (1991). *Adolescent suicide: Assessment and intervention.* Washington, DC: American Psychological Association.
42. Ross, J.G., Luepker, R.V., Nelson, G.D., Saavedra, P., & Hubbard, B.M. (1991). Teenage health teaching modules: Impact of teacher training on implementation and student outcomes. *Journal of School Health, 61,* 31–34.
43. Smith, D.W., McCormick, L.K., Steckler, A.B., & McLeroy, K.R. (1993). Teachers' use of health curricula: Implementation of Growing Healthy, Project SMART, and the Teenage Health Teaching Modules. *Journal of School Health, 63,* 349–354.
44. Burak, L.J. (1994). Examination and prediction of elementary school teachers' intentions to teach HIV/AIDS education. *Aids Education and Prevention, 6,* 310-321.
45. Klomek, A.B., Marrocco, F., Kleinman, M., Schonfeld, I.S., & Gould, M.S. (2007). Bullying, depression, and suicidality in adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(1), 40-49.
46. Klomek, A.B., Sourander, A., Kumpulainen, K., Piha, J., Tamminem, Moilen, I, . . . Gould, M.S. (2008). Childhood bullying as a risk for later depression and suicidal ideation among Finnish males. *Journal of Affective Disorders, 109,* 47-55.
47. Arsenault, L., Walsh, E., Trzesniewski, K., Newcombe, R., Caspi, A., & Moffitt, T.E. (2006). Bullying victimization uniquely contributes to adjustment problems in young children: A nationally representative cohort study. *Pediatrics, 118*(1), 130-138.

References continued

Suicide Prevention Guidelines

48. Feinberg, T. (2003). Bullying prevention and intervention. *Principal Leadership, 36*(1), 4-5.
49. Oregon Department of Human Services. (2000). *The Oregon plan for youth suicide prevention.* Retrieved from http://www.ohd.hr.state.or.us/ipe/2000plan/intro.cfm
50. Kalafat, J., & Elias, M. (1994). An evaluation of a school-based suicide awareness intervention. *Suicide and Life-Threatening Behavior, 24,* 224–233.
51. 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. *Journal of the American Academy of Child and Adolescent Psychiatry, 30,* 811–815.
52. Shaffer, D., Vieland, V., Garland, A., Rojas, M., Underwood, M., & Busner, C. (1990). Adolescent suicide attempters: Response to suicide-prevention programs. *Journal of American Medical Association, 264*(24), 3151–3155.
53. Shaffer, D., Garland, A., Vieland, V., Underwood, M., & Busner, C. (1991). The impact of curriculum-based suicide prevention programs for teenagers. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*(4), 588–596.
54. Shaffer, D., & Craft, L. (1999). Methods of adolescent suicide prevention. *Journal of Clinical Psychiatry, 60*(Supp2), 70–74.
55. Ciffone, J. (1993). Suicide prevention: A classroom presentation to adolescents. *Social Work, 38,*197–203.
56. 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,* 675– 687.
57. Silverman, M.M., & Felner, R.D. (1995). Suicide prevention programs: Issues of design, implementation, feasibility and developmental appropriateness. *Suicide and Life-Threatening Behavior, 25*(1), 92–104.
58. Conwell, Y., Duberstein, P.R., Cox, C., Herrmann, J.H., Forbes, N.T., & Caine, E.D. (1996). Relationships of age and axis I diagnoses in victims of completed suicide: A psychological autopsy study. *American Journal of Psychiatry, 153*(8), 1001–1008.
59. Harris, E.C., & Barraclough, B. (1997). Suicide as an outcome for mental disorders: A metaanalysis. *British Journal of Psychiatry, 170,* 205–228.
60. Sandoval, J., & Brock, S.E. (1996). The school psychologist's role in suicide prevention. *School Psychology Quarterly, 11,* 169–185.
61. Kalafat, J., & Gagliano, C. (1996). The use of simulations to assess the impact of an adolescent suicide response curriculum. *Suicide and Life-Threatening Behavior, 26,* 359–364.
62. 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*(2), 120–129.
63. Silbert, K.L., & Berry, G.L. (1991). Psychological effects of a suicide prevention unit on adolescents' levels of stress, anxiety, and hopelessness: Implications for counseling psychologists. *Counseling Psychology 4,* 45-58.
64. Eggert, L. L., Thompson, E.A., Herting, J.R., & Nicholas, L.J. (1995). Reducing suicidal potential among high-risk: Tests of school-based prevention program. *Suicide and Life-Threatening Behavior, 25*(2), 276–296.
65. Hazell, P., & King, R. (1996). Arguments for and against teaching suicide prevention in schools. *Australian and New Zealand Journal of Psychiatry 30,* 633–642.
66. Gallup, G. (1991). *The Gallup survey on teenage suicide.* Princeton, NJ: George H. Gallup International Institute.
67. Cole, D.A. (1989). Psychopathology of adolescent suicide: Hopelessness, coping beliefs, and depression. *Journal of Abnormal Psychology, 98,* 248–255.
68. Rotheram-Borus, M.J., Piacentini, J., Van Rossem, R, Graae, F., Cantwell, C, . . . Feldman, J. (1999). Treatment adherence among Latino female adolescent suicide attempters. *Suicide and Life-Threatening Behavior, 29,* 319–331.
69. Klingman, A., & Hochdorf, Z. (1993). Coping with distress and self-harm: The impact of a primary prevention program among adolescents. *Journal of Adolescent Psychiatry, 16,* 121–140.
70. Thompson, E.A., Eggert, L.L., Randell, B.P., & Pike, K.C. (2001). Evaluation of indicated suicide risk prevention approaches for potential high school dropouts. *American Journal of Public Health, 91*, 742–752.
71. Randell, B.P., Eggert, L.L., & Pike, K.C. (2001). Immediate post intervention effects of two brief youth suicide prevention interventions. *Suicide and Life-Threatening Behavior, 31,* 41–61.

References continued

Suicide Prevention Guidelines

72. World Health Organization. (2000). *Preventing suicide: A resource for teacher's and other school staff.* Mental and Behavioral Disorders, Department of Mental Health, Geneva.
73. Dwyer, K., & Osher, D. (2000). *Safeguarding our children: An action guide.* Washington, DC: US Department of Education and Justice, American Institutes for Research.
74. Slavin, R. (1990). *Cooperative learning: Theory, research, and practice.* Englewood Cliffs, NJ: Prentice Hall.
75. Bosworth, K. (2000). *Protective schools: Linking drug abuse prevention with student success.* Tucson, AZ: The University of Arizona, College of Education, Smith Initiatives for Prevention and Education.
76. Tolan, P., & Guerra, N. (1994). *What works in reducing adolescent violence: An empirical review of the field.* Boulder, CO: Center for the Study and Prevention of Violence.
77. Dusenbury, L., Falco, M. Lake, A., Brannigan, R., & Bosworth, K. (1997). Nine critical elements of promising violence prevention programs. *Journal of School Health, 67,* 409–414.
78. Weiler, R.M., & Dorman, S.M. (1995). The role of school health instruction in prevention interpersonal violence. *Educational Psychology Review, 7,* 69–91.
79. Prinz, R.J., Blechman, E.A., & Dumas, J.E. (1994). An evaluation of peer coping-skills training for childhood aggression. *Journal of Clinical and Child Psychology, 23,* 193–203.
80. Johnson, D.W., Johnson, R., Dudley, B., Mitchell, J., & Fredrickson, J. (1997). The impact of conflict resolution training on middle school students. *Journal of Social Psychology, 137,* 11–21.
81. California Department of Education, Safe schools and violence prevention center. Office of the Attorney General. (2002 Ed.). *Safe schools: A planning guide for action.* Sacramento, CA.
82. White, J., & Jodoin, N. (1998). *Before-the-fact interventions: A manual of best practices in youth suicide prevention.* Vancouver: University of British Columbia.
83. U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (1992). *Youth suicide prevention programs: A resource guide.* Retrieved from http://aepo-xdv-www.epo.cdc.gov/wonder/prevguide
84. McEvoy, M., & LeClaire, D. (1993). *The PAL (Peer Assistant Leadership) program: A comprehensive model for suicide prevention.* Workshop presented at the Conference of the National Organization of Student Assistance Programs and Partners. Chicago, IL.
85. Reynolds, W.M. (1991). A school-based procedure for the identification of adolescents at risk for suicidal behaviors. *Family and Community Health, 14,* 64–75.
86. Thompson, E.A., & Eggert, L.L. (1999). Using the suicide risk screen to identify suicidal adolescents among potential high school dropouts. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 1506-1514.
87. Joiner, T.E., Pfaff, J.J., & Acres, J.G. (2002). A brief screening tool for suicidal symptoms in adolescents and young adults in general health settings: Reliability and validity data from the Australian National General Practice Youth Suicide Prevention Project. *Behavioral Research and Therapy, 40,* 471–781.
88. Reynolds, W.M., & Mazza, J.J. (1994). Suicide and suicidal behaviors in children and adolescents. In W.M. Reynolds & H.F. Johnston (Eds.), *Handbook of depression in children and adolescents* (pp. 525–580). New York: Plenum.
89. Hayden, D.C., & Lizasuain, S.L. (1998 April). *Screening for suicide: An evaluation.* Paper presented at the American Association of Suicidology, Bethesda, MD.
90. Goldston, D.B. (2000). *Assessment of suicidal behaviors and risk among children and adolescents.* Wake Forest University School of Medicine.
91. National Registry for Evidence-based Programs and Practices [NREPP]. (2007). *Teen Screen.* Retrieved from http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=150
92. Screening for Mental Health. (2010). *Signs of Suicide* (SOS). Wellesley, MA. Retrieved from http://www.mentalhealthscreening.org/
93. Leenaars, A.A., & Wenckstern, S. (1990). *Suicide prevention in the schools.* New York, NY: Hemisphere Publishing Corporation.
94. Gould, M.S., & Kramer, R.A. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior, 31,* 6–31.
95. Marttunen, M.J., Aro, H.M., & Lonnqvist, J.K. (1993). Precipitant stressors in adolescent suicide. *Journal of the American Academy of Child and Adolescent Psychiatry, 32,* 1178–1183.

References continued

Suicide Prevention Guidelines

96. Lester, D. (1997). The effectiveness of suicide prevention centers: A review. *Suicide and Life-Threatening Behavior, 27,* 304–310.
97. U.S. Public Health Service. (1999). *The Surgeon General's Call to Action to Prevent Suicide.* Washington, DC.
98. Borowsky, I.W., Ireland, M., & Resnick, M.D. (2001). Adolescent suicide attempts: Risks and protectors. *Pediatrics, 107*(3), 485–493.
99. Tierney, R., & Lang, W. (1995). Cutting suicide prevention programs in schools. In S. Wenckstern, A. Leenaars, & R. Tierney (Eds.), *Suicide prevention in Canadian schools: A resource* (pp. 73-74). Calgary, Canada: Canadian Association for Suicide Prevention.
100. Morgan, H.G., Jones, E.M., & Owen, J.H. (1993). Secondary prevention of non-fatal deliberate self harm. *British Journal of Psychiatry, 163,* 111–112.
101. Stuart, C., Waalen, J.K., & Haelstromm, E. (2003). Many helping hearts: An evaluation of peer gatekeeper training in suicide risk assessment. *Death studies, 27*(4), 321–333.
102. Rhodes, R., & Paez, D. (1998). Immigrant parents and the schools: A handout for teachers. *National Association of School Psychologist Toolkit: Practical resources at your fingertips.* Retrieved from http://www.nasponline.org/communications/spawareness/Immigrant%20Parents.pdf
103. Epstein, J.L., & Sheldon, S.B. (2006). Moving forward: Ideas for research on school, family, and community partnerships. In C.F. Conrad & R. Serlin (Eds.), *SAGE Handbook for research in education: Engaging ideas and enriching inquiry* (pp. 117-138). Thousand Oaks, CA: Sage Publishing.
104. The National Association of State Mental Health Directors & The Policymaker Partnership for Implementing IDEA at The National Association of State Directors of Special Education. (2001). *Mental Health, Schools and Families Working Together for All Children and Youth.* U.S. Department of Education, Office of Special Education Programs.
105. Mental Health America. (2011). *Promoting Children's Mental Health.* Retrieved from http://www.nmha.org/go/promoting-childrens-mental-health
106. Suicide Prevention Resource Center. (2010). *Customized Information: Teachers.* Retrieved from http://www.sprc.org/featured_resources/customized/pdf/teachers.pdf
107. Capuzzi, D. (2002). Legal and ethical challenges in counseling suicidal students. *Professional School Counseling, 6*(1), 36-58.
108. Kumper, K.L., & Collings, S.J. (2004). Effectiveness of family focused interventions for school-based preventions. In K. E. Robinson (Ed.), *Advances in school-based mental health interventions: Best practices and program models.* Kingston, New Jersey: Civic Research Institute, Inc.
109. Maine, S., Shute, R., & Martin, G. (2001). Educating parents about youth suicide: Knowledge, response to suicidal statements, attitudes, and intention to help. *Suicide and Life-Threatening Behavior, 31*(3), 320-332.
110. Lewinsohn, P., Rohde, P., & Seeley, J. (1993). Psychosocial characteristics of adolescents with a history of suicide attempt. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*(1), 60–68.
111. Bontempo, D.E., & D'Augelli, A.R. (2002). Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. *Journal of Adolescent Health, 30*(5), 364–374.
112. Klomek, A.B., Sourander, A., Neimela, S., Kumpulainen, K., Piha, J., Tamminen, T, . . . Gould, M.S. (2009). Childhood bullying behaviors as a risk for suicide attempts and completed suicides: A population-based birth cohort study. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(3), 254-261.
113. Storey, K., Slaby, R., Adler, M., Minotti, J., & Katz, R. (2007). *Eyes on bullying...what can you do?: A toolkit to prevent bullying in children's lives.* Education Development Center, Inc. Retrieved from http://www.eyesonbullying.org/pdfs/toolkit.pdf

References continued

Suicide Prevention Guidelines

114. Wang, J., Iannotti, R.J., & Nansel, T.R. (2009). School bullying among adolescents in the United States: Physical, verbal, relational, and cyber. *Journal of Adolescent Health, 45*(4), 368-375.

115. Ordonez, J.W., & Cheng, M. (2010). Mental health meets new media: A powerful new portal for increased access to mental health services. In S. Estrine & H.R. Hettenbach (Eds.), *Service Delivery for Vulnerable Populations: New Direction in Behavioral Health*. New York: Springer Publishing.

116. Luxton, D.D., June, J.D., & Kinn, J.T. (2011). Technology-based suicide prevention: Current applications and future directions. *Telemedicine and e-Health, 17*(1), 50-54.

117. Free, C., Knight, R., Robertson, S., Whittaker, R., Edwards, P, … Roberts, I. (2011). Smoking cessation support delivered via mobile phone text messaging (txt2stop): A single-blind, randomised trial. *The Lancet, 378*(9785), 49-55.

118. Patrick, K., Raab, F., Adams, M.A., Dillon, L., Zabinski, M. . . Norman, G.,J. (2009). A text-message-based intervention for weight loss: A randomized control trial. *Journal of Medical Internet Research, 11*(1), e1.

120. Underwood, M., Kalafat, J., & the Maine Youth Suicide Prevention Program, lead by the Maine CDC. (2009). *Lifelines: A suicide prevention program*. Center City, Minnesota: Hazelden Foundation.

121. Rand Corporation. (2006). *Promising Practices Network on children, families, and communities, Resolving Conflict Creatively Program (RCCP)*. Retrieved from http://www.promisingpractices.net/program.asp?programid=119

122. Substance Abuse and Mental Health Services Administration. (2011). *National Registry of Evidence-based Programs and Practices, Promoting Alternative Thinking Strategies (PATHS)*. Retrieved from http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=20

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

Notes

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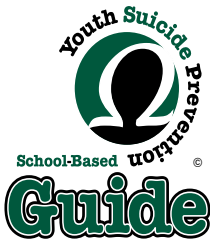

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Checklist 5

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Checklist 5

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

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

— continued next page

Checklist 5 continued

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

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Intervention Strategies

Establishing a Community Response

Too often the burden of responsibility falls solely upon the shoulders of the school when responding to a suicide crisis situation. While it is critical for the school to have procedures in place for responding to a crisis and for educating staff on how to respond effectively to a suicidal crisis, schools may find it extremely helpful and more effective to share the responsibility for successful and comprehensive intervention with the community (5, 6, 7, 8). The organized efforts of a community are the foundation of a public health approach. Schools are an integral partner in a public health approach for any area focused on children and youth.

The public health model, a multi-pronged, population-oriented model built on known best practices, is widely regarded as the approach that is most likely to produce significant and sustained reductions in suicide. Applying the public health approach to suicide prevention requires five steps:

1. **Define the problem** – collecting information about the rates of suicide or cost of injuries helps to define the extent to which suicide is a burden to the community.
2. **Identify causes** – identifying and understanding the relationship between risk and protective factors and how some protective factors can mitigate against risk factors for suicide helps to design effective programs.
3. **Develop and test interventions** – rigorous scientific testing prior to large scale implementation, is important to ensure that interventions are safe, ethical and feasible.
4. **Implement interventions** – by selecting a broad mix of interventions, analyzing cost and effectiveness, and considering ways to integrate interventions into existing programs, more comprehensive programs can be developed.
5. **Evaluate effectiveness** – evaluation can help a community determine the best strategy for a specific population and if necessary, how it can be modified (18, 31).

A growing body of evidence supports the effectiveness of a public health approach to suicide prevention (17, 19, 23, 24, 25, 29). In addition, research indicates that effective suicide prevention programs may reduce the severity and/or frequency of specific risk factors for suicidal behavior and other mental health issues (3). Perhaps one of the best-known population-oriented approaches to reducing risk of suicide is the US Air Force Suicide Prevention Program. A key finding was that personnel exposed to the program experienced a 33% reduction of risk of dying by suicide compared with personnel prior to implementation. Knox et al. (2010) suggested that the "*enduring public health message from 12 years of this program [US*

Issue Brief 6a

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Air Force Suicide Prevention Program] is that suicide rates can be reduced, and that program success requires interventions to be consistently supported, maintained, and monitored for compliance" (p. 2462) (19).

In a study of the efficacy of 15 years of a public health oriented suicide prevention program (i.e., the Western Athabaskan Tribal Nation's Adolescent Suicide Prevention Program) findings indicated that while suicide deaths neither declined significantly nor increased, there was a 73% decrease in self-destructive acts (17).

An example of how one community came together in response to the tragedy of teen suicide and incorporated best practices into a comprehensive program is Project Safety Net (PSN), in Palo Alto, California (22). The PSN report provides a comprehensive plan that includes 22 best-known practices for community-based mental health and suicide prevention. In addition, PSN uses the Questions, Persuade, Refer (QPR) gatekeeper training (26) and endorses the 40 Developmental Assets model identifying external assets (such as family support, community values, and activities) and internal supports (such as social competency and positive identity) as integral to the healthy development of young people (27).

A comprehensive school-based suicide prevention program cannot function properly without outside support from the community and this is especially true when addressing intervention (9). Research has suggested that one of the most essential components, if not the central component, for responding to a student potentially at risk for suicide is to have established relations and links to agencies within the community, such as mental health agencies, crisis centers, law enforcement agencies, youth health service agencies, psychiatric facilities, primary care physicians, the clergy, or the community health department (1, 2, 4-8, 10-12). Relationships with organizations such those above, have the potential to lead to changes in behaviors that impact rates of suicide. For example, research indicates that restricted access to lethal means is associated with decline in suicide with that specific method, and in many cases also with overall suicide mortality (16, 32). In addition, studies tend to indicate that 1) many persons seem to have a preference for a given means which would limit the possibility for substitution towards another method, and 2) that a suicide crisis is very often short-lived which would limit the possibility of the individual putting off plans to later (30).

Another study examining method specific fatality rates for suicide among persons 15 years and older found that poisoning with drugs accounted for 74% acts of suicide but only 14% of fatalities, whereas firearms and hanging accounted for only 10 percent of acts but 67% of fatalities. Firearms were the most lethal means (91% resulted in death) (20). One component of a community response to findings such as these may include working with local law enforcement to implement Project ChildSafe, a nationwide program implemented in 2003, whose purpose is to promote safe firearms handling and storage practices among firearms owners through the distribution of key safety educational messages and free gun locking devices through local participating law enforcement agencies. Project ChildSafe is an expansion of National Shooting Sports Foundation's (NSSF) Project HomeSafe program that was created in 1999 to educate gun owners about their responsibilities to safely handle and properly store firearms in the home with the goal of preventing tragic accidents among children (21). A public health approach would include examining relevant data used in developing intervention strategies that address current trends. For example, in a CDC analysis of trends in suicide methods among 10 – 19 year old youth in the United States from 1992 - 2001, results indicated a substantial decline in suicides by firearm and an increase in suicides by suffocation (28).

As with all school initiatives, establishing relationships with local family and youth organizations should be a major component of the suicide prevention program. Family organizations can provide peer-to-peer support to other family members and youth and help to ensure that families and youth know about and have access to needed relevant services (15). In addition to helping create awareness about the national hotline number 1-800-273-TALK (8255) and national public awareness resources, family organizations can help to encourage survivors of suicide to participate

in prevention task forces, coalitions, focus groups, peer programs, and special community events. It is also important to be aware of other local and national resources that might be helpful to youth who are struggling but not yet at imminent risk. For example, the Trevor Project is the leading national organization that provides crisis and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth. The Trevor Project (866-488-7386/866-4-U-TREVOR) website at http//www.thetrevorproject.org includes a search engine to help youth, families, organizations, schools, and communities find local, regional and national resources.

Because many educators are not adequately trained, (nor do they have the time), to counsel students longer than would be necessary for an immediate crisis response, only by establishing positive relationships with community agencies in advance will schools be able to effectively respond to a student's suicide attempt or threat (13). Utilizing community agencies increases the people-power necessary to effectively respond to the immediate crisis as well as its long-term consequences (5). Once these critical links have been established, it is necessary that schools inform staff, as well as students, about the services that these community links provide. This will ensure that should a student experience suicidal thoughts, or should an educator come in contact with (or experience suicidal thoughts themselves) a potentially suicidal adolescent, each will have contact information that could provide critical intervention and potentially prevent a suicidal event from occurring. It is essential that educators in particular understand the importance of knowing local and national resources and making an appropriate and effective referral.

When Making a Student Referral for Services

Kalafat and Underwood (14) provide some suggestions when making a student referral for services. The Guide has summarized these suggestions.

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

References

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1. The Maine Youth Suicide Prevention Program. (2002). *Youth suicide prevention intervention and postvention guidelines: A resource for school personnel.* A program of Governor Angus S. King Jr. and the Maine Children's Cabinet. Retrieved from www.maine.gov/suicide/
2. Center for Mental Health in Schools at UCLA. (2000). *A resource aid packet on responding to a crisis at a school.* Los Angeles, CA: Author.
3. Mazza, J.J., & Reynolds, W.M. (2008). School-wide approaches to prevention of and intervention for depression and suicidal behaviors. In B. Doll & J.A. Cummings (Eds.), *Transforming school mental health services* (pp. 213 – 214), Thousand Oaks, CA: Corwin Press.
4. King, K. (1999). High school suicide postvention: Recommendations for an effective program. *American Journal of Health Studies, 15*(4), 217–222.
5. Underwood, M.M., & Dunne-Maxim, K. (1997). *Managing sudden traumatic loss in the schools: New Jersey adolescent suicide prevention project (revised edition)*. Piscataway, New Jersey: University of Medicine and Dentistry of New Jersey-University Behavioral Healthcare.
6. Grossman, J., Hirsch, J., Goldenberg, D., Libby, S., Fendrich, M., Mackesy-Amiti, M. E, . . . Chance, G. (1995). Strategies for school-based response to loss: Proactive training and postvention consultation. *Crisis, 16*(1), 18-26.
7. Hicks, B.B. (1990). *Youth suicide: A comprehensive manual for prevention and intervention.* Bloomington, IN: National Education Service.
8. King, K. (2001). Developing a comprehensive school suicide prevention program. *The Journal of School Health, 71*(4), 132–137.
9. McKee, P.W., Jones. R.W., & Barbe, R.H. (1993). *Suicide and the school: A practical guide to suicide prevention.* Horsham, PA: LRP Publications.
10. *The Oregon Plan for Youth Suicide Prevention*. (2000). Oregon Department of Human Services. Retrieved from http://www.ohd.hr.state.or.us/ipe/2000plan/intro.cfm
11. Institute of Medicine. (2002). *Reducing suicide: A national imperative. Committee on Pathophysiology and prevention of adolescent and adult suicide,* Board of Neuroscience and Behavioral Health: Washington, DC: The National Academies Press.
12. Statewide Suicide Prevention Council. (2003). *The Alaska Suicide Prevention Plan*. Retrieved from http://www.hss.state.ak.us/suicideprevention
13. Wenckstern, S., & Leenaars, A.A. (1991). Suicide postvention: A case illustration in a secondaryschool. In A.A. Leenaars & S.Wenckstern (Eds.), *Suicide prevention in schools.* New York, NY: Hemisphere Publishing Corp.
14. Kalafat, J., & Underwood, M. (1989). *Lifelines: A school-based adolescent suicide response program.* Dubuque, Iowa: Kendall & Hunt Publishing.
15. Lazear, K., & Anderson, R. (2008). *Examining the relationship between family-run organizations and non-family organization partners in systems of care.* (RTC study 6: Family organizations and systems of care series, 244-3). Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health. Retrieved from http://cfs.cbcs.usf.edu/publications/detail.cfm?id=214
16. Nordentoft, M. (2007). Prevention of suicide and attempted suicide in Denmark. Epidemiological studies of suicide and intervention studies in selected risk groups. *Danish Medical Bulletine, 54*(4), 306-69.
17. May, P.A., Serna, P., Hunt, L., & DeBruyn, M. (2005). Outcome evaluation of a public health approach to suicide prevention in an American Indian tribal nation. *American Journal of Public Health, 95*(7), 1238 – 1244.
18. Suicide Prevention Resource Center. (2011). *Suicide prevention: The public health approach.* Retrieved from http://www.sprc.org/library/phasp.pdf

References continued

Establishing a Community Response

19. Knox, K.L., Pflanz, S., Talcott, G.W., Campise, R.L., Lavigne, J.E., Bajorska, A,…Caine, E.D. (2010). The US Air Force Suicide Prevention Program: Implications for public health policy. *American Journal of Public Health,100*(12), 2457 – 2463.
20. Miller, M., Azrael, D., & Hemenway, D. (2004). The epidemiology of case fatality rates for suicide in the northeast. *Annals of Emergency Medicine, 43*(6), 723-30.
21. National Shooting Sports Foundation. (2011). *Project ChildSafe.* Retrieved from http://www.projectchildsafe.org/
22. City of Palo Alto. (2011). *Project SafetyNet.* Retrieved from http://www.psnpaloalto.com/
23. Litts, D.A., Moe, K., Roadman C.H., Janke, R., & Miller, J. (2000). Suicide prevention among active duty Air Force personnel-United States, 1990-1999. *Journal of the American Medical Association, 283*(2), 193-194.
24. Knox, K., Conwell Y., & Caine, E. (2004). If suicide is a public health problem, what are we doing to prevent it? *American Journal of Public Health, 94*(1), 37 – 44.
25. McGinnis, J.M. (1987). Suicide in America-moving up the public health agenda. *Suicide and Life-Threatening Behavior, 17*(1), 18-32.
26. *Questions, Persuade, Refer (QPR).* (2011). Retrieved from http://www2.sprc.org/bpr/question-persuade-refer-qpr-gatekeeper-training-suicide-prevention
27. Search Institute. (2011). *40 Developmental Assets.* Retrieved from http://www.search-institute.org/research/assets
28. Center for Disease Control and Prevention. (2004), *MMWR Weekly, 53*(22), 471-474.
29. Lewis, G., Hawton, K., & Jones, P. (1997). Strategies for preventing suicide. *British Journal of Psychiatry, 171*, 351 – 354.
30. Daigle, M.S. (2005). Suicide prevention through means restriction: Assessing the risk of substitution. A critical review and synthesis. *Accident Analysis and Prevention, 37*(4), 625 – 632.
31. Center for Mental Health Services; Office of the Surgeon General. (2001). *National Strategy for Suicide Prevention: goals and objectives for action.* Rockville, MD: US Public Health Service. Retrieved from http://store.samhsa.gov/shin/content//SMA01-3517/SMA01-3517.pdf
32. Hawton, K. (2007). Restricting access to methods of suicide: Rationale and evaluation of this approach to suicide prevention. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 28(Suppl 1)*, 4-9. doi:10.1027/0227-5910.28.S1.4

Notes

Establishing a Community Response

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Intervention Strategies

Crisis Intervention and Crisis Response Teams

When responding to a student death by suicide it is crucial that a school have a plan and policy implemented long before the death or crisis happens, including the creation and implantation of a multidisciplinary crisis response team (2, 7, 9). The team's responsibilities include anticipating the various needs and tasks of the school that occur during emergencies (7, 9). An effective suicide response plan will establish and detail the roles of a crisis intervention team (1, 4, 5-10, 14, 18). Members of the school crisis team should consist of approximately five to ten people, depending on the school's size, and include a diverse group of individuals within the school, such as the principal, guidance counselor, school psychologist, teacher, social worker, school nurse, and if available, a member of the school's information technology or computer lab staff (5, 7, 8, 20). A school may also consider including outside members or consultants, such as mental health professionals, law enforcement, and/or clergy (6, 7).

Although experiencing a suicide in school is often unexpected, sad, and confusing, schools cannot afford to risk not being able to respond in an organized and well thought out manner because of the possibility of suicide contagion (2, 7, 20). Contagion is when one suicide may contribute to another, for example through the influence of media reports or a memorial (20).

How a school proceeds with developing a crisis response team will vary based on resources, but research shows that it is critical that the team is highly valued by administration, and comprised of fully interested members (2). One person should be designated as the Team Leader or Coordinator, who will be in charge of planning trainings, calling emergency meetings when there is a crisis, and serves as the liaison to the school principal and superintendant (2, 20). A good crisis team leader will have support from the administration and should be given the authority to coordinate team member assignments, while keeping an open channel with school administrators (5).

Once this has been done, the crisis team should be trained how to effectively respond and intervene with a student potentially at risk of suicide (it may be necessary at this stage to utilize community agencies to provide such training). After training has been completed by all of the crisis team members, it is the responsibility of the team leader, to schedule regular team meetings, preferably once every two to three months (2). Team member assignments may include mobilizing the team when needed, controlling rumors, responding to the media, contacting community links, providing first aid if necessary, contacting parents of student experiencing suicidal crisis, scheduling response team meetings, and providing training to school staff and faculty (2, 5, 7).

Issue Brief 6b

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Crisis Intervention and Crisis Response Teams continued

In the event that a school experiences a crisis that overwhelm its resources or capacity to intervene, the school crisis team may consider calling on a district-level team to assist.

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

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

Team Support

In order for a crisis team to be effective, it must be supported by the administration and should be acknowledged as a highly valuable resource within the school (2). Without such support, a crisis team will fall to the wayside, thereby greatly reducing the chances that the school will be able to effectively intervene with a student at risk for suicide.

In order for the crisis teams to run effectively, they must be alerted that a suicide crisis is occurring. Given the amount of contact with students that teachers and faculty have, the alarm is likely to be sounded by a teacher or other faculty member, such as a coach. Teachers are in ideal positions for identifying and intervening with a student expressing suicidal threats or gestures (21). Despite this situation, most educators do not receive training on how to identify or how to intervene with a student potentially at risk for suicidal threats or behaviors.

This could be, in part, the reason that in a survey of teachers' confidence level for identifying an at risk student, only 9% of those surveyed stated that they felt confident about being able to recognize a student at risk for suicidal threats or behaviors (22). If educators do not feel confident recognizing at risk students, that they certainly will be at a loss for how to effectively intervene with a potentially suicidal student. Further, a different study showed that 40% of surveyed high school teachers were unaware of any suicide prevention or intervention resources available at their school, and almost 70% of respondents reported doing "nothing" when they wondered about the suicidality of a student (23). In order to maintain and implement an effective school-based prevention program, schools must train staff on how to identify a student potentially at risk for suicidal threats or gestures and staff must have some training on how to intervene once a student at risk has been recognized (1, 17, 23, 24). Training faculty, staff, and administrators to be able to identify students who are at risk for suicide, determine the level of risk, know where to refer a potentially at-risk student, how to contact these referral sources, and what school policies are in place that relate to suicidal crisis situations is a universally advocated method for preventing suicide in schools (1, 3, 4, 8 10-13, 15-17, 19, 23-25). It is widely recognized that training staff about the warning signs, risk factors, protective factors, and where to refer a student at risk is critical to prevent adolescent suicide. For more on risk factors and warning signs refer to *Issue Brief 3: Risk Factors.* For more on community partnerships refer to *Issue Brief 8, Family Partnerships*, and *Issue Brief 6a: Establishing a Community Response*.

Creating and implementing a multidisciplinary crisis response team increases a school's capacity to provide a comprehensive and strategic response at the critical time of need (1, 2, 7, 20). When established well before a crisis occurs, crisis team members can be properly trained on how to appropriately respond, and information can be disseminated to all school faculty and staff regarding suicide intervention (1, 2, 7, 20). With an organized and well-implemented crisis team in place, the traumatic effects of a suicide crisis in a school can be mitigated and the school can, ideally, return to normalcy.

References

Crisis Intervention and Crisis Response Teams

1. The Maine Youth Suicide Prevention Program. (2009). *Youth suicide prevention intervention and postvention guidelines: A resource for school personnel.* Retrieved from http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf
2. Center for Mental Health in Schools at UCLA. (2008). *Responding to a crisis at a school.* Los Angeles, CA: Author. Retrieved from http://smhp.psych.ucla.edu/pdfdocs/crisis/crisis.pdf
3. Mazza, J.J. (1997). School-based suicide prevention programs: Are they effective? *The School Psychology Review, 26*(3), 382–96.
4. King, K. (1999). High school suicide postvention: Recommendations for an effective program. *American Journal of Health Studies, 15*(4), 217–222.
5. Underwood, M.M., & Dunne-Maxim, K. (1997). *Managing sudden traumatic loss in the schools: New Jersey adolescent suicide prevention project (revised edition).* Piscataway, New Jersey: University of Medicine and Dentistry of New Jersey-University Behavioral Healthcare.
6. James, R.K., Logan, J., & Davis, S.A. (2011). Including school resource officers in school-based crisis intervention: Strengthening student support. *School Psychology International, 32*(2), 210-224.
7. Klicker, R.L. (2000). *A Student Dies, A School Mourns*. Philadelphia, PA: Taylor and Francis.
8. King, K. (2001). Developing a comprehensive school suicide prevention program. *The Journal of School Health, 71*(4), 132–137.
9. Horenstien, J. (2002). Provision of trauma services to school populations and faculty. In M.B. Williams & J.F. Sommer (Eds.), *Simple and complex post-traumatic stress disorder: Strategies for comprehensive treatment in clinical practice* (pp. 241-259). Binghamton, NY: The Haworth Press.
10. Oregon Department of Human Services. (2000). *The Oregon Plan for Youth Suicide Prevention*. Retrieved from http://public.health.oregon.gov/PreventionWellness/SafeLiving/SuicidePrevention/Documents/YSuicide.pdf
11. Berman, A.L., & Jobes, D.A. (1995). Suicide prevention in adolescents (ages 12–18). *Suicide and Life-Threatening Behavior, 25,* 143–154.
12. Gould, M., Greenberg, T., Velting, D., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(4), 386–405.
13. Garland, A.F., & Zigler, E. (1993). Adolescent suicide prevention: Current research and social policy implications. *American Psychologist, 48*(2), 169–182.
14. U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (1992). *Youth suicide prevention programs: A resource guide.* Retrieved from http://aepo-xdvwww. epo.cdc.gov/wonder/prevguide
15. Parental Division of the American Association of Suicidology. (1999). *Guidelines for school-based suicide prevention programs*. Retrieved from http://www.suicidology.org/associations/ 1045/files/School%20guidelines.pdf
16. O'Carroll, P.W., Potter, L.B., & Mercy, J.A. (1994). Programs for the prevention of suicide among adolescents and young adults. *Morbidity and Mortality Weekly Report, 43*(9) (RR-6); 1–7. Atlanta: US Department of Health and Human Services, Public Health Service, CDC.
17. Zenere, F.J., & Lazarus, P. J. (1997). The decline of youth suicidal behavior in an urban, multicultural public school system following the introduction of a suicide prevention and intervention program. *Suicide and Life-Threatening Behavior, 27*(4), 387–403.
18. Goldenberg, D., Grossman, J., Pokorny, S., & Mazur, C. (1996). *Creating a safe environment: Training gatekeepers.* Presentation at the 29th annual conference of the American Association of Suicidology, St. Louis, MO.
19. Kalafat, J., & Brown, C.H. (2001). *Suicide prevention and intervention: Summary of a workshop.* The National Academy of Sciences. Retrieved from www.nap.edu/openbook/0309076242/html/4.html
20. American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2011). *After a Suicide: A Toolkit for Schools.* Newton, MA: Education Development Center, Inc. Retrieved from http://www.sprc.org/library/AfteraSuicideToolkitforSchools.pdf
21. Malley, P.B., Kush, F., & Bogo, R.J. (1994). School-based adolescent suicide prevention and intervention programs: A survey. *School Counselor, 42,* 130–136.

References

Crisis Intervention and Crisis Response Teams

22. Mackesy-Amiti, M.E., Fendrich, M., Libby, S., Goldenberg, D., & Grossman, J. (1996). Assessment of knowledge gains in proactive training for postvention. *Suicide and Life- Threatening Behavior, 26,* 161–174.

23. Westefeld, D.W., Kettmann, J.D., Kenks, L., Lovmo, C., & Hey, C. (2007). High school suicide: Knowledge and opinions of teachers. *Journal of Loss and Trauma, 12*(1), 31-42.

24. Zenere, F.J., & Lazarus, P. J. (2009). The Sustained Reduction of Youth Suicidal Behavior in an Urban, Multicultural School District. *School Psychology Review, 38*(2), 189-199.

25. Kalafat, J. (2003). School approaches to youth suicide prevention. *American Behavioral Scientist, 46*(9), 1211–1223.

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Intervention Strategies

Issue Brief 6c

Responding to a Student Crisis

Planning how to respond to a suicidal crisis refers to how a school and its faculty and staff respond to a student that threatens or attempts suicide. A suicidal crisis occurs any time when the risk for suicide is raised by any peer, teacher, or other staff member that identifies a student as potentially suicidal (1). A student may make a statement about suicide in writing assignments, in a drawing or indirect verbal expression, or overtly voice suicidal threats or behaviors (2). Additionally, there is increasing research on Internet activity on suicide by students following a death by suicide and the issue of interactive suicide notes and cybersuicide (25, 26, 27). Interactive suicide notes and cybersuicide refer to use of the Internet as a public platform for displaying suicidal ideation and behavior (28). Some approaches to reducing potential harm from suicide sites may include self regulation by Internet service providers, use of filtering software by parents and schools to block sites from susceptible youth, and monitoring Internet connections (26).

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

Faculty and staff should be made aware of established intervention procedures that a school will take when a student expresses suicidal ideations (thoughts) or demonstrates suicidal behavior (1, 7, 8). Some recommend that these policies and procedures be contained in a crisis management guide that provides information about warning signs, risk/protective factors, and suicide prevention guidelines (gatekeeper training, curriculum, or screening) (13). An effective crisis response will be guided by a response plan developed in advance of a suicidal crisis, which identifies step-by-step what to do should a student threaten or attempt suicide (5, 8, 9, 10). See Issue Brief 6a for more information on establishing a Community Response within a Public Health Approach and Issue Brief 6b for information on Crisis Intervention and Response Teams.

Many schools tend to respond to a suicidal crisis in an unorganized fashion and a contributing factor for this unorganized response is due to the lack of an established plan of action when faced with a suicidal crisis (4). By acting in an unorganized way, schools may not be successful at intervening with a student experiencing a suicidal crisis, which could result in a tragic loss of a life, or in some cases, may contribute to further copycat behaviors by other students (11) or suicide contagion. Contagion is the

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process by which one suicide may contribute to another, for example through the influence of media reports (22, 23). When responding to a suicide crisis, understanding and addressing risk factors may help to alleviate effects of contagion. For example, one study found that friendship was a predictor of posttraumatic stress disorder (PTSD) and high intensity grief. Further, inadequate crisis intervention was a risk factor for high intensity grief (21). Other research suggests that complicated grief is associated with a heightened risk of suicidal thoughts and actions among peers of adolescent friends who died by suicide (24). A clearly written plan will help facilitate an organized and more effective response to a suicidal crisis (6, 12). Although each suicidal crisis situation is unique there are some commonly held do's and don'ts when responding to a student that may be experiencing a suicidal crisis and is need of help.

The following checklist was created by synthesizing materials from several sources, all of which discussed ways for responding to a student threatening suicide or actually attempting suicide (1, 2, 5-7, 14-19).

What to DO When Faced with a Student Experiencing a Crisis

- **Always ensure a student's safety.** The main goal when encountering a student expressing suicidal thoughts or behaviors is to prevent the act from happening (9). One way to do this is to ask whether the student is having suicidal thoughts or has a plan in mind: "Have you thought about how you would kill yourself?" or "Have you made any plans or preparations?" If the student does have a plan, then does he or she have access to a method for completing/attempting this plan: "Do you have access to a gun?" or "Do you have the pills?" It would also be important to find out if the student has a time or location, when or where he or she plans on attempting suicide.
  - » If the student does have a plan and has access to a method or just seems unsafe, remain with the student until a crisis team member arrives.
- **Send someone for help.** This is essential. Most often the crisis team member in the building or closest to the building where the crisis is occurring should be notified first.
- **Listen.**
  - » Acknowledge feelings and problems in the student's terms. Try to avoid complicated language.
  - » Allow the student to express feelings – a teacher may want to openly communicate giving the student permission to express his or her feelings.
  - » Try to avoid giving advice or opinions. Try and repeat back the feelings that you hear the student expressing ("you sound frustrated" or "you feel hopeless").
  - » Listen for warning signs such as hopelessness or a fixation with death.
- **Be direct.** Talk openly about suicide. Do not be afraid to say the word suicide. Do not worry about planting the idea in the student's head. Suicide is a crisis of non-communication and despair; by asking about it you allow for communication to occur and provide hope (14). Be direct with depressed and/or suicidal students, asking whether the student has been accessing Internet sites, obtaining suicide information from such sites, and talking in suicide chat rooms.
  - » Remain calm.
  - » Be empathetic.
  - » Always take the student seriously.
  - » Know what resources are available in your school before hand.
  - » Know who your nearest crisis team member is and where to find them.
- **Be honest.** Offer hope, but do not offer condescending or unrealistic reassurance.
- **Know your limits.** If you feel that you are in way over your head, or if you feel uncomfortable, minimize your level of involvement. Make a referral to someone else that may be in a better position to help. If you feel the student is in immediate danger, escort the student to the referral yourself. If you do not feel that the student needs an escort, you still should check to see if the referral was followed up on. Usually a simple phone call to the person you referred the student should be sufficient.
- **Make sure that at each stage of the intervention the student knows what is going on.** Do not surprise the student by escorting him/her to a room with a ten-member crisis team waiting. Make sure that you explain to the student what events and responses they can expect.

Responding to a Student Crisis continued

Remember a suicide crisis is a chaotic and confusing situation. By not providing and communicating structure in your response, you may unintentionally create more chaos and confusion, thereby increasing the likelihood that the student will refuse to cooperate.

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

What NOT to DO When Faced with a Student Experiencing a Crisis

- **Don't ever dare a student to attempt suicide.**
- **Don't debate with the student about whether suicide is right or wrong.**
- **Don't promise secrecy or confidentiality.** It may be advisable just to let the student know that you don't want to see him or her kill themselves and that you just want to make sure that he or she gets the best help possible, and that maybe you are not the best person to provide such care. Limitations to confidentiality should be explained to the student without pushing him or her away. Issues such as danger to self or others and physical and sexual abuse will not be kept secret. Florida educators are mandated reporters, which means if they know, or reasonably suspect abuse or neglect, they are required to call the Florida Abuse Hotline at 1-800-96ABUSE (1-800-962-2873).
- **Don't panic.**
- **Don't rush or lose patience with the student.** Realize that you may need to spend some time with this student in order to ensure that he or she will remain safe. Try to have as much privacy as possible when talking to the student.
- **Don't act shocked.** If you do so, the student is likely to feel that the situation is so bad that no one can help. This will destroy any chance for rapport and is likely to put distance between you and the student.
- **Don't be judgmental.** Avoid offering opinions of right vs. wrong or ethical vs. unethical. The main aspect of communication is just to listen and show concern.
- **Don't preach to the student.** Avoid discussing the value of life and how such a tragic act would affect his family and friends. These people may be contributing to the student's suicidal crisis and the student may wish to hurt these people through suicide.
- **Never leave the student alone or send the student away.** This may just reinforce feelings of isolation and hopelessness.
- **Don't worry about silence during discussion.** Just let the student know that you are there, and you are willing to listen.
- **Don't under-react or minimize.** By under-reacting, you communicate that you don't really respect the student's feeling and don't believe that the student is serious. By doing this, you just reinforce the student's feeling that no one understands or cares. Assuming that a student is attention seeking is usually the reason behind underreacting. Even if a student is seeking attention, you should act. The benefits could certainly out way the costs.
- **If a student is threatening suicide and does have a weapon, never try to physically take the weapon from the student.** This could endanger your life, the life of the student, and the lives of other persons in the school.

Responding to Various Levels of Risk

In order to make an appropriate referral it is important that someone who is trained in lethality and risk determination assess the risk of the student (1, 5, 6, 8, 9, 18). Although it is beyond the scope of educators and or administrators to directly assess risk, some important notes must be made and should be disseminated to all school faculty and staff. In all of these situations remember the do's and don'ts when responding to a student experiencing a suicidal crisis.

- **Level 1: Low or moderate risk**
  - » Faculty and staff member observes behaviors or warning signs that indicate that a student may be at risk.
  - » Student may have verbalized suicidal thoughts, but does not have a plan and does not have access to a potentially lethal weapon. In a low risk situation, the school-based crisis team member nearest the situation should be notified. The crisis team member will meet with student to determine extent of the problem, and if the possibility of harm is not imminent then the parents should be notified. The crisis team member should also follow-up periodically (once a week maybe for first month or two and then less frequently). If, however, in the assessment, there is a potential that the student may harm him/herself, then risk is increased to level two or severe risk situation.
- **Level 2: Severe risk**
  - » Student has overtly voiced the intent to engage in a suicidal act.
  - » Student has gone beyond mere thoughts and has thought of actual actions.
  - » Student does have a suicidal plan, but does not have the means to carry out his/her plan.

  In a severe risk situation, the crisis team member nearest the situation should be notified, as well as school administration that a student has expressed the intent to engage in suicidal behavior. The student should be kept under constant supervision until student is under the care of a community professional or until parent(s) take the child home. Before leaving, however, it is critical that the parent(s) attend a brief intervention meeting where the crisis team, the parent(s), and the student agree upon a treatment plan. It is also essential that parents be informed about the importance of restricting or hiding any potentially lethal means. If parents do not appear willing to take any steps to intervene school crisis team member and/or school administrators have the option of calling the local Department of Social Services in order to help ensure that the student will remain safe. Follow up must be done by the crisis team in order to make sure the student is progressing and that treatment is being maintained.
- **Level 3: Extreme risk**
  - » Student has voiced the intent to engage in a suicidal act.
  - » Student has the access to lethal means needed to carry out this act.
  - » Student may have access to lethal means on person.

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

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

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

Responding to a Student Crisis continued

faculty should be allowed to express and process their feelings, their worries, concerns, or even their suggestions about what was done well and what could have been done better (8).

While this issue brief focuses on what to do during a suicide crisis, see *Issue Brief 6a: Establishing a Community Response* and *Issue Brief 6b: Crisis Intervention and Response Teams*. In addition, After a Suicide: A Toolkit for Schools (2011) (20) includes the following principles and key considerations for action when responding to a death.

- "Schools should strive to treat all student deaths in the same way. Having one approach for a student who dies of cancer (for example) and another for a student who dies by suicide reinforces the unfortunate stigma that still surrounds suicide and may be deeply and unfairly painful to the deceased student's family and close friends.
- At the same time, schools should be aware that adolescents are vulnerable to the risk of suicide contagion. It is important not to inadvertently simplify, glamorize, or romanticize the student or his/her death" (p. 6) (20).
- Help is available for any student who may be struggling with mental health issues or suicidal feelings" (p. 6) (20).

Schools should be cautioned about developing protocols to honor the lives of students that have died. Consistent practices are essential, as memorializing a student's death by suicide has been cited in the literature as a contributory factor in suicide contagion among other students (20). Promoting a healthy, consistent response is recommended. Some examples include promoting education of the early signs and symptoms for the detection of the cause of death for all deaths, having a memorial plaque for all students and staff that died in the entire district during that academic year in a place of honor in the district, setting up a memorial garden or planting a tree at the end of each year and invite students and staff for a moment of silence or service to honor all who have lost friends or family that year. Those that died do not have to be students or staff. Another idea would be to promote a walk or activity that supports prevention such as a cancer walk, Out of the Darkness walk, etc. School faculty and staff should also be aware of any spontaneous memorials that students may create, such as leaving flowers, cards, or photos at the deceased student's locker. Such memorials should be monitored for inappropriate or upsetting messages, and yet not directly prohibited or taken down, which would draw excessive, and negative attention (20).

Although *The Guide* does not endorse any program over another, the following programs are simply meant to provide schools with some samples of programs that have used intervention strategies as part of their program. What components a school chooses to use and from what programs these components come from is the decision that each school will have to make. The important point is to provide an effective and comprehensive program that has the greatest potential to help and the least likely chance to harm. Below is a sample list of suicide prevention programs that have used intervention strategies, but may or may not be listed in the Best Practices Registry:

- **Safe: Teen** (Suicide Awareness for Everyone) (formerly known as the Adolescent Suicide Awareness Program [ASAP]), http://www.centermh.org/services/suicide-prevention/safeteen
- **Lifelines*: A Suicide Prevention Program,** http://www.hazelden.org/web/go/lifelines
- **Virginia Suicide Prevention Initiative**, http://www.vahealth.org/Injury/preventsuicideva/documents/2009/PDF/Program%20Description.pdf
- **BRIDGES program** (Building Skills to Reach Suicidal Youth), http://ubhc.umdnj.edu/OPSR/programs/BRIDGES.htm
- **Miami-Dade County Public Schools Crisis Management Resource Manual**, http://mhcms.dadeschools.net/crisis/pdfs/CM_resource_man08.pdf
- **The Maine Youth Suicide Prevention Program,** http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf
- **The Oregon Plan for Youth Suicide Prevention,** http://public.health.oregon.gov/PreventionWellness/SafeLiving/SuicidePrevention/Documents/YSuicide.pdf
- **The American Life Skills Development*/Zuni Life Skills Development**, http://nrepp.samhsa.gov/ViewIntervention.aspx?id=81

**These programs are listed in SAMHSA's National Registry of Evidence-based Practices and Procedures [NREPP] as evidence-based suicide prevention programs.*

References continued

Responding to a Student Crisis

1. The Maine Youth Suicide Prevention Program. (2009). *Youth suicide prevention intervention and postvention guidelines: A resource for school personnel.* Retrieved from http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf
2. Center for Mental Health in Schools at UCLA. (2000). *A resource aid packet on responding to a crisis at a school.* Los Angeles, CA: Author. Retrieved from http://smhp.psych.ucla.edu
3. Goldman, S., & Beardslee, W.R. (1999). Suicide in children and adolescents. In, D.G. Jacobs (Ed.), *The Harvard medical school guide to suicide assessment and intervention (1st ed.)*. San Francisco, CA: Jossey-Bass Publishers.
4. King, K. (1999). High school suicide postvention: Recommendations for an effective program. *American Journal of Health Studies, 15*(4), 217–222.
5. Underwood, M.M., & Dunne-Maxim, K. (1997). *Managing sudden traumatic loss in the schools: New Jersey adolescent suicide prevention project (revised edition)*. Piscataway, New Jersey: University of Medicine and Dentistry of New Jersey- University Behavioral Healthcare.
6. Maples, M.F., Packman, J., Abney, P., Daugherty, R.F., Casey, J.A., & Pirtle, L. (2005). Suicide by teenagers in middle school: A postvention team approach. *Journal of Counseling and Development, 83,* 397-405.
7. Hicks, B.B. (1990). *Youth suicide: A comprehensive manual for prevention and intervention.* Bloomington, IN: National Education Service. Retrieved from https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=124179
8. King, K. (2001). Developing a comprehensive school suicide prevention program. *The Journal of School Health, 71*(4), 132–137.
9. McKee, P.W., Jones. R.W., & Barbe, R.H. (1993). *Suicide and the school: A practical guide to suicide prevention.* Horsham, PA: LRP Publications.
10. U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (1992). *Youth suicide prevention programs: A resource guide.* Retrieved from http://aepo-xdvwww.epo.cdc.gov/wonder/prevguide
11. Leenaars, A.A., & Wenckstern, S. (1990). *Suicide prevention in the schools.* New York, NY: Hemisphere Publishing Corporation.
12. Roberts, R.L., Lepkowski, W.J., & Davidson, K.K. (1998). Dealing with the aftermath of a student suicide: A T.E.A.M approach. *National Association of Secondary School Principals Bulletin, 82*(597), 53–59.
13. Zenere, F.J., & Lazarus, P.J. (1997). The decline of youth suicidal behavior in an urban, multicultural public school system following the introduction of a suicide prevention and intervention program. *Suicide and Life-Threatening Behavior, 27*(4), 387–403.
14. Capuzzi, D., & Golden, L. (1988). *Preventing adolescent suicide.* Muncie, IN: Accelerated Development, Inc.
15. Thompson, R.A. (1988). In D. Capuzzi & L. Golden (Eds.), *Preventing adolescent suicide.* Muncie, IN: Accelerated Development, Inc.
16. Kalafat, J. (2003). School approaches to youth suicide prevention. *American Behavioral Scientist, 46*(9), 1211–1223.
17. Kalafat, J., & Underwood, M. (1989). *Lifelines: A school-based adolescent suicide response program.* Dubuque, Iowa: Kendall & Hunt Publishing.
18. *Broward County Suicide Prevention Manual.* Retrieved from Blair Middle School.
19. Center for Mental Health in Schools at UCLA. (2003). *A technical assistance sampler on school interventions to prevent youth suicide.* Los Angeles, CA: Author.

References continued

Responding to a Student Crisis

20. The American Foundation for Suicide Prevention and Suicide Prevention Resource Center. (2011). *After a Suicide: A Toolkit for Schools.* Newton, MA: Education Development Center, Inc. Retrieved from http://www.sprc.org/library/AfteraSuicideToolkitforSchools.pdf
21. Soili, P., Atle, D., Wahlberg, K., & Jokelainen, J. (2001). Reactions to adolescent suicide and crisis intervention in three secondary schools. *International Journal of Emergency Mental Heath, 3*(2), 97-106.
22. Gould, M., Jamieson, P., & Romer, D. (2003). Media contagion and suicide among the young. *American Behavioral Scientist, 46*(9), 1269-1284.
23. Romer, D., Jamieson, P.E., & Jamieson, K.H. (2006). Are news reports of suicide contagious? A stringent test in six U.S. cities. *Journal of Communication, 56,* 253-270.
24. Prigerson, H. G., Bridge, J., Maciejewski, P. K., Beery, L. C., Rosenheck, R. A., Jacobs, S.C, . . . Brent, D.A. (1999). Influence of traumatic grief on suicidal ideation among young adults. *American Journal of Psychiatry, 156*(12), 1994–1995.
25. Baume, P., Cantor, C.H., & Rolfe, A. (1997). Cybersuicide: The role of interactive suicide notes on the Internet. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 18*(2), 73-79. doi:10.1027/0227-5910.18.2.73
26. Biddle, L., Donovan, J., Hawton, K., Kapur, N., & Gunnell, D. (2008). Suicide and the Internet. *British Medical Journal, 336*(7648), 800-802. doi:10.1136/bmj.39525.442674.AD
27. Alao, A.O., Soderberg, M., Pohl, E.L., & Alao, A.L. (2006). Cybersuicide: Review on the role of the Internet on suicide. *CyberPsychology & Behavior, 9*(4), 489-493. doi:10.1089/cpb.2006.9.489
28. Birbal, R., Maharajh, H.D., Birbal, R., Clapperton, M., Jarvis, J., Ragoonath, A., & Uppalapati, K. (2009). Cybersuicide and the adolescent population: Challenges of the future? *International Journal of Adolescent Medicine and Health, 21*(2), 151-159.
29. Biddle, L., Donovan, J., Hawton, K., Kapur, N., & Gunnell, D. (2008). Suicide and the internet. *BMJ, 335,* 800-802.

Notes

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Checklist 6

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Intervention Strategies

Checklist 6

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

Yes	No	
☐	☐	Has your school defined the problem and the extent to which suicide impacts the school community?
☐	☐	Do school personnel understand the relationship between risk and protective factors and how some protective factors can mitigate against risk factors?
☐	☐	Does your school have established links to crisis intervention services in the community?
☐	☐	Does your school have established procedures in place when making a student referral for services? (See Issue Brief 6a, page 3, *When Making a Student Referral for Services*).
☐	☐	Does your school have established links to family and youth organizations in the community?
☐	☐	Does your school have a crisis response plan in place to respond to potential crisis situations?
☐	☐	Do all staff members know about the crisis response plan and how your school will respond to a crisis situation?
☐	☐	Does your school educate and inform all staff members on who they should contact in the community or in the school should a student express or demonstrate any signs of suicidal behavior (verbal threats, written warnings, or overt suicidal behaviors)?

— continued next page

Checklist 6 continued

Yes	No	
☐	☐	Does your school provide all staff with training about how to effectively intervene with a student who has directly or indirectly expressed suicidal thoughts and/or behaviors, or has demonstrated other warning signs consistent with suicide (see Issue Brief 3 for list of warning signs)?
☐	☐	Does your school train all staff members on the warning signs of adolescent suicide?
☐	☐	Does your school define what type of event warrants a school-based crisis response?
☐	☐	Does your school have an established crisis response team?
☐	☐	Does your school have an established crisis response team that is formally recognized for its contribution to the schools mission? (See *Issue Brief 6b: Crisis Intervention and Response Teams*).
☐	☐	Does your school have an established crisis response team whose members know their roles for responding to a suicidal crisis?
☐	☐	Does your school have an established crisis response team with an established leader as well as a backup leader?
☐	☐	Does your school have an established method for following up with a student who has gone through a suicidal crisis?
☐	☐	Does your school have procedures in place to help other students during a suicidal crisis?
☐	☐	Does your school have established methods for identifying the victim's close friends and other vulnerable students?
☐	☐	Does your school provide support to close friends of a student who attempts or dies by suicide and other vulnerable students?
☐	☐	Does your school provide parents with a list of community resources or agencies that they may contact should they suspect that their son/daughter is considering suicide or has expressed suicidal thoughts or behaviors?
☐	☐	Does your school provide parent education regarding risk factors and the importance of disposing of or restricting access to lethal means (such as firearms)?
☐	☐	Does your school "debrief" all staff members or school faculty that may have been involved or impacted by a suicidal crisis?
☐	☐	Does your school have an established procedure for working with the media? (See *Issue Briefs 6c: Responding to a Student Crisis* and *7b: Responding to and Working with the Media*.)
☐	☐	Does your school have established procedures to respond to issues dealing with student activity on the Internet and social media? (See *Issue Brief 6c: Responding to a Student Crisis*).

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Preparing for and Responding to a Death by Suicide

Issue Brief 7a

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Steps for Responding to a Suicidal Crisis

An effective suicide prevention program should be comprehensive; it should not limit its scope to include only preventative and intervention measures, but should also address postvention measures, or measures that are taken after a suicide crisis (1, 2, 7, 8, 10, 15, 16, 17, 20, 24). The school community must address suicide attempts and deaths by suicide in order to provide appropriate support for students, faculty, and staff.

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

The best way to address the needs of the school is to be prepared with a comprehensive, effective, and recognized plan of action. Unfortunately, however, many schools lack a preplanned postvention program and tend to respond to a suicidal crisis in an unorganized fashion (4).

Appropriate postvention programs can be viewed as a form of prevention since, if carried out correctly and successfully, can reduce potential cluster (copycat) suicides (5).

By not having an adequate postvention program in place, schools may unknowingly contribute to further suicidal behaviors or copycat suicides.

Schools also play an important role in alleviating suicide contagion through their relationship with the media. According to *After Suicide: A Toolkit for Schools* (1), by the American Foundation for Suicide Prevention (AFSP) and The Suicide Prevention Resource Center (SPRC), *"A coordinated approach can be especially critical when the suicide receives a great deal of media coverage and when the community is looking to the school for guidance, support, answers, and leadership"* (p.7). Educating journalists and media programmers can decrease the effects of media contagion on vulnerable youth (12, 17).

The importance of understanding the role of technology cannot be overstated. The Internet has increased the global range of the mass media. With the growing use of social networking sites, postvention strategies must also consider the role of the Internet and focus on existing online communities (e.g., Facebook, MySpace, Twitter)

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(24). This is especially important for young people between age 15 - 24, as data indicates this age group is very active online (23). Although these actions often take place outside of school, they can be used as part of the school's response strategies responding to a student's suicide. The American Foundation for Suicide Prevention (AFSP) and Suicide Prevention Resource Center (SPRC) *After a Suicide: A Toolkit for Schools* (1) recommends that schools build "partnerships with key students to identify and monitor the relevant social networking sites, strategically use social media to share prevention-oriented safe messaging, offer support to students who may be struggling to cope, and identify and respond to students who could be at risk themselves" (pp. 7-8).

The rationale behind postvention programs in schools is not only to reduce subsequent morbidity and mortality of suicide in fellow students, but also to reduce the onset and degree of debilitation by psychiatric disorders, such as posttraumatic stress disorder (3). After a suicidal crisis, friends and family are at an increased risk of developing posttraumatic stress disorder, as well as relying more heavily on alcohol and drug use to numb the pain (6). It is not enough for a suicide prevention program to implement and maintain "before the fact" prevention elements, designed at preventing a suicidal event from occurring, but a program must have an established method of responding to a suicidal crisis. An effective postvention plan may also decrease the chance that an acute stress reaction caused by the suicide will lead to a more chronic and debilitating reaction for those left traumatized and grieving. This could be prevented through counseling and utilizing community links to get those individuals help. A comprehensive postvention plan increases the likelihood that a school can decrease the risk of copycat suicides and provide much needed services to those left behind following a suicide.

Relationships with community agencies and organizations, such as police, Orange County Department of Mental Health, local mental health services, funeral directors, and the media, are an important component to any suicide postvention plan. In addition, as with any school program, the involvement of families and partnerships with local family organizations, such as the Parent Teacher Association (PTA), are critical linkages and resources to effective planning and implementation of a postvention plan. Other local and family organizations, such as the local Federation of Families for Children's Mental Health (www.ffcmh.org) or the National Alliance on Mental Illness (www.nami.org) may also offer support and assistance in the aftermath of a death by suicide.

After a Suicide: A Toolkit for Schools (1) includes the following principles and key considerations for action when responding to a death by suicide.

- "Schools should strive to treat all student deaths in the same way. Having one approach for a student who dies of cancer (for example) and another for a student who dies by suicide reinforces the unfortunate stigma that still surrounds suicide and may be deeply and unfairly painful to the deceased student's family and close friends.
- At the same time, schools should be aware that adolescents are vulnerable to the risk of suicide contagion. It is important not to inadvertently simplify, glamorize, or romanticize the student or his/her death.
- Schools should emphasize that the student who died by suicide was likely struggling with a mental diagnosis, such as depression or anxiety, that can cause substantial psychological pain but may not have been apparent to others (or that may have shown as behavior problems or substance abuse).
- Help is available for any student who may be struggling with mental health issues or suicidal feelings" (p. 6).

Schools should be careful to have consistent practices in honoring student/staff deaths keeping in mind the danger in memorializing the death of a student that died by suicide. There is research-based evidence of the link between memorialization and contagion (1).

Responding to a Suicidal Crisis: Steps for Schools

1. **The school principal should contact the police or medical examiner in order to verify the death and get the facts surrounding the death.** It is important to know the facts in order to reduce imitative behaviors and to place focus on means restriction strategies for parents, as well as the school.
2. **The superintendent of the school district needs to be informed of the death.** He or she should also be involved in the school's response to the suicide through information dissemination with other school districts and media contacts.
3. **Prepare and activate procedures for responding to the media.** Suicide is newsworthy and as such can be

Steps for Responding to a Suicidal Crisis continued

expected to attract the media. Utilize a designated media spokesperson and remind staff not to talk with press or spread rumors and if asked refer to media spokesperson. Media coverage of suicide can influence behavior negatively by contributing to contagion or positively by encouraging help-seeking. Encourage the media to refer to "Recommendations for Reporting on Suicide," (19) available at http://reportingonsuicide.org. For more information refer to *Issue Brief 7b: Responding to and Working with the Media*.

4. **Notify and activate the school's crisis response team** (for more information on crisis response teams refer to *Issue Brief 6b: Crisis Intervention and Crisis Response Teams)*.

5. **Contact the family of the deceased.** Find out if the deceased has any siblings enrolled in other schools or school districts. If so, then notify the principals of those schools. Obtain permission to release the cause of death from the parents. If the parents do not give permission to release the cause of death as a suicide, respect for their wishes should be maintained.

6. **Schedule a time and place to notify faculty members and all other school staff.** This meeting should be arranged as soon as possible. After this has been done, staff can provide critical and appropriate support for students.
   - » Inform all staff about the facts behind the suicide and dispel rumors.
   - » Allow time for staff to ask questions and express feelings.
   - » Ensure that all staff have an updated list of referral resources.
   - » Review the process for students leaving school grounds and tracking student attendance.
   - » Announce to staff how the school will interact with the media and inform staff who will act as the school's media spokesperson. Remind staff not to talk with the press and refer any questions to the designated media spokesperson.
   - » Review planned in-class discussion formats and disclosure guidelines for talking to students. Prepare staff for student reactions.
   - » Compile a list of all students who were close to the deceased.
   - » Compile a list of all staff members who had contact with the deceased.
   - » Update and compile a list of students who may be at-risk for suicide (see Issue Brief 3a: Risk Factors for more information on risk factors).
   - » Remind staff about the risk factors and warning signs for adolescent suicide.
   - » Provide staff counseling opportunities and supportive services available to them.

7. **Contact community support services.** (See Issue Briefs 6a and 7c for additional information).

8. **Arrange a meeting for parents/caregivers,** however, avoid a large parent/caregiver meeting and try to keep the number of parents/caregivers at a minimum.
   - » Provide parents/caregivers with warning signs for children and adolescents who may be suicidal.
   - » Provide information about supportive services available to students at the school.
   - » Provide information about community resources, services, and family support organizations they may wish to utilize.
   - » Provide information about how to respond to their child's questions about suicide.
   - » Remind parents/caregivers of their child's special needs during this time.
   - » Communicate with other students' parents/caregivers through telephone or written notice.
   - » In a letter to parents or at a meeting, alert parents that their child and other students may choose to use social media and other online venues to communicate about the suicide, and encourage them to monitor their child's Internet use periodically following the death.

9. **Meet with all students in small groups** (classrooms).
   - » Notify students as early as possible following the staff meeting.
   - » If parents/family of the deceased student give permission, make sure all teachers announce the death of the student to their first class of the day. It is preferable to describe the deceased as "having died by suicide," rather than as "a suicide," or having "committed suicide." The latter two expressions reduce the person to the mode of death, or connote criminal or sinful behavior.
   - » Disclose only relevant facts pertaining to the student's death. Do not provide details, such as method or exact time and location of suicide.

Steps for Responding to a Suicidal Crisis continued

- » Allow students an opportunity to express their feelings. "What are your feelings and how can I help?" should be the mantra behind the structure of discussion.
- » Explain and predict what students can anticipate as they grieve (e.g., feeling angry, guilty, shocked, anxious, lonely, sad, numb, or experiencing physical pain). Express to students there is no one right way to grieve. What is important is to recognize feelings and communicate them. Below are some age-appropriate signs of grief reactions in children (25):
  - Very young children may respond to a death or traumatic experience by reverting to earlier behavioral stages, and begin thumb sucking, wetting the bed, and clinging to parents again.
  - Children ages five through approximately eleven may withdraw from playgroups, compete for more attention from parents and teachers, become aggressive, and/or fear things they didn't use to. Their behavior may also revert to earlier stages.
  - Adolescents may complain about vague physical symptoms. They may become more disruptive at school and at home, and may become at risk for drug and alcohol use.
- » Inform students of the available support services in the school (and outside the school, including family and peer support groups) and encourage them to use them.
- » Re-orient students to ongoing classroom activities.
- » Avoid assemblies for notification and do not use impersonal announcements over the public address system. Notify students in small, individual classrooms through faculty members or crisis team members.

10. Provide additional survivor support services, such as suicide bereavement support groups (see http://www.afsp.org). A school may want to invite friends of the deceased to join a support group so they can be counseled separately with more focused attention. Provide individual counseling to all students identified as at-risk.

11. Members of the school's crisis team should follow the victim's classes throughout the day providing counseling and discussion to assist students and teachers. This could also help to identify and refer students who may be at-risk.

12. Establish support stations or counseling rooms in the school and make sure that everyone including faculty, students, and other school staff members know where these are located. There should be more than one location and should be set up in small to mid-size rooms. Provide water, kleenex, fruit and information about follow-up contacts.

13. De-brief staff (including members of the crisis team) at the end of the day for approximately five days following the suicidal crisis. Provide post-action staff support to school staff involved in student support during the crisis. The staff included could be teachers, bus drivers, monitors, cafeteria staff, etc.

14. Reschedule any immediate stressful academic exercises or tests if at all possible, however, avoid changing the school day's regular schedule.

15. Avoid flying the school flag at half-mast in order to avoid glamorizing the death. Memorialization should be consistent with other types of deaths of students.

16. Memorialization should focus on prevention, education, and living. Encourage staff and students to memorialize the deceased through contributions to prevention organizations such as Mothers Against Drunk Driving, a suicide hotline, or a suicide survivors group.

17. Collaborate with students to utilize social media effectively to disseminate information and promote suicide prevention efforts. Social media can be used to disseminate important and accurate information to the school community, identify students who may be in need of additional support or further intervention, share resources for grief support and mental health care, and promote safe messages that emphasize suicide prevention and minimize the risk of suicide contagion. Some schools (with the permission and support of the deceased student's family) may choose to establish a memorial page on the school website or on a social networking site. Such pages should not glamorize the death in ways that may lead other at-risk students to identify with the person who died. Memorial pages should utilize safe messaging, include resources, be monitored by an adult, and be time-limited, remaining active for up to 30 to 60 days after the death, at which time they should be taken down and replaced with a statement acknowledging the supportive messages that had been posted and encouraging students who wish to further honor

Steps for Responding to a Suicidal Crisis continued

their friend to consider other creative expressions. School personnel should also join any student-initiated memorial pages so that they can monitor and respond as appropriate.

18. **Inform local crisis telephone lines and local mental health agencies about the death** so that they can prepare to meet the needs of students and staff.

19. **Provide information about visiting hours and funeral arrangements to staff, students, parents, and community members.** Funeral attendance should be in accordance with the procedures for other deaths of students.

20. **The family of the deceased should be encouraged to schedule the funeral after school hours** to facilitate the attendance of students.

21. **Arrange for students, faculty, and staff to be excused from school to attend the funeral,** if necessary.

22. **Follow up with students who are identified as at-risk** and provide on-going assessment and monitoring, including Internet use, of these students following the death. Follow-up should be maintained as long as possible.

Major Resources

Nine major sources were utilized and synthesized into developing the preceding list for responding to a suicidal crisis, steps for schools:

- American Association of Suicidology guidelines for postvention actions. (2003). In L. Davidson & M. Marshall (Eds.), *School-based suicide prevention: A guide for schools and the students, families, and communities they serve* (pp. 13-17). The Task Force for Child Survival and Development.
- American Foundation for Suicide Prevention and Suicide Prevention Resource Center. (2011). *After a Suicide: A toolkit for schools.* Newton, MA: Education Development Center, Inc., available at http://www.sprc.org/library/AfteraSuicideToolkitforSchools.pdf or http://www.afsp.org/index.cfm?page_id=7749A976-E193-E246-7DD0A086583342A1
- The Maine Youth Suicide Prevention Program available at http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf (9).
- King, K. (1999). High school suicide postvention: Recommendations for an effective program. *American Journal of Health Studies, 15*(4), 217-222.
- Underwood, M.M., & Dunne-Maxim, K. (1997). *Managing sudden traumatic loss in the schools: New Jersey adolescent suicide prevention project (revised edition).* Piscataway, New Jersey: University of Medicine and Dentistry of New Jersey-University Behavioral Healthcare.
- Poland, S. (1989). *Suicide intervention in the schools.* New York, NY: Guilford Publications.
- Washington State Department of Health. (2000). *Youth suicide prevention program toolkit.* Seattle, WA: Delauney/Phillips Communications Inc. Retrieved from http://here.doh.wa.gov/materials/washington-states-plan-for-youth-suicide-prevention-2009/33_SuicPlan_E09L.pdf (11).
- The Oregon Plan for Youth Suicide Prevention. (2010). *Oregon Department of Human Services* is available at http://public.health.oregon.gov/PreventionWellness/SafeLiving/SuicidePrevention/Documents/YSuicide.pdf
- National Suicide Prevention Lifeline. (2011). *Lifeline Online Postvention Manual.* Retrieved from http://www.sprc.org/library/LifelineOnlinePostventionManual.pdf

Other Resources

In addition, comprehensive training programs, such as the **American Association of Suicidology**'s (AAS) School Suicide Prevention Accreditation Program (18), can help school staff to become more knowledgeable about youth suicide and youth suicide prevention. Additional information is available at http://www.suicidology.org/web/guest/school-accreditation.

Center for Disease Control and Prevention. *Youth suicide prevention programs: A resource guide* (22). Atlanta: US Department of Health and Human Services, Public Health Service. Retrieved from http://www.cdc.gov/ncipc/dvp/Chapter%201.PDF

An example of how one community came together in response to the tragedy of teen suicide is **Project Safety Net** (PSN), Palo Alto, California (21). The PSN report provides a comprehensive plan that includes 22 best known practices for community-based mental health and suicide prevention. In addition, PSN uses the Questions, Persuade, Refer (QPR) gatekeeper training

Steps for Responding to a Suicidal Crisis continued

(14) and endorses the 40 Developmental Assets (13) model identifying external assets (such as family support, community values and activities) and internal supports (such as social competency and positive identity) as building blocks of healthy child development that help young people grow up healthy and productive adults.

The *Youth Suicide Prevention School-Based Guide: —Checklist 7a: Preparing for and Responding to a Suicidal Crisis*, presents a brief overview of some of the necessary components of a postvention plan. It must be noted that the checklist is flexible and should be used in a way that is complementary to the school's needs and abilities.

References

1. American Foundation for Suicide Prevention and Suicide Prevention Resource Center. (2011). *After a Suicide: A toolkit for Schools.* Newton, MA: Education Development Center, Inc. Retrieved from http://www.sprc.org/library/AfteraSuicideToolkitforSchools.pdf or http://www.afsp.org/index.cfm?page_id=7749A976-E193-E246-7DD0A086583342A1
2. Garland, A.F., & Zigler, E. (1993). Adolescent suicide prevention: Current research and social policy implications. *American Psychologist, 48*(2), 169–182.
3. Gould, M., Greenberg, T., Velting, D., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(4), 386–405.
4. King, K. (1999). High school suicide postvention: Recommendations for an effective program. *American Journal of Health Studies, 15*(4), 217–222).
5. Leenaars, A.A., & Wenckstern, S. (1990). *Suicide prevention in the schools.* New York, NY: Hemisphere Publishing Corporation.
6. Lester, D. (2000). *Suicide prevention: Resources for the millennium*. Ann Arbor, MI: Sheridan Books.
7. Silverman, M.M., & Felner, R.D. (1995). Suicide prevention programs: Issues of design, implementation, feasibility and developmental appropriateness. *Suicide and Life-Threatening Behavior, 25*(1), 92–104.
8. Zenere, F.J., & Lazarus, P.J. (1997). The decline of youth suicidal behavior in an urban multicultural public school system following the introduction of a suicide prevention and intervention program. *Suicide and Life-Threatening Behavior, 27*(4), 387–403.
9. Maine Youth Suicide Prevention Program. (2009). Retrieved from http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf
10. Oregon Department of Human Services. (2010). *The Oregon Plan for Youth Suicide Prevention.* Retrieved from http://public.health.oregon.gov/PreventionWellness/SafeLiving/SuicidePrevention/Documents/YSuicide.pdf

References continued

Preparing for and Responding to a Death by Suicide

11. Washington State Department of Health. (2000). *Youth Suicide prevention program toolkit.* Seattle, WA: Delauney/ Phillips Communications Inc. Retrieved from http://here.doh.wa.gov/materials/washington-states-plan-for-youth-suicide-prevention-2009/33_SuicPlan_E09L.pdf
12. Gould, M., Jamieson, P., & Romer, D. (2003). Media contagion and suicide among the young. *American Behavioral Scientist, 46*(9), 1269-1284.
13. Search Institute. (2011). *40 Developmental Assets.* Retrieved from http://www.search-institute.org/research/assets
14. QPR Institute. (2011). *Questions, Persuade, Refer (QPR).* Retrieved from http://www2.sprc.org/bpr/question-persuade-refer-qpr-gatekeeper-training-suicide-prevention
15. Maples, M.F., Packman, J., Abney, P., Daugherty, R.F., Casey, J.A., & Pirtle, L. (2005). Suicide by teenagers in middle school: A postvention team approach. *Journal of Counseling & Development, 83,* 397–405.
16. Center for Mental Health Services: Office of the Surgeon General: US Department of Health and Human Services. (2001). *National strategy for suicide prevention: Goals and objectives for action.* Rockville: MD: US Public Health Service. Retrieved from http://www.sprc.org/library/nssp.pdf
17. Centers for Disease Control. (1994). Programs for the prevention of suicide among adolescents and young adults. Suicide contagion and the reporting of suicide: Recommendations from a national workshop. *Morbidity and Mortality Weekly Report, 43*(RR-6).
18. American Association of Suicidology (AAS). (2011). *School Suicide Prevention Accreditation Program.* Retrieved from http://www.suicidology.org/web/guest/school-accreditation
19. American Association of Suicidology, American Foundation for Suicide Prevention, Annenburg Public Policy Center, Associated Press Editing Managers, Canterbury Suicide Project-University of Otago, Christchurch, New Zealand, Columbia University Department of Psychiatry . . . UCLA School of Public Health, Community Health Sciences. (2011). *Recommendations for the Media.* Retrieved from www.reportingonsuicide.org
20. Grossman, J., Hirsch, J., Goldenberg, D., Libby, S., Fendrich, M., Mackesy-Amiti, M.E, . . . Chance, G. (1995). Strategies for school-based response to loss: Proactive training and postvention consultation. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 16*(1), 18-26.
21. City of Palo Alto. (2011). *Project safety net.* Retrieved from http://www.psnpaloalto.com/
22. Center for Disease Control and Prevention. (1992). *Youth suicide prevention programs: A resource guide.* Atlanta: US Department of Health and Human Services, Public Health Service. Retrieved from http://www.cdc.gov/ncipc/dvp/Chapter%201.pdf
23. Pew Internet & American Life Project. (2005). *Teens and Technology: Youth are leading the transition to a fully wired and mobile nation.* Washington, DC.
24. National Suicide Postvention Lifeline. (2011). *LifeLine Online Postvention Manual.* Retrieved from http://www.sprc.org/library/LifelineOnlinePostventionManual.pdf
25. U.S. Department of Health & Human Services. (2007). *Tips for talking to children and youth after traumatic events: A guide for parents and educators.* Retrieved from http://www.enc.ed.gov/PDFS/ED499053.pdf

Notes

Preparing for and Responding to a Death by Suicide

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Checklist 7a

Preparing for and Responding to a Death by Suicide

Youth Suicide Prevention School-Based Guide ©

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Checklist 7a

Steps for Responding to a Suicidal Crisis

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

What to DO Following a Suicide

Do

- ☐ Utilize and follow the school's guidelines for dealing with a suicidal crisis. If the school does not have guidelines please refer to Issue *Brief 7a Steps for Responding to a Suicidal Crisis.*
- ☐ Respond to the suicide within 24 hours of the suicide.
- ☐ Act in a concerned and empathetic manner.
- ☐ Inform all staff members about the suicide and provide a debriefing session where staff may voice their concerns, apprehensions, and any questions they may have (See Issue Brief 7a, page 3, #6 *Responding to a Suicidal Crisis: Steps for Schools*).
- ☐ Inform school board members and school superintendent.
- ☐ Contact the police or medical examiner to verify the death and get the facts surrounding the death.

— continued next page

Checklist 7a continued

Steps for Responding to a Suicidal Crisis

- ☐ Make sure all teachers announce the death of the student to their first class of the day. It is preferable to describe the deceased as "having died by suicide," rather than as "a suicide," or having "committed suicide." The latter two expressions reduce the person to the mode of death, or connote criminal or sinful behavior.
- ☐ Provide counseling sites throughout the school for students.
- ☐ Avoid any glorification or romanticizing of the student or the student's death.
- ☐ Continually monitor the school's emotional climate (Has there been an increase in fights or school delinquency following a death by suicide?).
- ☐ Closely monitor Internet connections and collaborate with students to utilize social media effectively (e.g., developing memorial pages) (See Issue Brief 7a, page 4, #17 *Responding to a Suicidal Crisis: Steps for Schools*).
- ☐ Emphasize that the student who died by suicide was likely struggling with depression or anxiety that may not have been apparent to others.
- ☐ Utilize an established linkage system or community network in order to make referrals to the appropriate services as well to exchange information concerning the appropriate steps for treating those affected by the suicide (including local crisis telephone lines and web-site supports).
  - » Find out if the deceased has any siblings enrolled in other schools and notify the principals of those schools.
- ☐ Activate procedures for responding to the media (e.g., assign a school liaison to handle all media inquiries in order to avoid sensationalistic stories concerning the suicide). Follow the steps outlined in *Issue Brief 7b Responding to the Media*.
  - » Arrange a meeting for parents/caregivers (See Issue Brief 7a, page 3, #8 *Responding to a Suicidal Crisis: Steps for Schools*).
  - » Evaluate all activities done following a death by suicide (How did your school respond? What worked and what did not work?).
  - » Acknowledge the traumatic impact the death of a student may have on those who knew the youth and all persons in the school and community and encourage all to seek help as needed.

What NOT to Do Following a Suicide

Do NOT

- ☐ Behave in a quiet and overly conservative manner or in a desperate and frantic manner.
- ☐ Respond to the student's death differently than any other student death (e.g., plant a tree in order to honor the student).
- ☐ Hold a memorial service for the student at the school.
- ☐ Describe in great detail the suicide (method or place).
- ☐ Dramatize the impact of suicide through descriptions and pictures of grieving relatives, teachers or classmates.
- ☐ Glamorize, romanticize, simplify, or sensationalize the suicide.
- ☐ Underestimate the effect of the traumatic experience on the students, school personnel and community.

Notes

Steps for Responding to a Suicidal Crisis

Notes

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Preparing for and Responding to a Death by Suicide

Issue Brief 7b

Responding to and Working with the Media

Suicide is often a newsworthy occurrence, particularly when young people take their lives. After the suicide of a child or adolescent occurs, it is likely that the event will be reported in the media. The last twenty years has yielded much research on the effect of media coverage of suicide on those who consume information from newspapers and television, and school staff and faculty can use the findings of these studies to assist journalists to safely and appropriately report on youth suicide.

Evidence suggests that exposure to suicide through the media can lead others to take their life or attempt suicide under the theory that much human behavior is learned observationally through modeling, and that this effect is especially strong for young people as they navigate adolescence and the transition to adulthood (2, 4, 9, 11). This effect is sometimes referred to as suicide contagion or suicide imitation/modeling (2, 4, 5, 6, 9, 11). Additionally, research has shown that media coverage may have an influence on whether, following a suicide, copycat or imitation suicides will occur (1, 2, 4, 7, 11).

An example of the impact of suicide media coverage occurred during the early 1980s, when Viennese journalists dramatically and extensively covered the deaths of individuals who jumped in front of subway cars to their death. In 1987, a campaign alerted reporters to the dangers of their coverage, and they were given suggestions on how to more appropriately report the news of the suicides. As a result of the new media guidelines in Vienna, Austria, suicide rates declined by 7% in the first year, and nearly 20% in the four-year follow-up (8, 10). These studies also found that subway suicides decreased by approximately 75% (8, 10). More recently, researchers found that the majority of journalists they interviewed were unaware that reporting on suicide could produce an imitative effect (9), but that once educated, journalists and editors are interested in considering the possibility of contagion when reporting about suicides (2, 9).

It is important to note, when working with the media, that the kind of suicide that is being covered, and how it is being covered can impact the possibility of suicide contagion. Research indicates that it is five times more likely that an imitative effect will occur following the coverage of a celebrity who dies by suicide than the death of someone who is not famous (4, 7), so it is critical that those news stories be handled

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with extreme care (16). Additionally, it has been found that the coverage of suicide deaths in newspapers may be responsible for 80% more contagion than those stories that appear on televised news (possibly because of the fact that newspapers can be clipped and saved) (4, 7), demonstrating that journalists who report for newspapers and magazines may have an additional responsibility when covering death by suicide.

In addition to simply reporting an incident of a death by suicide, the media has the potential to play a powerful role in educating the public about suicide prevention. The following guidelines can be helpful for schools in effectively responding to and working with the media who may contact them after death by suicide. These guidelines are based upon those formulated by the Annenberg Public Policy Center of the University of Pennsylvania (2, 13), the American Association of Suicidology (AAS) (13), the American Foundations for Suicide Prevention (AFSP)(13), and the World Health Organization (WHO) (12). More examples of media education programs and information include: The Texas Suicide Prevention Project (14), the Washington State Youth Suicide Prevention Program (YSPP) (15), and Maine Youth Suicide Prevention Implementation Plan (3).

What to DO When Responding to and Working with the Media

Recommendations for dealing with the media include:

- Have an established person that will act as the media spokesperson and who will act as a liaison between the school and the media.
- Have an established set of procedures in place for dealing with the media. Before approaching a reporter write down key points that you want to get across.
- The media spokesperson should try to ascertain what questions the media will ask. Common questions include:
  - » How many students attend the school?
  - » What prevention tools does the school currently have in place?
  - » What does the school plan to do following the suicide?
  - » What feedback has there been from families, friends, other students, and community agencies?
- State appropriate concern for the victim and his or her family.
- Provide the appropriate factual information about the student such as age and grade.
- The suicide of the student should be honestly acknowledged, but do so very succinctly and avoid discussing the method (firearm, overdose).
- Encourage news reporters to provide information that increases public awareness of risk factors and warning signs.
- Provide the press written information from a reliable source indicating the warning signs and symptoms of suicide for use in publications.
- Always provide information on state, local, and school resources available for suicide prevention and crisis intervention, including crisis hotlines.
- "No comment" is not an appropriate response to media representatives who are covering a story about suicide. Use a media request for information as an opportunity to influence the contents of the story and to educate about suicide prevention.
- Assist news professionals in providing accurate and responsible information.
- Communicate to news professionals the dangers of suicide imitation and how inappropriate reporting may contribute to more suicidal behavior.
- Acknowledge the deceased person's problems and struggles, as well as the positive aspects of his or her life, which will contribute to a more balanced picture and will decrease the chance for imitation.

What Not to DO When Responding to and Working with the Media

Caveats when dealing with the media include:

(These guidelines should be communicated to the media and should probably be done by a crisis response member through the designated media spokesperson):

- Avoid presenting simplistic explanations for suicide. Suicide is never the result of a single factor or event, but rather from

a complex interaction between many factors. There is no research evidence that will corroborate a simple attribution of responsibility.

- Avoid sensationalizing, romanticizing, or glorifying the suicide. Do not report or show pictures of flags at half-mast or a permanent public memorial such as planting a tree, establishing a scholarship fund, or presenting a plaque. Such displays have been found to increase the likelihood of imitation suicides. Keep in mind that consistent practices in managing student deaths is essential. When setting up practices, consideration should be made about possible contagion in the event the death is by suicide.
- Avoid dramatizing the impact of suicide through descriptions and pictures of grieving friends, family, teachers, or classmates. This could lead other adolescents to see suicide as a way of getting attention or, as a form of retaliation against others.
- Avoid using adolescents on television or in print media to tell their suicide attempt story. Other students may identify with these students and imitate their behavior.
- Avoid engaging in repetitive, prominent, or excessive reporting of the suicide. Repetitive or prominent coverage of a suicide tends to promote and maintain preoccupation among at-risk persons. This preoccupation has been linked to imitation suicides.
- Avoid placing the story on the front page of the newspaper and using large headlines. Avoid dramatic or sensational headlines (for example, "Boy, 12, Kills Himself Over Poor Grades").
- Avoid reporting "how-to" descriptions of the suicide. Do not describe the technical details about the suicide, such as detailed descriptions or pictures of the location where the suicide took place and the means used.
- Do not present suicide as a tool for accomplishing certain ends. Do not present suicide as a means of coping with personal problems. Although such factors may precipitate a suicidal act, other psychological predispositions are almost always involved.
- Avoid focusing only on the positive characteristics of the youth that attempted or died by suicide. News professionals should acknowledge that the person had problems and struggles along with the positive aspects of his/her life. This will contribute to a more balanced picture and may make suicide appear less attractive to other students at risk.
- Avoid unhelpful narratives regarding suicide. For example, reporting that suicide rates increase during the holiday season (a common myth), or comparing a young couple's death to Romeo and Juliet.
- Avoid using language that may contribute to more suicides.
  - » In the body of the story, describe the deceased as having "died by suicide" rather than as "a suicide" or having "committed suicide." The latter two expressions connote criminal or sinful behavior.
  - » Contrasting "suicidal deaths" with "non-fatal attempts" is preferable to using terms such as "successful", "unsuccessful", or "failed."

References

1. Gould, M.S. (2001). Suicide and the media. *Annals of the New York Academy of Sciences, 932,* 200-221.
2. Gould, M., Jamieson, P., & Romer, D. (2003). Media contagion and suicide among the young. *American Behavioral Scientist, 46*(9), 1269-1284. doi:10.1177/0002764202250670
3. Maine Center for Disease Control and Prevention. (2007). *Maine Youth Suicide Prevention Implementation Plan*. Retrieved from http://www.state.me.us/suicide/myspp/program/plan.htm
4. Stack, S. (2005). Suicide in the media: A quantitative review of studies based on nonfictional stories. *Suicide and Life-Threatening Behavior, 35*(2), 121-133. doi:10.1521/suli.35.2.121.628777
5. Institute of Medicine. (2002). *Reducing suicide: A national imperative.* Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide, Board of Neuroscience and Behavioral Health: Washington, DC: The National Academies Press.
6. Gould, M.S., Wallenstein, S., Kleinman, M.H., O'Carrol, P.W., & Marcy, J.A. (1990). Suicide clusters: An examination of age-specific effects. *American Journal of Public Health, 80*(2), 211–212.
7. Stack, S. (2000). Media impacts on suicide: A quantitative review of 293 findings. *Social Science Quarterly, 81*(4), 957-971.

References continued

Responding to and Working with the Media

8. Etzersdorfer, E., & Sonneck, G. (1998). Preventing suicide by influencing mass-media reporting: The Viennese experience 1980-1996. *Archives of Suicide Research, 4*(1), 67–74. doi:10.1080/13811119808258290
9. Jamieson, P., Jamieson, K.H., & Romer, D. (2003). The responsible reporting of suicide in print journalism. *American Behavioral Scientist, 46*(12), 1643-1660.
10. Sonneck, G., Etzersdorfer, E., & Nagel-Duess, S. (1994). Imitation suicide on the Viennese subway. *Social Science and Medicine, 38,* 453–457.
11. Romer, D., Jamieson, P.E., & Jamieson, K.H. (2006). Are news reports of suicide contagious? A stringent test in six U.S. cities. *Journal of Communication, 56,* 253-270. doi:10.1111/j.1460-2466.2006.00018.x
12. World Health Organization. (2008). *Preventing Suicide: A Resource for Media Professionals.* Retrieved from http://www.who.int/mental_health/prevention/suicide/resource_media.pdf
13. American Association of Suicidology, American Foundation for Suicide Prevention, Annenburg Public Policy Center, Associated Press Editing Managers, Canterbury Suicide Project-University of Otago, Christchurch, New Zealand, Columbia University Department of Psychiatry, . . . UCLA School of Public Health, Community Health Sciences. (2011). *Recommendations for the Media.* Retrieved from www.reportingonsuicide.org
14. The Texas Suicide Prevention Council. (2009). *Coming Together to Care: A Suicide Prevention and Postvention Toolkit for Texas Communities.* Retrieved from http://texassuicideprevention.org/docs_pdf/24215-Mental_Health_09_Suicide_Prev_Book_Complete_FINAL.pdf
15. Washington State Youth Suicide Prevention Program. (2010). *Reporting Guidelines.* Retrieved from http://www.yspp.org/resources/resourcesguidelinesmediamenu.htm#top
16. Mesoudi, A. (2009). *The cultural dynamics of copycat suicide.* PLoS ONE 4(9), e7252, 1-9. doi:10.1371/journal.pone.0007252

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Checklist 7b

Preparing for and Responding to a Death by Suicide

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Responding to and Working with the Media

Sample Forms for Schools

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

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

- *Managing Sudden Traumatic Loss in the Schools: New Jersey Adolescent Suicide Prevention Project* (Revised Edition) by Underwood & Dunne-Maxim.
- *Youth Suicide Prevention Intervention and Postvention Guidelines: A Resource for School Personnel* by The Maine Youth Suicide Prevention Program.
- *After a Suicide: A Toolkit for Schools* by The American Foundation for Suicide Prevention and the Suicide Prevention Resource Center.
- *Suicide Postvention Guidelines: Suggestions for Dealing with the Aftermath of Suicide in the Schools* by the American Association of Suicidology.

Sample Forms for Schools 7a continued

Announcements to Students, Faculty, and Staff Morning Day 1

Sample Announcements for When a Suicide has Occurred

"This morning we heard the extremely sad news that _____ died by suicide last night. I know we are all saddened by his death and send our condolences to his family and friends. Crisis stations will be located throughout the school today for students who wish to talk to a counselor. Information about the funeral will be provided when it is available, and students may attend with parental permission." (2)

Or

"It is with great sadness that I have to tell you that one of our students, _____, has taken [his/her] own life. All of us want you to know that we are here to help you in any way we can.

A suicide death presents us with many questions that we may not be able to answer right away. Rumors may begin to circulate, and we ask that you not spread rumors you may hear. We'll do our best to give you accurate information as it becomes known to us.

Suicide is a very complicated act. It is usually caused by a mental disorder such as depression, which can prevent a person from thinking clearly about his or her problems and how to solve them. Sometimes these disorders are not identified or noticed; in other cases, a person with a disorder will show obvious symptoms or signs. One thing is certain: there are treatments that can help. Suicide should never, ever be an option.

Each of us will react to _____'s death in our own way, and we need to be respectful of each other. Feeling sad is a normal response to any loss. Some of you may not have known _____very well and may not be as affected, while others may experience a great deal of sadness. Some of you may find you're having difficulty concentrating on your schoolwork, and others may find that diving into your work is a good distraction.

We have counselors available to help our school community deal with this sad loss and to enable us to understand more about suicide. If you'd like to talk to a counselor, just let your teachers know.

Please remember that we are all here for you." (3)

Sample Announcement for a Suspicious Death Not Declared Suicide

"This morning we heard the extremely sad news that _____ died last night. This is the only information we have officially received on the circumstances surrounding the event. I know we are all saddened by _____'s death and send our condolences to his family and friends. Crisis stations will be located throughout the school today for students who wish to talk to a counselor. Information about the funeral will be provided when it is available, and students may attend with parental permission." (1, 2)

Or

"It is with great sadness that I have to tell you that one of our students, _____, has died. All of us want you to know that we are here to help you in any way we can.

The cause of death has not yet been determined by the authorities. We are aware that there has been some talk about the possibility that this was a suicide death. Rumors may begin to circulate, and we ask that you not spread rumors since they may turn out to be inaccurate and can be deeply hurtful and unfair to _____ as well as [his/her] family and friends. We'll do our best to give you accurate information as it becomes known to us.

Each of us will react to _____'s death in our own way, and we need to be respectful of each other. Feeling sad is a normal response to any loss. Some of you may not have known _____ very well and may not be as affected, while others may experience a great deal of sadness. Some of you may find you're having difficulty concentrating on your schoolwork, and others may find that diving into your work is a good distraction. We have counselors available to help our school community deal with this sad loss. If you'd like to talk to a counselor, just let your teachers know.

Please remember that we are all here for you." (3)

Sample Forms for Schools 7a continued

Announcements Morning Day 1

Sample Announcement for a Primary or Middle School

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

It is very important to be able to express our feelings about _____'s death, especially our loss and sadness. We want you to know that there are teachers and counselors available in the library all through the day to talk with you about your reaction to _____'s death. If you want to talk with somebody, you will be given a pass to go to the library where we have people who will help us through this difficult time." (1, 2)

Announcements End of Day 1

At the end of the first day, another announcement to the whole school prior to dismissal can serve to join the whole school in their grieving in a simple, non-sensationalized way. In this case, it is appropriate for the building administrator to make an announcement similar to the following over the loud speaker (1, 2):

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

Announcements Day 2

On the second day following the death, many schools have found it helpful to start the day with another announcement by each teacher in their homeroom. This announcement can include additional verified information, re-emphasize the continuing availability of in-school resources, and provide information to facilitate grief. Here's a sample of how this announcement might be handled (2):

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

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

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

Sample Forms for Schools 7a continued

Notification Letter for Parents Following a Suicide

When cause of death has been confirmed as suicide (3, 4)

Date: _____

Dear parents of _____ students,

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

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

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

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

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

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

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

Sincerely,

School Principal

Sample Forms for Schools 7a continued

Notification Letter for Parents Following a Suicide

When cause of death has NOT been confirmed as suicide (3)

Date: _____

Dear parents of _____ students,

I am writing with great sadness to inform you that one of our students, _____, has died. Our thoughts and sympathies are with [his/her] family and friends.

All of the students were given the news of the death by their teacher in [advisory/homeroom] this morning. I have included a copy of the announcement that was read to them.

The cause of death has not yet been determined by the authorities. We are aware that there has been some talk about the possibility that this was a suicide death. Rumors may begin to circulate, and we have asked the students not to spread rumors since they may turn out to be inaccurate and can be deeply hurtful and unfair to _____ as well as [his/her] family and friends. We'll do our best to give you accurate information as it becomes known to us.

Members of our Crisis Response Team are available to meet with students individually and in groups today as well as over the coming days and weeks. Please contact the school office if you feel your child is in need of additional assistance; we have a list of school and community mental health resources.

Information about the funeral service will be made available as soon as we have it. If your child wishes to attend, we strongly encourage you to accompany him or her to the service. If the funeral is scheduled during school hours, students who wish to attend will need parental permission to be released from school.

Please do not hesitate to contact me or one of the school counselors with any questions or concerns.

Sincerely,

School Principal

Sample Forms for Schools 7a continued

Responding to and Working with the Media

Samples of Formal Statement to Notify Media of Suicide

To be provided to local media either upon request or proactively.

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

He/she was a resident of _____ and was active in _____ at the school. Funeral arrangements are not available at this time. School counselors and community mental health representatives are available to any student who wishes to talk about _____'s death." (1)

Or

"School personnel were informed by the coroner's office that a [__]-year-old student at [_____] school has died. The cause of death was suicide.

Our thoughts and support go out to [his/her] family and friends at this difficult time.

The school will be hosting a meeting for parents and others in the community at [date/time/location]. Members of the school's Crisis Response Team [or mental health professionals] will be present to provide information about common reactions following a suicide and how adults can help youths cope. They will also provide information about suicide and mental illness in adolescents, including risk factors and warning signs of suicide, and will address attendees' questions and concerns. A meeting announcement has been sent to parents, who can contact school administrators or counselors at [number] or [e-mail address] for more information.

Trained crisis counselors will be available to meet with students and staff starting tomorrow and continuing over the next few weeks as needed." (3)

Be sure to provide local media outlets with a list community resources, suicide warning signs, and ways the media can be helpful with postvention.

Sample Response to Incoming Calls from Media

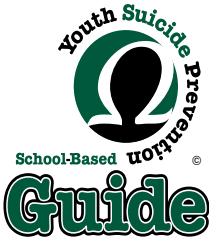
"The school has designated a media spokesperson. Please feel free to contact _____ with your questions and concerns. We would like to respond to your questions in an organized manner. To assist you, _____(name) will be meeting with concerned members of the media at _____ (time) in _____ (place). At that time we will provide information about the school's response to our loss and identify additional resources in the community to support the bereaved. " (1)

References

Responding to and Working with the Media

1. Underwood, M.M., & Dunne-Maxim, K. (1997). *Managing sudden traumatic loss in the schools: New Jersey adolescent suicide prevention project* (revised edition). Piscataway, New Jersey: University of Medicine and Dentistry of New Jersey—University Behavioral Healthcare.
2. The Maine Youth Suicide Prevention Program. (2009). *Youth suicide prevention intervention and postvention guidelines: A resource for school personnel.* Retrieved from http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf
3. The American Foundation for Suicide Prevention and Suicide Prevention Resource Center. (2011). *After a suicide: A toolkit for schools.* Newton, MA: Education Development Center, Inc. Retrieved from http://www.sprc.org/library/AfteraSuicideToolkitforSchools.pdf
4. American Association of Suicidology. (n.d.). *Suicide postvention guidelines: Suggestions for dealing with the aftermath of suicide in the schools (2nd Edition).* Washington, DC: Author.

Notes



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Family Partnerships

Issue Brief 8

"The warning signs were there, but as a parent, I didn't see them."

—Clark Flatt, who lost his 16-year-old son Jason to suicide, and subsequently began the Jason Foundation, a national youth suicide prevention organization.

In the mission to prevent youth suicide, it is critical that school faculty and staff connect with and involve the parents, guardians, and family members of students (22, 23, 24). Family involvement in schools benefits both the student and the school as it increases student achievement and attendance, enhances school climate, and fosters student emotional and social growth (4, 10). Research has also shown that when schools communicate and involve parents with school activities and programs, students feel more competent, and both students and parents are more likely to work toward maintaining those activities and programs (2, 3, 4). The Report of the Surgeon General's Conference on Children's Mental Health (17) stresses that the family is a child's first system of care, and that familial and educational partnership is critical not only to children's mental well-being, but to their academic success as well. Research has shown that children with parents and families who were highly engaged in their school life were less likely to experience detention or expulsion from school (11). Both educators and parents should think of children's mental health and well-being as a critical part of their educational success. "Achieving the Promise: Transforming Mental Health Care in America" (2003), the report of the President's New Freedom Commission on Mental Health made strong recommendations about collaboration with schools in the treatment of children who have mental health challenges (27). We can assume that the principles, goals, and ideas promoted in the report apply to the education system in their efforts to educate children (21).

Sometimes parents may find it difficult to navigate the emotional journeys their children are experiencing, or are not sure what behavior is typical development or normal "growing pains" and what is problematic. And, there is still an unfortunate stigma that surrounds mental illness. Parents may feel that the social stigma of mental crisis is "not what happens to my child." Research has found that parents often do not know how to identify suicidal signs in their children, with one study showing that as many as 86% of parents were unaware of their children's suicidal behavior (25). Another study found that parents were unaware of their children's depressive symptoms, as well as their alcohol use, both risk factors for youth suicidal behavior (18). These studies highlight the difficult reality that parents are sometimes ill equipped to recognize and respond appropriately to their children's mental health crises (15, 18, 23, 25, 26). However, research also indicates that with education, parent's knowledge of suicidal signs and attitude about the importance of youth suicide prevention can improve. One study found that parents who watched a video on youth suicide were able to choose more appropriate responses

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to suicide statements and had more rejecting attitudes of suicide compared to a control group (26). This study also found that parents who were educated about youth suicidal issues increased their intention to assist children and teens that may be facing a suicidal crisis (26).

The importance of educating students' families about mental health and suicide issues is highlighted by the most recent results of the Youth Risk Behavioral Surveillance Survey 2009 (20), where the following percentages of U.S. students responded Yes to the corresponding questions:

- Have you seriously considered suicide? 13.8%
- Have you attempted suicide? 6.3%
- Have you attempted suicide that required medical attention? 1.9%

So how are educators and school personnel to effectively partner with the parents and families of their students in order to prevent youth suicide? Teachers and school counselors must first be well educated in suicidality, its risk factors, warning signs, protective factors, and myths (13). An evidence-based program to educate the faculty and staff is critical, and ideally would include warning signs, risk factors, and what to and not to do when confronted with a student in crisis (23). The school should then work towards gaining support from parents, administrators, and various community members in order to inform them about the prevalence and risk of suicide in their community (6-9, 12, 14, 16, 19). Parents and families have a right to know why a school is engaging their children in suicide-prevention efforts, and why their involvement is so critical (15).

School personnel can assist parents with direction and ideas to become more involved in their children's school in order to foster a positive home/school relationship (19). The following are some ideas to involve parents and families in school-based mental health awareness, coming from a variety of fields, including mental health, substance abuse, special education, and suicide prevention (1, 3, 5, 18, 23, 26):

- Present to the school's Parent-Teacher Association or School Advisory Council on issues surrounding mental health and stigma.
- Empower parents by involving them in decision-making and the planning of topics to be discussed at PTA meetings and Parent-Teacher conferences.
- Help parents feel part of the school community by including them in activities that are not directly related to children's health or disciplinary issues, such as school-improvement projects or chaperoning field trips.
- Schedule meetings, activities, and groups at a variety of times, including afternoon and evenings in order to accommodate families and parents who work "second" or "third" shifts.
- Use the language "family and parental partnership" instead of "involvement" in an effort to stress the shared responsibility that educators and families share in their children's health and success.
- Print articles to parents in the school's newsletter and develop handouts in parent's first language emphasizing the importance of parental involvement.
- Schools usually have a working relationship with the local newspapers for school news, so provide educational information to the media.
- Reach out to faith-based communities (where parents are sometimes involved) to offer educational programs.
- Offer after-school programs or support groups where parents can join with students for peer and family counseling.
- Contact local survivor or suicide prevention advocacy groups (e.g., Suicide Prevention Action Network [SPAN], or the local chapter of the American Foundation for Suicide Prevention).
- Teacher-to-parent contacts should occur frequently. Make sure that you know what problems the student may be having, and let parents know the best time to contact teachers.
- Inform parents well in advance of their child's participation in school activities such as assemblies and programs
- Expand the concept of "volunteerism" and actively recruit parents as classroom volunteers during registration process.

Should teachers and/or school staff believe a child to be at high risk for self harm or suicidal behavior, parents and families should be notified immediately, as well as the school's mental health professional (10, 13, 15). If the youth's parents or guardians do not believe that their child is suicidal or at-risk for self-injury, the school should confer with administration and legal counsel in order to make sure that best practices are implemented when navigating legal and ethical considerations (15).

Developing partnerships with family-run and youth-run organizations can be an effective strategy to reaching and engaging families and youth in suicide prevention activities. Many of these organizations engage in peer support activities to reduce isolation and gather and disseminate accurate information.

Education and partnership is the key. Take every opportunity to discuss and present the facts regarding children's mental health and suicide concerns with parents and families. When families, educators, and youth team up about these issues, all parties will benefit.

References

Family Partnerships

1. Rhodes, R., & Paez, D. (1998). Immigrant parents and the schools: A handout for teachers. *National Association of School Psychologist Toolkit: Practical resources at your fingertips.* Retrieved from http://www.nasponline.org/communications/spawareness/Immigrant%20Parents.pdf

2. Carlyon, P., Carlyon, W., & McCarthy, A.R. (1998). Family and community involvement in school health. In E. Marx, S.F. Wooley, & D. Northrop (Eds.) *Health is academic: A guide to coordinated school health programs* (pp. 67-95). New York, NY: Teachers College Press.

3. Epstein, J.L., & Sheldon, S.B. (2006). Moving forward: Ideas for research on school, family, and community partnerships. In C.F. Conrad & R. Serlin (Eds.), *SAGE Handbook for research in education: Engaging ideas and enriching inquiry* (pp. 117-138). Thousand Oaks, CA: Sage Publishing.

4. Johnson, J., & Duffet, A. (2003). *Where we are now: 12 things you need to know about public opinion and public schools. A digest of a decade of survey research.* New York: Public Agenda. Retrieved from http://www.publicagenda.org/files/pdf/where_we_are_now.pdf

5. The National Association of State Mental Health Directors & The Policymaker Partnership for Implementing IDEA at The National Association of State Directors of Special Education. (2001). *Mental Health, Schools and Families Working Together for All Children and Youth*. U.S. Department of Education, Office of Special Education Programs.

6. Hayden, D.C., & Lauer, P. (2000). Prevalence of suicide programs in schools and roadblocks to implementation. *Suicide and Life-Threatening Behavior, 30*(3), 239-251.

7. Maine, S., Shute, R., & Martin, G. (2001). Educating parents about youth suicide: Knowledge, response to suicidal statements, attitudes, and intention to help. *Suicide and Life-Threatening Behavior, 31*(3), 320-332.

8. Miller, D.N., & Dupaul, G.J. (1996). School-based prevention of adolescent suicide: Issues, obstacles and recommendations for practice. *Journal of Emotional and Behavioral Disorders, 4*(4), 221-230.

9. Kalafat, J., & Ryerson, D.M. (1999). The implementation and institutionalization of a school-based youth suicide prevention program. *The Journal of Primary Prevention, 19*(3), 157-175.

10. Mental Health America (2011). *Promoting Children's Mental Health.* Retrieved from http://www.nmha.org/go/promoting-childrens-mental-health.

11. Osher, T.W., Desai, D., Zaro, S., Xu, Y., Allen, S., CrossBear, S., … Baker, P. (2007). First findings from the family-driven study of family involvement in systems of care. In C. Newman, C. Liberton, K. Kutash, & R.M. Friedman (Eds). *A System of Care for Children's Mental Health: Expanding the Research Base* (pp. 123-127). Tampa, FL: University of South Florida, Louis de la Parte Mental Health Institute, Research and Training Center for Children's Mental Health.

12. King, K. (2001). Developing a comprehensive school suicide prevention program. *The Journal of School Health, 71*(4), 132-137.

13. Suicide Prevention Resource Center. (2010). *Customized Information: Teachers.* Retrieved from http://www.sprc.org/featured_resources/customized/pdf/teachers.pdf

14. Kalafat, J. (2003). School approaches to youth suicide prevention. *American Behavioral Scientist, 46*(9), 1211-1223.

15. Capuzzi, D. (2002). Legal and ethical challenges in counseling suicidal students. *Professional School Counseling, 6*(1), 36-58.

16. Marx, E., & Northrop, D. (1995). *Educating for health: A guide for implementing a comprehensive approach to school health education.* Newton, MA: Education Development Center.

17. U.S. Public Health Service. (2000). *Report of the Surgeon General's conference on children's mental health: A national action agenda.* Washington, DC: Department of Health and Human Services.

18. Velting, D.M., Shaffer, D., Gould, M.S., Garfinkel, R., Fisher, P., & Davies, M. (1998). Parent-victim agreement in adolescent suicide research. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*(11), 1161-1166.

19. Kumper, K.L., & Collings, S.J. (2004). Effectiveness of family focused interventions for school-based preventions. In K. E. Robinson (Ed.) *Advances in School-based Mental Health Interventions: Best Practices and Program Models.* Kingston, New Jersey: Civic Research Institute, Inc.

References continued

Family Partnerships

20. Centers for Disease Control and Prevention. (2010). Youth risk behavior surveillance-United States, 2009. *Morbidity and Mortality Weekly Report, 59*(SS 5), 1-148. Atlanta: US Department of Health and Human Services, Public Health Service, CDC.

21. Duchnowski, A. J., & Kutash, K. (2007). *Family-driven care*. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

22. Borowsky, I.W., Ireland, M., & Resnick, M.D. (2001). Adolescent suicide attempts: Risks and protectors. *Pediatrics, 37*(3), 485-493.

23. Gould, M.S., Marrocco, F.A., Hoagwood, K., Kleinman, M., Amakawa, L., & Altschuler, E. (2009). Service use by at-risk youths after school-based suicide screening. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(12), 1193-1201.

24. Sharaf, A.Y., Thompson, E.A., & Walsh, E. (2009). Protective effects of self-esteem and family support on suicide risk behaviors among at-risk adolescents. *Journal of Child and Adolescent Psychiatric Nursing, 22*(3), 160-168.

25. Kashani, J.H., Goddard, P., & Reid, J.C. (1989). Correlates of suicidal ideation in a community sample of children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 28*, 912-917.

26. Maine, S., Shute, R., & Martin, G. (2001). Educating parents about youth suicide: Knowledge, response to suicidal statements, attitudes, and intention to help. *Suicide and Life-Threatening Behavior, 31*(3), 320-332.

27. President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report* (U.S. DHHS Pub. No. SMA-03-3832). Rockville, MD: U.S. Department of Health and Human Services.

Youth Suicide Prevention School-Based Guide ©

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Culturally and Linguistically Diverse Populations

Issue Brief 9

Youth Suicide Prevention School-Based Guide ©

Suicide rates, and beliefs and attitudes about suicide and suicidal behavior have historically varied across cultures, and it is critical that schools have mental health plans in place that serve several different populations, especially those populations that are represented in the school. For culturally and linguistically diverse students, school climate plays an increasingly important role in suicide prevention. Research has shown that students who feel connected to their school (e.g., felt teachers treated them fairly, felt close to people at school) are less likely to experience suicidal thoughts and emotional distress (13, 14). Research has also shown that school problems can be a risk factor for suicide in adolescents (14), and many teenagers in one psychological autopsy study were found to have died by suicide after an acute disciplinary crisis or rejection or humiliation (9).

A comprehensive suicide prevention program will plan for the provision of translation and interpretation services whenever necessary. Community partners, such as local colleges and universities or specific ethnic/cultural organizations, as well as national organizations, can be instrumental in developing a culturally and linguistically competent prevention program.

Much research has found that individuals of color, or who do not identify as white, have less access to and are less likely to receive quality mental health services (2, 6, 7). Perspectives about mental health and mental illness are influenced by a variety of factors, including but not limited to cultural factors such as race and ethnicity, age, socioeconomics, gender identity, sexual identity and sexual orientation, religion/spiritual beliefs, and physical abilities. The consequences of not understanding these influences can result in unintended and negative effects, including death by suicide. With minority youth more likely to express feelings of alienation, cultural and societal conflicts, academic anxieties, and feelings of victimization, it has become clear that careful attention must be paid to the needs of minority youth and their families within the context of their culture (2, 12, 18).

For the purpose of this Issue Brief, culture can be broadly defined as the shared learned behavior, belief systems, and value orientations that influence customs, norms, and social institutions of a group of people (1). The term race typically is used to describe a person's physical characteristics, including skin color and facial features, although the biological basis of race has been debated (1, 37). Ethnicity is used to refer to people who have common cultural traits, such as language, place of origin, sense of history, or common traditions (1). The concept of ethnicity has similarly been debated (1). Given this more broadened consideration of culture, many students may consider themselves to have multiple cultural identities (2). Following are some unique issues facing some of a variety of cultural groups that are represented in the United States school system regarding suicide and suicide prevention.

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Populations

Latino/Latina Youth

Latinos represent the largest "minority" group in the United States, and yet are an extremely diverse population, including people from Mexico, the Caribbean, and Central and South America (5, 30). One can identify as another race and Hispanic (3, 4), and indeed terms "Latino" and Hispanic" are often used interchangeably, as they are by the U.S. Census Bureau (5, 30). Suicide is the third leading cause of death for youth of Hispanic descent, although it is important to note that 11% of Latina females attempted suicide at least once within a year before taking the 2009 Youth Risk Behavior Surveillance System [YRBSS] (3). The percent of Latina females attempting suicide (11.1%) is higher than most other female racial groups: Black (10.4%), White (6.5%), and Asian (3.7%) and over twice as high as compared to their Latino male peers (5%). Although the Latina female percentage for non fatal suicide attempts is lower than females of multiple races (13.7%), it's higher than the U.S. average (8.1%). Additionally, 40% of Latina females reported feeling sad or hopeless within the last year (3). Unlike many other ethnic groups Latino youth are at an increased risk of dying by suicide than Latinos overall (4, 30).

While Hispanic and Latino cultures can be quite diverse, many Latino populations place high importance on family and interdependence over individualism and independence (12, 43, 45). One study found that Latina females who felt that their mothers were interested and involved in their lives were significantly less likely to make a suicide attempt (44). Similarly, researchers reviewing the literature on Latina suicide found that prevention and intervention needs to be family-oriented (45).

Language barriers are also a unique issue facing suicide prevention efforts in this population. Latinos are less likely to receive formal mental health services, and one study found that adult Latinos are even less likely than other ethnic minority groups to receive quality care for depression (10), possibly because of language barriers (2, 12, 30). While adolescent Latino suicide attempters living in the United States tend to be U.S.-born English speakers, because of the importance placed on family, they tend to want to involve non-English speaking family, potentially causing further barriers if few or no bi-lingual services are available (12, 42).

Feelings of distress may be expressed uniquely by different cultures, and one way that Latino youth, particularly females, tend to express mental health problems is somatization, or the expression of distress through physical symptoms, such as stomach disturbances, chest pain, dizziness, or a burning sensation in the hands and feet (2, 12, 30). This is sometimes referred to "nervios," (nerves) and sometimes Latina females express "ataques de nervios," (dissociative loss of control and sometimes self-injurious behavior) during stressful events (45).

African American Youth

As of 2007, suicide was the third leading cause of death for African Americans ages 15-19, and it is important to note that between the years 1981 and 1995, there was a 133% increase in death by suicide of African American 10 to 19 year-olds (4). While this group has relatively lower rates of death by suicide compared to their white peers, this fact sometimes leads to the myth that African Americans do not die by suicide and is not a group needing special emphasis for prevention (6, 8). Results of the 2009 YRBSS show that about 13% of African American high school students had considered attempting suicide at least once within the past year, and about 8% made at least one attempt (3).

African American youth have a few unique factors influencing their mental well-being, including racial discrimination. Research has shown that systematic discrimination prejudice has been linked with physiological and psychological problems throughout the African American population (2, 37). These difficulties can lead to depression, substance abuse, and hopelessness, which are all risk factors for youth suicide (14, 38).

African American youth have been found to have some unique symptoms and warning signs of suicidal behavior, including extreme anger, acting out, and high-risk behaviors, making it more difficult for clinicians to assess suicidal intent (11, 12). Additionally, suicidal male African American youth may be at higher risk for finding ways to die that do not at first appear to be suicide, including the death-by-police method (12).

As with other ethnic minorities, African Americans have less access to formal mental health services than their white peers, and African American youth seek formal mental health services at lower rates as well (6, 7, 8, 39). Currently there appear to be no published studies of effective suicide prevention programs specifically for African American youth (7). Some research suggests, however, that suicide interventions for these youth may be coupled with religion and spirituality, as, compared to their white peers, African American youth report more involvement in religious activity, and tend to seek mental health services and help through the more informal avenues provided by church members and clergy (6, 7, 39). Family support, coupled with church involvement, have been suggested as protective factors for African American suicidality, although the leading researchers in the field agree that more work needs to be done on this population (6, 7, 11, 38, 39).

American Indian/Alaska Native Youth

Suicide continues to be the second leading cause of death for young American Indian/Alaska Natives [AI/AN], and remains at that rank until their mid-thirties (4). Suicide accounts for the death of almost 20% of AI/AN youth, and in 2009, 19% had seriously considered suicide within the last year, with 10% reporting making an attempt (3). AI/AN teen females die by suicide at three times the rate of their peers in different cultural populations (4), making suicide prevention in these communities vital. It is important to note there is much heterogeneity across AI/AN tribes and communities, with unique circumstances, histories, and suicide rates for each group (7, 12, 32, 34). Approximately two thirds of American Indian children live in urban areas (12, 40) and suicide research on AI/AN groups tend to focus on those who live on reservations, where AI/AN suicide rates are higher (7).

As with the African American community, an important issue to note is the historical trauma experienced by the AI/AN population by the American government (2, 7, 12, 32). Abuses against AI/AN tribes include the forced relocation of entire communities onto reservations, the removal of AI/AN children into boarding schools where they would be prohibited from speaking native languages or performing cultural traditions, and the outlawing of traditional religious practices (7, 12).

Some specific suicide risk factors for AI/AN youth include feeling that one is disconnected from the family or the community, and/or that one is a burden to the community (12, 34, 35). Additionally, these groups are at a higher risk than others for suicide contagion (where exposure to suicide or reports of suicide influence others to attempt suicide), possibly because of the small, intense social systems among youth on reservations (12, 33).

Another important risk factor for many AI/AN populations, including youth, is an elevated rate of alcohol abuse (7, 12). One study that followed American teenagers from 1976 to 2000 found that almost 25% of AI middle school students reported drinking five or more alcoholic drinks in one sitting within the past two weeks (41). As substance abuse is a risk factor for youth suicidal behavior for all youth, and is unfortunately a specific problem in AI/AN populations, it is critical that suicide prevention efforts be integrated into and presented with substance abuse prevention programs.

Some targeted prevention efforts in tribal and public schools have taken into account culture-specific risk factors, such as lack of cultural and spiritual development, loss of ethnic identity, cultural confusion, and acculturation (the socialization process by which minority groups gradually learn and adopt selective elements of the dominant culture) (2, 12), notably the best-practice Zuni Life Skills Development Curriculum, which has shown positive gains (32, 34). A culturally tailored intervention program for the Zuni Pueblo, the curriculum was developed in collaboration with the Zuni community, and has since been adapted for other tribes, and is now known as the American Indian Life Skills Develoment Curriculum (34).

Another significant program utilizing a public health approach and gathering extensive suicide related data is the White Mountain Apache Tribally Mandated Suicide Surveillance System. As a community-wide and community-based system utilizing a participatory research process, the White Mountain Apache Suicide Surveillance System is informing the design and evaluation of the tribe's suicide prevention interventions (31).

Asian American and Pacific Islander Youth

Suicide is the second leading cause of death among Asian American and Pacific Island [AA/PI] youth between the ages of 15 and 19 (4). Like other ethnic minority groups in the United States, this classification is made up of people across Asia, and each group has its unique intergroup cultural differences, as well as suicide rates. Similar to many Latino populations, many Asian ethnicities, including Chinese and Japanese cultures, value interdependence over individualism (20). Therefore a specific risk factor for AA/PI youth suicide is feeling that one has disrupted family or community harmony (12, 20). Another risk factor is being in a family that came to the U.S. as refugees, particularly from South East Asia (12, 28). As with Latino youth, AA/PI youth in mental health crises tend to focus on the somatic symptoms (12).

Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Youth

Unlike the classifications for race and ethnicity, there is no formal tracking of suicide statistics for youth who identify as lesbian, gay, bisexual, or transgender/sexual. Additionally, research in this area does not always use the same criteria when identifying gay, lesbian, bisexual, transgender, or questioning youth. Some research, including the subsets of the Youth Risk Behavior Surveillance System (YRBSS) (54) and the National Longitudinal Study of Adolescent Health [Add Health Study], use two ways to identify LGBQ adolescents: their self-identity as gay, lesbian, bisexual, or unsure, and the sex/gender of their sexual contacts. Some discuss "unsure" as questioning (Q) in research findings including research citing the YRBSS (18, 54).

Studies using data from regional YRBSs have found that LGBQ youth are at higher risk for victimization (18, 22, 55), and were more likely to have suicidal thoughts and attempts than their peers who identified as heterosexual and/or did not engage in same-sex sexual behaviors (14, 19, 23, 55).

Other research uses only respondent's self-identity when categorizing LGBQ youth. One study found that over half of surveyed youth who identified as LGB had been verbally harassed at school, and half of those students had been threatened with violence (56). A recent study that asked Oregon high school students how they self-identify (heterosexual, gay, lesbian, bisexual, or unsure) found that youth who identified as LGBQ were more likely to have attempted suicide in the past year compared to their peers who identified as heterosexual (53).

For sexual minority students, research has shown sexual orientation to be correlated with identified risk factors for suicide and is less of a factor after controlling for these risk factors (14, 25, 26, 27). That is, being LGBQ alone does not put an adolescent at higher risk for suicide, but living "in the closet," being "outed" by someone else, or being ridiculed are specific stressors for this population (18, 19). African American and Latino youth who engage in same-gender sex or identify as LGB, may also be at increased risk as they are less likely than Whites to "come out" to family and friends (48).

The term transgender is used to classify those who do not identify with the gender or sex that they were assigned at birth (15). This could include those who have altered their sexual organs, or those who superficially alter their appearance through dress, hairstyle, or accessories. There is an unfortunate paucity of research on the suicide risk of transgender adolescents, as they are a relatively "hidden" population (22, 57, 58). Transgender youth may be at higher risk for victimization because of gender non-conformity, possibly leading to depression and low self-worth (15). One study using a small sample of self-identified transgender adolescents (55 respondents) found that half of the respondents had thought seriously about taking their lives with half of these youth who reported that those thoughts were related to their trans identity (58). This study also found that one quarter of all 55 respondents had actually made a suicide attempt (58).

Research has shown that supportive communities are a protective factor for LGBQ students (53), specifically with the presence of a Gay/Straight Alliance [GSA] or a similar school-based support group for sexual minority students and heterosexual allies (55). One study found that LGB students who attended schools with GSAs or similar groups were less than half as likely to report feeling victimized, and less than one-third as likely to report making a suicide attempt in the past year than those LBG students from schools with no such support groups (55). In order to make a more inclusionary and supportive school, the Human Rights Watch (22) recommends that faculty, staff, administrators, and volunteers be educated and trained about LGBTQ issues, and additionally, that faculty and staff who are "out" as LGBT be supported institutionally (22). The Suicide Prevention Resource Center also recommends including sexual minority students in LGBTQ program and education development (57). In order to serve the needs of transgender and questioning students, it is recommended that they be able to define themselves in a way that is most appropriate for them and where dress codes are enforced, that they are done so in a gender-neutral manner (22). For developing a safe school environment, the CDC and leading researchers recommend that schools train their staff how to identify harassing behavior, effectively intervene in bullying situations, and include the needs of LGBTQ students in mental health campaigns (21, 22, 29, 54, 57).

Other Risk Factors

Geographic diversity is also a factor in developing effective suicide prevention strategies. For example, research suggests that in inner city areas, African American youth suicide attempts occur at about twice the national rate (46). Another study suggests that tribal communities located within urban areas had substantially lower rates of suicide than did those for which the "lights of the city" were only on the horizon (47). Additionally, one study revealed that the risk of suicidal ideation is higher for urban African American and Latino youth when basic needs are unmet (48). While much attention has been given lately to the bullying and victimization of LGBTQ students, research shows that in fact any student who doesn't "fit in" or those who differ from the majority of their classmates in regards to race, religion, or ethnicity are also at risk for bullying, which may increase certain risk factors for suicide. Subsequently, bullied adolescents may be at increased risk for suicide attempts and death by suicide (7, 16, 17, 19, 24).

Protective Factors

The role of protective factors (factors and experiences that appear to reduce risks for suicide) is an important focal point in any youth suicide prevention strategy, and especially for culturally and linguistically diverse youth. Addressing protective factors (i.e., success at school, interpersonal connectedness and belonging, and supportive family dynamics) can help to identify and build upon youths' strengths and assets. The role of the family cannot be overstated. For LGBT youth, family acceptance predicts greater self-esteem, social support, and general health status; it also protects against depression, substance abuse, and suicidal ideation and behaviors (49). During the complex developmental period of adolescence, the formation of strong cultural and ethnic identity may protect

against suicidal and other risk behaviors as youth may feel less isolated and alone (50, 51, 52).

While most of the research literature about LGB youth has historically focused on risk factors and problem behaviors as well as socio-cultural and psychological challenges that LGB youth experience, research on protective factors and resilience for LGB youth is starting to emerge and shows early promise for approaches that will enhance the care and well-being of LGBT youth and their families (36).

Resources

The following are some resources that may be helpful for gathering additional information:

The Suicide Prevention Resource Center (SPRC) has several links and resources for special populations on its website, including: http://www.sprc.org/links/spoplinks.asp http://www2.sprc.org/aian/index - for AI/AN suicide prevention

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

To Live to See the Great Day that Dawns is a comprehensive US Department of Health and Human Services resource about preventing American Indian and Alaska Native youth suicide. Free PDF at http://www.sprc.org/library/Suicide_Prevention_Guide.pdf

Indian Health Service Injury Prevention Program Website seeks to raise the health status of American Indians and Alaska Natives to the highest possible level by decreasing the incidence of severe injuries and death to the lowest possible level and increasing the ability of tribes to address their injury problems. http://www.ihs.gov/MedicalPrograms/InjuryPrevention/index.cfm

Suicide Prevention Links in Spanish lists links to public information materials in Spanish language on mental health and suicide, including two specific to suicide among adolescents: Understanding Suicide: The Basics and Suicide Prevention: A Parent and Teen Guide to Recognizing Suicide Warning Signs. http://www.helppromotehope.com/documents/Spanish_Materials.pdf

Communities that Care is a coalition-based community prevention operating system that uses a public health approach to prevent youth problem behaviors such as violence, delinquency, school drop out and substance abuse. http://www.sdrg.org/CTCInterventions.asp

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

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

DiversityRx
www.diversityRx.org

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

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

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

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

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

References

1. American Psychological Association. (2002). *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists.* Washington DC: Author.
2. U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD.
3. U.S. Department of Health and Human Services. (2010). Youth Risk Behavior Surveillance-United States, 2009. *MMWR, 59*(SS-5).
4. Centers for Disease Control and Prevention (CDC), WISQARS. (2011). *Leading Causes of Death.* Retrieved from http://webappa.cdc.gov/sasweb/ncipc/leadcaus10.html
5. Flores G., Fuentes-Afflick E., Barbot O., Carter-Pokras O., Claudio L., Lara M, . . . Gomez, F. J. (2002). The health of Latino children: Urgent priorities, unanswered questions, and a research agenda. *JAMA, 288,* 82–90. doi:10.1001/jama.288.1.82
6. Barnes, D.H. (2010). Suicide. In R.L. Hampton, T.P. Gullotta, & R.L. Crowel (Eds.), *The Handbook of African American Health* (pp. 444-460). New York: Guilford Press.
7. Goldston, D.B., Molock, S.D., Whitbeck, L.B., Murakami, J.L., Zayas, L.H., & Hall, G.N. (2008). Cultural considerations in adolescent suicide prevention and psychosocial treatment. *American Psychologist, 63*(1), 14-31.

References continued

Culturally & Linguistically Diverse Populations

8. Garlow, S. J., Purselle, D., & Heninger, M. (2005). Ethnic differences in patterns of suicide across the life cycle. *American Journal of Psychiatry, 162*(2), 319-323.

9. Shaffer, D. (1988). Preventing teenage suicide: A critical review. *Journal of the American Academy of Child and Adolescent Psychiatry, 27,* 675–687.

10. Schoenbaum, M., Miranda, J., Sherbourne, C., Duan, N., & Wells, K. (2004). Cost effectiveness of interventions for depressed Latinos. *Journal of Mental Health Policy Economics, 7,* 69-76.

11. Gibbs, J. T. (1988). Conceptual, methodological and sociological issues in black youth suicide: Implications for assessment and early intervention. *Suicide and Life-Threatening Behavior, 18*(1), 73–89.

12. U.S. Department of Health and Human Services. (2010). *To live to see the great day that dawns: Preventing suicide by American Indian and Alaska Native youth and young adults.* DHHS Publication SMA (10)-4480, CMHS-NSPL-0196. Center for Mental Health Services, Substance Abuse and Mental Health Service Administration.

13. King, K. A. (2001). Developing a comprehensive school suicide prevention program. *The Journal of School Health, 71*(4), 132–137.

14. Borosky, I. W., Ireland, M., & Resnick, M. D. (2001). Adolescent suicide attempts: Risks and protectors. *Pediatrics, 107*(3), 485–493.

15. Transgender Suicide Prevention Working Group. (2008). *Preventing Transgender Suicide: An Introduction for Providers.* Boston, MA: Massachusetts Department of Public Health. Retrieved from www.masstpc.org/publications/suicideprevention.shtml

16. Klomek, A. B., Sourander, A., Neimela, S., Kumpulainen, K., Pila, J., Tamminen, T, . . . Gould, M.S. (2009). Childhood bullying behaviors as a risk for suicide attempts and completed suicides: A population-based birth cohort study. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(3), 254-261.

17. Klomek, A. B., Marrocco, F., Kleinman, M., Schonfeld, I. S., & Gould, M. S. (2007). Bullying, depression, and suicidality in adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(1), 40-49.

18. Bontempo, D. E., & D'Augelli, A. R. (2002). Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. *Journal of Adolescent Health, 30*(5), 364–374.

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

20. Oyserman, D., Coon, H., & Kemmelmeier, M. (2002). Rethinking individualism and collectivism: Evaluation of the theoretical assumptions and meta-analysis. *Psychological Bulletin, 128*(1), 3-72.

21. Klomek, A.B., Sourander, A., Kumpulainen, K., Piha, J., Tamminem, Moilen, I, … Gould, M. S. (2008). Childhood bullying as a risk for later depression and suicidal ideation among Finnish males. *Journal of Affective Disorders, 109,* 47-55.

22. Durant, R.H., Krowchuk, D.P., & Sinal, S.H. (1998). Victimization, use of violence, and drug use at school among male adolescents who engage in same-sex sexual behavior. *Journal of Pediatrics, 132,* 113-118.

23. Russel, S. T., Franz, B. T., & Driscoll, A. K. (2001). Same-sex romantic attraction and experiences of violence in adolescence. *American Journal of Public Health, 91*, 903–906.

24. Nansel, T. R., Overpeck, M., Pilla, R. S., Ruan, W. J., Simons-Morton, B., & Scheidt, P. (2001). Bullying behaviors among US youth: Prevalence and association with psychological adjustment. *Journal of the American Medical Association, 285,* 2094–2100.

25. Gould, M., Greenberg, T., Velting, D., & Shaffer, D. (2003). Youth suicide risk and prevention interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 33,* 1080–1086.

26. Moscicki, E. (1999). Epidemiology of suicide. In D. G. Jacobs (Ed.), *The Harvard Medical School guide to suicide assessment and intervention* (pp. 40–51). San Francisco: Jossey-Bass Publishing.

27. Shaffer, D., Gould, M., & Fisher, P. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry, 53,* 339–348.

28. Nidorf, J. (2001). Mental health and refugee youths: A model for diagnostic training. In J. T. Gibbs & L. N. Huang (Eds.), *Children of color, Psychological interventions with culturally diverse youth.* Jossey-Bass Publishers, San Francisco, CA.

29. Davidson, L., & Marshall, M. (2003). *School-based suicide prevention: A guide for the students, families, and communities they serve.* American Association of Suicidology: The Task Force for Child Survival and Development.

References continued

Culturally & Linguistically Diverse Populations

30. National Council of La Raza, Institute for Hispanic Health. (2005). *Critical disparities in Latino mental health: Transforming Research into action.* Retrieved from http://depressionisreal.org/pdfs/file_WP_Latino_Mental_Health_FNL.pdf

31. Mullany, B., Barlow, A., Goklish, N., Larzelere-Hinton, F., Cwik, M., Craig, M., & Walkup, J.T. (2009). Toward understanding suicide among youths: Results from the White Mountain Apache Tribally Mandated Suicide Surveillance System, 2001-2006. *American Journal of Public Health, 99*(10), 1840-1848. doi:10.2105/AJPH.2008.154880

32. LaFromboise, T. D., & Lewis, H. A. (2008). The Zuni Life Skills Development Program: A school/community-based suicide prevention intervention. *Suicide and Life-Threatening Behavior, 38*(3), 343-353.

33. Wissow, L., Walkup, J., Barlow, Reid, R., & Kane, S. (2001). Cluster and regional influences on suicide in a Southwestern American Indian tribe. *Social Science and Medecine, 53*(9), 1115-1124.

34. LaFromboise, T. (2006). American Indian youth suicide prevention. *The Prevention Researcher, 13*(3), 16-18.

35. Borowsky, I. W., Resnick, M. D., Ireland, M., & Blum, R. W. (1999). Suicide attempts among American Indian and Alaska Native youth: Risk and protective factors. *Archives of Pediatric Adolescent Medicine, 153,* 573-580.

36. Lazear, K.J., & Gamach, P.E. (in press). The resilience u-turn: Understanding risks and strengths to effectively support LGBT youth and families in systems of care. In C. Ryan, S. Fisher, G. Blau, & J. Poirier (Eds.), *Addressing the needs of youth who are LGBT and their families: A system of care approach.* Brooks Publishing Co.

37. Clark, R., Anderson, N., Clark, V., & Williams, D. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist, 54*(10), 805-816.

38. Gibbons, F., Gerard, M., Cleveland, M., Wills, T., & Brody, G. (2004). Perceived discrimination and substance use in African American parents and their children: A panel study. *Journal of Personality and Social Psychology, 86,* 517-529.

39. Molock, S. D., Matlin, S., Barksdale, C., & Lyles, J. (2008). Developing suicide prevention programs for African American youth in African American churches. *Suicide and Life-Threatening Behavior, 38*(3), 323-333.

40. Snipp, C. M., (2005) *American Indian and Alaska Native children: Results from the 2000 census.* Washington DC: Population Reference Bureau.

41. Wallace, J., Backman, J., O'Malley, P., Schulenberg, J., Cooper, S., & Johnston, L. (2003). Gender and ethnic differences in smoking, drinking, and illicit drug use among American 8th, 10th, and 12th grade students, 1976-2000. *Addiction, 98*(2), 225-234.

42. Cabassa, L., Lester, R., & Zayas, L. (2007). "It's like being in a labyrinth:" Hispanic immigrants' perceptions of depression and attitudes towards treatments. *Journal of Immigrant Health, 9*(1), 1-16.

43. Zayas, L., Lester, R., Cabassa, L., & Fortuna, L. (2005). "Why do so many Latina teens attempt suicide?:" A conceptual model for research. *American Journal of Orthopsychiatry, 75*(2), 275-287.

44. Turner, S., Kaplan, C.P., Zayas, L., & Ross, R. (2002). Suicide attempts by adolescent Latinas: An explanatory study of individual and family correlates. *Child and Adolescent Social Work Journal, 19*(5), 357-373.

45. Zayas, L. H., & Allyson, M. P. (2008). Suicidal behavior in Latinas: Explanatory cultural factors and implications for intervention. *Suicide and Life-Threatening Behavior, 32*(3), 334-342.

46. Price, J. H., Drake, J. A., & Kucharewski, R. (2001). Assests as predictors of suicide attempts in African American inner-city youths. *American Journal of Health Behavior, 25,* 367-375.

47. Chandler, J. M., & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry, 35*(2), 191-219.

48. O'Donnell, L., O'Donnell, C., Wardlaw, D. M., & Stueve, A. (2004). Risk factors influencing suicidality among urban African American and Latino youth. *American Journal of Community Psychology, 33*(1/2), 37-49.

49. Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2009). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing, 23*(4), 205–213.

50. French, S. E., Seidman, E., Allen, L., & Aber, J. L. (2000). Racial/ethnic identity, congruence with the social context, and the transition to high school. *Journal of Adolescent Research, 15*(5), 587-602.

51. Phinney, J. S. (1992). The multigroup ethnic identity measure: A new scale for use with diverse groups. *Journal of Adolescent Research, 7,* 156-176.

52. Oyserman, D., Brickman, D., & Rhodes, M. (2007). Racial

References continued

Culturally & Linguistically Diverse Populations

ethnic identity: Content and consequences for African American and Latino youth. In A. Fuligni (Ed.), *Contesting stereotypes and creating identities: Social categories, social identities and educational participation* (pp. 91-114). New York: Russell Sage Foundation.

53. Hatzenbuehler, M.L. (2011). The social environment and suicide attempts in lesbian, gay, and bisexual youth. *Pediatrics, 127*(5), 895-903.
54. U.S. Department of Health and Human Services. (2011). *Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9-12-Youth Risk Behavior Surveillance, selected sites, United States, 2001-2009.* MMWR, 6 [Early Release]. Retrieved from http://www.cdc.gov/mmwr/pdf/ss/ss60e0606.pdf
55. Goodenow, C., Szalacha, L., & Westheimer, K. (2006). School support groups, other school factors, and the safety of sexual minority adolescents. *Psychology in the Schools, 43*(5), 573-589.
56. D'Augelli, A.R., Pilkington, N.W., & Hershberger, S.L. (2002). Incidence and mental health impact of sexual orientation victimization of lesbian, gay, and bisexual youths in high school. *School Psychology Quarterly, 17*(2), 148-167.
57. Suicide Prevention Resource Center. (2008). *Suicide risk and prevention for lesbian, gay, bisexual, and transgender youth.* Newton, MA: Education Development Center, Inc. Retrieved from http://www.sprc.org/library/SPRC_LGBT_Youth.pdf
58. Grossman, A., & D'Augelli, A.R. (2007). Transgender youth and life-threatening behaviors. *Suicide and Life-Threatening Behavior, 37*(5), 527-537.

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Checklist 9

Culturally and Linguistically Diverse Populations

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Checklist 9

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

Yes	No	
☐	☐	Your school acknowledges that culture, as it is broadly defined beyond race and ethnicity, is an integral part of the physical, emotional, intellectual, and overall development and well being of its students and their families.
☐	☐	Your school provides on-going opportunities for all students to experience feelings of "connectedness" to the school.
☐	☐	Your school conducts regular annual assessments at all levels to identify needs, barriers, challenges, strengths, and readiness to develop a welcoming and safe environment for all youth.
☐	☐	Your school has and enforces anti-harassment and anti-discrimination policies, including an anti-bullying program, and staff intervenes in an appropriate manner when they observe students or other staff engage in behaviors that show cultural insensitivity, bias, or prejudice.
☐	☐	Your school considers cultural factors such as language, race, ethnicity, customs, family structure, sexual orientation, and tribal and/or community dynamics when planning, designing, and delivering programs and curriculums.

— continued next page

Checklist 9 continued

Yes	No	
☐	☐	Your school respects the culture, diversity, and rights of its students and their families, as well as those of school staff.
☐	☐	Your school's administrative policies and procedures acknowledge and respond to the need for services to culturally diverse families.
☐	☐	Your school provides opportunities for youth who are LGBTQ to discuss experiences, exchange ideas, and obtain needed information in a confidential, nurturing, safe, and supportive environment.
☐	☐	Your school's informative materials (such as letters home to parents and announcements) are designed in culturally and linguistically diverse print and other forms of media to meet the linguistic needs of students and their families, and makes bilingual services available when needed or requested by a student or family.
☐	☐	Your school leadership and board actively promote the recruitment of culturally diverse staff members, and includes cultural competency requirements in staff job descriptions and discusses the importance of cultural awareness and competency with potential employees.
☐	☐	Your school has enough staff who are proficient in writing and speaking the languages of its students and their families.
☐	☐	Your school addresses health education and health services in a culturally and linguistically competent manner to meet the needs of all students, including LGBT youth.
☐	☐	Your school seeks information from family members or other knowledgeable community members that will assist in the school's ability to respond to the needs and preferences of culturally and ethnically diverse students and families.
☐	☐	Your school considers whether the physical appearance (decorations, displays, etc.) is respectful of different cultural groups, and displays pictures, posters, and other materials that reflect the cultures and ethnic backgrounds of students and their families.
☐	☐	Your school is knowledgeable about federal and state statutes and regulations that relate to culturally and linguistically diverse populations.
☐	☐	Your school provides all staff with continuous cultural competency training and information relevant to the diversity of its students and families.
☐	☐	Your school is committed to creating an atmosphere of understanding, respect, and support for cultural diversity throughout its programs.
☐	☐	Your school educates all staff regarding unique suicide risk factors and warning signs for certain ethnic groups and cultures, including specific histories and difficulties experienced by some communities.
☐	☐	Your school's suicide prevention program addresses the unique mental health needs of children of various ethnic groups, sexual orientations, and gender identities.
☐	☐	Your school promotes positive attitudes and supports staff working with diverse youth.
☐	☐	Your school builds relationships with other community organizations that support culturally and linguistically diverse youth (including youth who are LGBTQ) and collaborate with appropriate youth and family advocacy organizations.

Notes

The Guide's checklist was adapted from

- The Child Welfare League of America's *Cultural Competence Agency Self-Assessment Instrument* (http://www.cwla.org/programs/culturalcompetence/culturalabout.htm)
- The National Association of School Psychologists' *Provision of Culturally Competent Services in the School Setting* (http://www.nasponline.org/resources/culturalcompetence/definingcultcomp.aspx)
- National Center for Cultural Competence, Georgetown University Center for Child and Human Development's *Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Special Health Needs and Their Families* (http://nccc.georgetown.edu/documents/ChecklistCSHN.pdf)
- National Center for Cultural Competence, Georgetown University Center for Child and Human Development's *Practice Brief 1: Providing Services and Supports for Youth who are Lesbian, gay, Bisexual, Transgender, Questioning, Intersex or Two-Spirit* (http://nccc.georgetown.edu/documents/lgbtqi2s.pdf)

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Suicide Prevention Programs

Programs

P

This Issue Brief is adapted from information from **The Best Practices Registry** (**BPR**). This Brief contains programs/projects/efforts included as of February 2012. Please go online to Suicide Prevention Resource Center's (SPRC's) Best Practices Registry (BPR) at **http://www2.sprc.org/bpr/index** for the most current listings and to obtain program descriptions and additional information about the BPR. This Issue Brief includes all youth and school-related programs (as of 2/12) on the BPR. While some are not specifically school-based, a number may have application to youth-focused intervention programs (e.g., clinical). An abbreviated program description is included in this Issue Brief for school-based interventions listed in Section 1b: List of SPRC Reviewed Evidence-Based Practices. More detailed descriptions are provided at the above link. It is the reader's sole responsibility to determine whether any of the information contained in these materials is useful to them. *No specific endorsement is implied with the inclusion of a given program*. Absence of a program does not presume negative judgment of its value.

Purpose and Structure of the BPR

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

The BPR has three sections or categories:

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

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

This section contains interventions that have undergone rigorous evaluation and have demonstrated positive and successful outcomes (generally, reductions in suicidal behaviors or risks) based on well-designed research studies. Section

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

Section I: Evidence-Based Programs

I includes listings from two sources: (a) interventions reviewed and rated by SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP); and (b) programs reviewed as part of the SPRC/AFSP Evidence-Based Practices Project (which stopped conducting reviews in 2005). This section is divided into two subsections:

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

Section 1a: List of NREPP–Reviewed Suicide Interventions

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

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

Twelve programs were reviewed and classified as evidence-based (either Effective or Promising) by SPRC/AFSP. A brief description of school-based programs reviewed are included below. The most current information along with each program description can be found at the BPR at http://www2.sprc.org/bpr/section-i-evidence-based-programs under SPRC/AFSP Evidence-Based Practices Project (EBPP).

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

Table 1: School Based Programs

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

[1] National Registry of Evidenced-based Programs and Practices (NREPP)
[2] SPRC/AFSP Evidence-Based Practices Project

School Based Programs

C-Care/CAST

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

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

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

Columbia University TeenScreen

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

Lifelines

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

Reconnecting Youth

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

SOS Signs of Suicide

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

American Indian Life Skills Development/Zuni Life Skills Development

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

Section II: Expert and Consensus Statements

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

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

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

The most current information along with each program description can be found at the BPR at http://www2.sprc.org/bpr/section-ii-expertconsensus-statements.

Table 2: Expert and Consensus Statements

BPR Section II Program listing	Author
A Resource Guide for Implementing the Joint Commissions 2007 Patient Goals on Suicide	Screening for Mental Health, Inc.
Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment: A Treatment Improvement Protocol TIP 50	Substance Abuse and Mental Health Services Administration
Consensus Statement on Youth Suicide by Firearms	Youth Suicide by Firearms Task Force and the American Association of Suicidology
Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student	Jed Foundation
Guidelines for School Based Suicide Prevention Programs	American Association of Suicidology
National Guidelines for Seniors' Mental Health: The Assessment of Suicide Risk and Prevention of Suicide	Canadian Coalition for Seniors' Mental Health
Reporting on Suicide: Recommendations for the Media	Multiple Authors
Recommendations for Youth Suicide Prevention Training for Early Identification and Referral (Gatekeeper Training)	Lessons Learned Working Group
Standards for the Assessment of Suicide Risk Among Callers to the National Suicide Prevention Lifeline	National Suicide Prevention Lifeline
Student Mental Health and the Law	Jed Foundation
Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority	National Association of State Mental Health Program Directors
Talking About Suicide & LGBT Populations	Multiple Authors
Towards Good Practice: Standards and Guidelines for Suicide Bereavement Support Groups	Lifeline Australia
Video Evaluation Guidelines (for Youth Suicide Prevention)	American Association of Suicidology
Warning Signs for Suicide Prevention	American Association of Suicidology

Section III: Adherence to Standards

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

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

The most current information along with each program descriptions can be found at the BPR at http://www2.sprc.org/bpr/section-iii-adherence-standards.

Table 3: Programs, Practices, and Policies that Adhere to Standards

BPR Section III Program, Practices, & Policies Listing with Author	Awareness Materials	Educational & Training Programs	Guidelines & Protocols	Screening
"Is Your Patient Suicidal?" Emergency Department Poster and Clinical Guide, Suicide Prevention Resource Center	X			
After an Attempt: A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors, National Suicide Prevention Lifeline	X			
After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department, National Suicide Prevention Lifeline	X			
After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department, National Suicide Prevention Lifeline	X			
Depression and Bipolar Wellness Guides for Parents and Teens, Families for Depression Awareness	X			
Depression Wellness Guide for Adults with Depression and their Family and Friends, Families for Depression Awareness	X			
Not My Kid: What Parents Should Know About Teen Suicide	X			
Parents as Partners: A Suicide Prevention Guide for Parents	X			
Preventing Transgender Suicide: An Introduction for Providers	X			
Saving Our Lives: Transgender Suicide Myths, Reality and Help	X			
Suicide: Coping with the Loss of a Friend or Loved One	X			
Supporting Survivors of Suicide Loss: A Guide for Funeral Directors	X			
What is Depression? How to Treat It and What to Do--A Suicide Prevention Guide for Young People	X			
Survivor Voices: Sharing the Story of Suicide Loss		X		
Applied Suicide Intervention Skills Training (ASIST), LivingWorks		X		

Table 3: Programs, Practices, and Policies that Adhere to Standards continued

BPR Section III Program, Practices, & Policies Listing with Author	Awareness Materials	Educational & Training Programs	Guidelines & Protocols	Screening
Army ACE Suicide Intervention Program, U.S. Army		X		
Ask 4 Help Suicide Prevention for Youth, Yellow Ribbon Suicide Prevention Program		X		
Assessing and Managing Suicide Risk: Core Competencies (AMSR), SPRC Training Institute		X		
At-Risk for High School Educators, Kognito Interactive		X		
At-Risk for University and College Faculty: Identifying and Referring Students in Mental Distress, Kognito Interactive		X		
At-Risk for University and College Students		X		
At-Risk in the ED		X		
Be A Link Suicide Prevention Gatekeeper Training, Yellow Ribbon Suicide Prevention Program		X		
CALM: Counseling on Access to Lethal Means, Prevention Center at Children's Hospital at Dartmouth		X		
Campus Connect: A Suicide Prevention Training for Gatekeepers, Syracuse University		X		
Connect/Frameworks Suicide Prevention Program, NAMI New Hampshire		X		
EndingSuicide.com, Med Student Learning		X		
Family of Heroes: Training for Family Members of Veterans		X		
Gryphon Place Gatekeeper Suicide Prevention Program-A Middle School Curriculum, Gryphon Place		X		
Healthy Education for Life (HELP), Heartline Oklahoma		X		
Helping Every Living Person (HELP) Depression and Suicide Prevention Curriculum, Washington Youth Suicide Prevention Program		X		
High School Gatekeeper Curriculum, Gryphon Place		X		
How Not To Keep A Secret		X		
Late Life Suicide Prevention Toolkit, Canadian Coalition for Seniors' Mental Health		X		
LEADS for Youth: Linking Education and Awareness of Depression and Suicide, Suicide Awareness Voices of Education		X		
Let's Talk Gatekeeper Training, Massachusetts Department of Public Health		X		
LifeSavers Training		X		
LOOK LISTEN LINK: A Health Curriculum for Middle School, Gryphon Place		X		
Making Educators Partners in Youth Suicide Prevention, Society for the Prevention of Teen Suicide		X		
More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel, American Foundation for Suicide Prevention		X		
More Than Sad: Teen Depression, American Foundation for Suicide Prevention		X		

Table 3: Programs, Practices, and Policies that Adhere to Standards continued

BPR Section III Program, Practices, & Policies Listing with Author	Awareness Materials	Educational & Training Programs	Guidelines & Protocols	Screening
Operation S.A.V.E.: VA Suicide Prevention Gatekeeper Training, Veterans Administration		X		
QPRT Suicide Risk Assessment and Management Training, QPR Institute		X		
Question, Persuade, Refer (QPR) Gatekeeper Training for Suicide Prevention, QPR Institute		X		
Recognizing and Responding to Suicide Risk in Primary Care (RRSR—PC), American Association of Suicidology		X		
Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians, American Association of Suicidology		X		
Response: A Comprehensive High School-based Suicide Awareness Program, ColumbiaCare		X		
Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version, Department of Veterans Affairs		X		
School Suicide Prevention Accreditation, American Association of Suicidology		X		
SOS Signs of Suicide Middle School Program, Screening for Mental Health, Inc.		X		
Sources of Strength, Sources of Strength, Inc.		X		
Student Support Network, Worcester Polytechnic Institute		X		
Suicide Alertness for Everyone (safeTALK), LivingWorks		X		
Suicide Prevention Multicultural Competence Kit, PACE University Counseling Center		X		
Suicide Prevention Training for Gatekeepers of Older Adults, Samaritans of Merrimack Valley, MA		X		
Teens for Life, Crisis Support Services of Alameda County, CA		X		
The DORA College Program (Depression OutReach Alliance)		X		
Working Minds: Suicide Prevention in the Workplace, Carson J Spencer Foundation		X		
After a Suicide: A Toolkit for Schools			X	
Lifelines Postvention: Responding to Suicide and Other Traumatic Death, Hazelden			X	
Riverside Trauma Center Postvention Protocols			X	
Suicide Assessment Five-Step Evaluation and Triage (SAFE-T), Screening for Mental Health			X	
Youth Suicide Prevention School-based Guide Checklists, Louis de la Parte Florida Mental Health Institute, University of South Florida			X	
Youth Suicide Prevention, Intervention, and Postvention Guidelines: A Resource for School Personnel, The Maine Youth Suicide Prevention Program			X	
Interactive Screening Program, American Foundation for Suicide Prevention				X

Using the BPR

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

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

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

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

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

Youth Suicide Prevention School-Based Guide ©

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Developed by

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

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Resources and Links

Resources

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

Crisis Lines

1-800-273-TALK (8255)

The National Suicide Prevention Lifeline is a free, confidential, 24-hour, 7-day a week hotline available to anyone in suicidal crisis or emotional distress; connects the caller to certified help from nearest crisis center; can call for self or someone individual cares about.

http://www.suicidepreventionlifeline.org/

1-866-4-U-TREVOR or 1-866-488-7386

The Trevor Lifeline is a national, confidential 24-hour toll-free suicide prevention hotline aimed at lesbian, gay, bisexual, transgender, and questioning youth. If a young person is looking for someone to listen and understand without judgment or if he/she is feeling suicidal, The Trevor Lifeline is available at 866-488-7386. All calls are handled by trained counselors.

http://www.thetrevorproject.org/

1-800-448-3000

The Boys Town National Hotline℠ is open 24 hours a day, 365 days a year and staffed by specially trained Boys Town counselors. Parents, teens and families can find help with the following: Suicide Prevention, Runaways, Parenting troubles, School issues, and more. Spanish-speaking counselors and translation services, representing more than 140 languages, are available, along with a TDD line (1-800-448-1833) that allows counselors to communicate with speech-impaired and deaf callers.

http://www.boystown.org/national-hotline

Resources

R

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CFS Community SOLUTIONS
All Children & Youth—Every Community

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

Florida Organizations

Florida Initiative for Suicide Prevention

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

http://www.fisponline.org

Florida Suicide Prevention Coalition (FSPC)

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

http://www.floridasuicideprevention.org

YES Institute

YES Institute provides education that gets at the source of why youth are harassed. Their mission is to prevent suicide and ensure the healthy development of all youth through powerful communication and education on gender and orientation. Their mission is accomplished through powerful communication and education with people in all segments of the community—throughout the U.S. and Latin America.

http://www.yesinstitute.org

Suicide Stops Here: The Florida Suicide Prevention Implementation Project

A site for individuals, schools, coalitions, task forces, faith-based organizations, employers, health providers, and state and system leaders who are interested in taking action to prevent the tragic loss of life from suicide. The Florida Suicide Prevention Implementation Project (FSPIP) is a collaborative effort between the Louis de la Parte Florida Mental Health Institute (FMHI) at the University of South Florida, the Statewide Office of Suicide Prevention and the Suicide Prevention Coordinating Council to implement the Florida Suicide Prevention Strategy on the local level. This project serves as the avenue through which the state plan is rooted and sustained in the community.

http://preventsuicide.fmhi.usf.edu/

Statewide Office of Suicide Prevention and Suicide Prevention Coordinating Council

The Web site is designed to be used by the Suicide Prevention Coordinating Council, school personnel, state agencies, community members, faith-based organizations, employers, and others as a resource for suicide prevention. The website goals include:

- Build collaboration and facilitate cooperation between the State and communities
- Assist in the implementation of the Florida Suicide Prevention Strategy
- Ensure accessibility to suicide prevention resources statewide
- Provide updates to the people of Florida on current suicide prevention initiatives and activities overseen by the Statewide Office of Suicide Prevention

http://www.helppromotehope.com/

Advocacy Groups/Organizations

Yellow Ribbon Suicide Prevention Program®
Light for Life Foundation International

Yellow Ribbon is dedicated to preventing youth suicide and suicide attempts by making suicide prevention accessible to everyone and removing barriers to help by empowering communities and individuals through leadership, awareness and education and by collaborating and partnering with support networks to save lives.

http://www.yellowribbon.org

National Alliance on Mentally Illness (NAMI)

NAMI offers an array of peer education and training programs, initiatives and services for individuals, family members, health care providers and the general public. NAMI's education and support programs provide relevant information, valuable insight, and the opportunity to engage in support networks. These programs draw on the lived experience of individuals who have learned to live well with mental illness and have been extensively trained to help others, as well as the expertise of mental health professionals and educators.

http://www.nami.org

Resources and Links continued

National Federation of Families for Children's Mental Health (FFCMH)

The FFCMH is a U.S. national parent-run organization supporting family-run programs to meet the needs of children and youth with emotional, behavioral, or mental disorders.

http://www.ffcmh.org

National Traumatic Stress Network (NTSN)

The mission of the NTSN is to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States.

http://www.nctsn.org

SAVE - Suicide Awareness Voices of Education

SAVE believes that suicide is preventable and that suicide prevention works. In order to accomplish its mission and goals, SAVE uses the public health model along with a media campaign to raise awareness of suicide. SAVE uses an educational approach to dispel the myths about suicide and to let others know about the realities surrounding what in 1999 the former U.S. Surgeon General David Satcher called a "public health crisis."

http://www.save.org

Suicide Prevention Action Network (SPAN)

SPAN USA is the policy division of the American Foundation for Suicide Prevention.

http://www.spanusa.org

Youth M.O.V.E. National

Youth M.O.V.E. National (Motivating Others through Voices of Experience) is a youth led national organization devoted to improving services and systems that support positive growth and development by uniting the voices of individuals who have lived experience in various systems including mental health, juvenile justice, education, and child welfare.

http://www.youthmovenational.org

National Organizations

The American Academy of Child & Adolescent Psychiatry (AACAP)

The AACAP (American Academy of Child and Adolescent Psychiatry) is the leading national professional medical association dedicated to treating and improving the quality of life for children, adolescents, and families affected by these disorders. The AACAP widely distributes information online, and elsewhere, in an effort to promote an understanding of mental illnesses and remove the stigma associated with them; advance efforts in prevention of mental illnesses, and assure proper treatment and access to services for children and adolescents.

http://www.aacap.org

American Association of Suicidology (AAS)

AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.

http://www.suicidology.org

The American Foundation for Suicide Prevention (AFSP)

The AFSP has been at the forefront of a wide range of suicide prevention initiatives -- each designed to reduce loss of life from suicide. AFSP is investing in groundbreaking research, new educational campaigns, innovative demonstration projects and critical policy work. AFSP is expanding their assistance to people whose lives have been affected by suicide, reaching out to offer support and offering opportunities to become involved in prevention.

http://www.afsp.org

American Psychiatric Association

The American Psychiatric Association is a medical specialty society representing more than 38,000 psychiatric physicians from the United States and around the world. Its member physicians work together to ensure humane care and effective treatment for all persons with mental disorders, including intellectual disability and substance-related disorders.

http://www.psych.org

Resources and Links continued

American Psychological Association (APA)

Based in Washington, DC, the APA is a scientific and professional organization that represents psychology in the United States. With more than 154,000 members, APA is the largest association of psychologists worldwide. A search of the website produced more than 200 documents related to suicide.

http://www.apa.org/

Depression and Bipolar Support Alliance (DBSA)

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

http://www.dbsalliance.org

Mental Health America (MHA)

Mental Health America (formerly known as the National Mental Health Association) is the country's leading nonprofit dedicated to helping ALL people live mentally healthier lives. MHA represents a growing movement of Americans who promote mental wellness for the health and well-being of the nation – everyday and in times of crisis.

http://www.nmha.org

National Association of School Psychologists

NASP represents school psychology and supports school psychologists to enhance the learning and mental health of all children and youth. The website below has some suicide prevention and intervention-related material accessible to the general public while other material is restricted to NASP members.

http://www.nasponline.org/resources/crisis_safety/suicideresources.aspx

National Organization for People of Color Against Suicide

NOPCAS has a primary focus and mission to increase suicide awareness and education in populations that are racially and ethically diverse. Additionally, its aim is to develop prevention, intervention, and postvention support services to these families and communities impacted adversely by the effects of violence, depression, and suicide in an effort to decrease life-threatening behavior.

http://www.nopcas.com/

Striving To Reduce Youth Violence Everywhere (STRYVE)

STRYVE is a national initiative, led by the Centers for Disease Control and Prevention (CDC), which takes a public health approach to preventing youth violence before it starts. To support this effort, STRYVE Online provides communities with the knowledge and resources to be successful in preventing youth violence.

http://www.safeyouth.org

Suicide Prevention Resource Center (SPRC)

SPRC provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies, and to advance the National Strategy for Suicide Prevention. SPRC also hosts the Best Practice Registry listing programs and practices reviewed according to specific criteria for that section.

http://www.sprc.org

Resources and Links continued

Government Agencies

American Indian and Alaska Native Suicide Prevention Website

The purpose of the Indian Health Service's (IHS) Community Suicide Prevention Website is to provide American Indian and Alaska Native communities with culturally appropriate information about best and promising practices, training opportunities, and other relevant information regarding suicide prevention and intervention. The goal of the Website is to provide Native communities with the tools and information to create, or adapt to, their own suicide prevention programs.

http://www.ihs.gov/nonmedicalprograms/nspn/

Centers for Disease Control and Prevention (CDC)

The CDC is an agency of the U.S. Department of Health and Human Services. It provides statistics, publications, health information, and funding announcements. A search for youth suicide yields a number of valuable resources

http://www.cdc.gov

National Institute of Mental Health (NIMH)

The mission of NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure. A search of "suicide" provides a number of resources some focused on youth.

http://www.nimh.nih.gov

Office of the Surgeon General

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

http://www.surgeongeneral.gov

Substance Abuse & Mental Health Services Administration (SAMHSA) Publications Ordering

SAMHSA provides a number of suicide prevention-related resources to order for free (or sometimes shipping costs). Suicide-related resources can be found under Issues, Conditions, and Disorders on the menu banner or through a search.

http://store.samhsa.gov/home

Additional Resources

Children's Safety Network (CSN)

Children's Safety Network - National Injury and Violence Prevention Resource Center site contains publications and resources produced by CSN and other Education Development Center injury prevention projects related to youth suicide prevention.

http://www.childrenssafetynetwork.org/topics/showtopic.asp?pkTopicID=5

Center for Mental Health in Schools at UCLA

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

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

Find Youth Info

Through the Youth Topics series, the Interagency Working Group on Youth Programs provides information, strategies, tools, and resources for youth, families, schools and community organizations related to a variety of cross-cutting topics that affect youth. Topics include: preventing youth violence, bullying, and positive youth development.

http://findyouthinfo.gov/

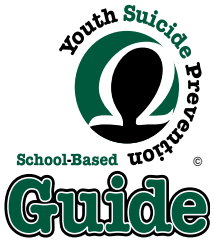
Jason Foundation

JFI is a nationally recognized provider of educational curriculums and training programs for students, educators/youth workers and parents. JFI's programs build an awareness of the national health problem of youth suicide, educate participants in recognizing the "warning signs or signs of concern", provide information on identifying at-risk behavior and elevated risk groups, and direct participants to local resources to deal with possible suicidal ideation. JFI's student curriculums are presented in the "third-person" perspective – how to help a friend.

http://www.jasonfoundation.com

Resources and Links continued

Resources and Links continued



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National Suicide-Related Statistics

National Statistical Information

The American Association of Suicidology (AAS) makes a summary of national suicide statistics available on an annual basis [following the release of official data from the Center from Disease Control and Prevention (CDC)]. Dr. John L. McIntosh has prepared the AAS suicide statistics summary for numerous years with a consistent format making comparisons and finding the data on the summary sheet convenient. The two-page summary appears on the following pages and includes:

- State and District of Columbia rankings by suicide death rates.
- Recorded number of official deaths by suicide in each state.
- Rates by regions of the USA.
- A national breakdown of rates by age groups over 10 years.
- Suicide deaths broken down by leading methods.
- A listing of leading causes of death in the USA.
- A delineation of rates by gender and groups.

The AAS Summary of Statistics pages are a valuable resource and are provided here with permission from the American Association of Suicidology.

Contact information for AAS:

American Association of Suicidology (AAS)
5221 Wisconsin Avenue, NW
Washington, D.S. 20015
(202) 237-2280
http://www.suicidology.org

Additional suicide data and an archive of state/national data are located at Dr. John L. McIntosh's website. Please visit the website (http://mypage.iu.edu/~jmcintos/) and click on the "Recent Suicide Statistics" link from the left hand menu.

Statistics

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

U.S.A. SUICIDE: 2009 OFFICIAL FINAL DATA

	Number	Per Day	Rate	% of Deaths
Nation	36,909	100.8	12.0	1.5%
Males	29,089	79.5	19.2	2.4%
Females	7,820	21.4	5.0	0.6%
Whites	33,425	91.3	13.5	1.6%
Nonwhites	3,484	9.5	5.8	1.0%
Blacks	2,084	5.7	5.1	0.7%
Elderly (65+ yrs.)	5,858	16.0	14.8	0.3%
Young (15-24 yrs.)	4,371	11.9	10.1	14.4%

Group (Number of Suicides)	Rate
White Male (26,426)	21.6
White Female (6,999)	5.6
Nonwhite Male (2,663)	9.2
Nonwhite Female (821)	2.6
Black Male (1,684)	8.6
Black Female (400)	1.9
Hispanic (1,053)	5.3
Native Americans (429)	12.3
Asian/Pacific Islanders (971)	6.3

Fatal Outcomes (Suicides): ***a rate increase was seen from 2008 to 2009, continuing the recent rate increases after long-term trends of decline***

- Average of 1 person every 14.2 minutes killed themselves
- Average of 1 old person every 1 hour and 30 minutes killed themselves
- Average of 1 young person every 2 hours killed themselves. (If the 265 suicides below age 15 are included, 1 young person every 1 hour and 53 minutes)
- 10th ranking cause of death in U.S.— 3rd for **young** ---------->>
- 3.7 male deaths by suicide for each female death by suicide
- Suicide ranks 10th as a cause of death; Homicide ranks 15th

Leading Causes of Death 15-24 yrs

Cause	Number	Rate
All Causes	30,416	70.6
1-Accidents	12,458	28.9
2-Homicide	4,862	11.3
3-Suicide	4,371	10.1
10-14 yrs	259	1.3
15-19 yrs	1,669	7.8
20-24 yrs	2,702	12.5

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

- 922,725 annual attempts in U.S. (using 25:1 ratio); 2008-9 SAMHSA study: 1.058 million adults (18 and up)
- Translates to one attempt every 34 seconds (based on 922,725 attempts) [1.058 million = 1 every 30 seconds]
- 25 attempts for every death by suicide for nation (one estimate); 100-200:1 for young; 4:1 for elderly
- 3 female attempts for each male attempt

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

- *Each suicide intimately affects at least 6 other people* (estimate)
- Based on the 787,761 suicides from 1985 through 2009, estimated that the number of survivors of suicides in the U.S. is 4.73 million (1 of every 65 Americans in 2009); number grew by at least 221,454 in 2009
- If there is a suicide every 14.2 minutes, then there are 6 new survivors every 14.2 minutes as well

Suicide Methods	Number	Rate	Percent of Total		Number	Rate	Percent of Total
Firearm suicides	18,735	6.1	50.8%	All but Firearms	18,174	5.9	49.2%
Suffocation/Hanging	9,000	2.9	24.4%	Poisoning	6,398	2.1	17.3%
Cut/pierce	669	0.2	1.8%	Drowning	389	0.1	1.1%

U.S.A. Suicide Rates 1999-2009

(Rates per 100,000 population)

Group/ Age	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Group/ Age
5-14	0.6	0.8	0.7	0.6	0.6	0.7	0.7	0.5	0.5	0.6	0.7	5-14
15-24	10.3	10.4	9.9	9.9	9.7	10.3	10.0	9.9	9.7	10.0	10.1	15-24
25-34	13.5	12.8	12.8	12.6	12.7	12.7	12.4	12.3	13.0	12.9	12.8	25-34
35-44	14.4	14.6	14.7	15.3	14.9	15.0	14.9	15.1	15.6	15.9	16.1	35-44
45-54	14.2	14.6	15.2	15.7	15.9	16.6	16.5	17.2	17.7	18.7	19.3	45-54
55-64	12.4	12.3	13.1	13.6	13.8	13.8	13.9	14.5	15.5	16.3	16.7	55-64
65-74	13.6	12.6	13.3	13.5	12.7	12.3	12.6	12.6	12.6	13.9	14.0	65-74
75-84	18.3	17.7	17.4	17.7	16.4	16.3	16.9	15.9	16.3	16.0	15.7	75-84
85+	19.2	19.4	17.5	18.0	16.9	16.4	16.9	15.9	15.6	15.6	15.6	85+
65+	15.9	15.3	15.3	15.6	14.6	14.3	14.7	14.2	14.3	14.8	14.8	65+
Total	10.7	10.7	10.8	11.0	10.8	11.0	11.0	11.1	11.5	11.8	12.0	Total
Men	17.6	17.5	17.6	17.9	17.6	17.7	17.7	17.8	18,3	19.0	19.2	Men
Women	4.1	4.1	4.1	4.3	4.3	4.6	4.5	4.6	4.8	4.9	5.0	Women
White	11.7	11.7	11.9	12.2	12.1	12.3	12.3	12.4	12.9	13.3	13.5	White
Nonwh	6.0	5.9	5.6	5.5	5.5	5.8	5.5	5.5	5.6	5.7	5.8	NonWh
Black	5.6	5.6	5.3	5.1	5.1	5.2	5.1	4.9	4.9	5.2	5.1	Black

15 Leading Causes of Death in the U.S.A., 2009

(total of 2,437,163 deaths; 793.8 rate)

Rank & Cause of Death	Rate	Deaths
1 Diseases of heart (heart disease)	195.2	599,413
2 Malignant neoplasms (cancer)	184.9	567,628
3 Chronic lower respiratory diseases	44.7	137,353
4 Cerebrovascular diseases (stroke)	42.0	128,842
5 Accidents (unintentional injuries)	38.4	118,021
6 Alzheimer's disease	25.7	79,003
7 Diabetes mellitus (diabetes)	22.4	68,705
8 Influenza & pneumonia	17.5	53,692
9 Nephritis, nephrosis (kidney disease)	15.9	48,935
10 Suicide [Intentional Self-Harm]	**12.0**	**36,909**
11 Septicemia	11.6	35,639
12 Chronic liver disease and cirrhosis	10.0	30,558
13 Essential hypertension and renal disease	8.4	25,734
14 Parkinson's disease	6.7	20,565
15 Homicide [Assault]	5.5	16,799
- All other causes (Residual)	152.9	469,367

Old made up 12.9% of 2009 population but represented 15.9% of the suicides.

Young were 14.0% of 2009 population and comprised 11.8% of the suicides.

1,064,358* Years of Potential Life Lost Before Age 75 (33,968 of 36,909 suicides were below age 75)

* WISQARS YPLL figure: 1,063,300 using individual years rather than 10-year age groups as above.

Many figures appearing here are derived or calculated from data in the following *official data source:* Highlights section and Detailed Tables for the *NVSR* (2012, January). Deaths: Final Data for 2009. *National Vital Statistics Reports, 60*(3). obtained 5 January 2012; released with the appearance of the 2009 Mortality Multiple Cause Micro-data files at http://www.cdc.gov/nchs/data_access/Vitralstatsonline.htm. Additional data from CDC's WISQARS website http://www.cdc.gov/injury/wisqars/index.html obtained 12 January 2012.

Rate, Number, and Ranking of Suicide for Each U.S.A. State, 2009*

Rank	State [Division] (2008 rank)	Deaths	Rate
1	Montana [M] (2)	219	22.5
2	Alaska [P] (1)	143	20.5
3	Wyoming [M] (4)	111	20.4
4	Idaho [M] (11T)	304	19.7
5	Nevada [M] (5)	505	19.1
6	New Mexico [M] (3)	376	18.7
6	Colorado [M] (6)	941	18.7
8	Oregon [P] (9)	644	16.8
9	Arizona [M] (8)	1,060	16.1
9	Utah [M] (15T)	449	16.1
11	South Dakota [WNC] (25T)	129	15.9
12	Oklahoma [WSC] (13)	567	15.4
12	Florida [SA] (17T)	2,858	15.4
14	Tennessee [ESC] (20T)	947	15.0
15	Maine [NE] (14)	197	14.9
16	Arkansas [WSC] (17T)	422	14.6
17	Missouri [WNC] (20T)	860	14.4
18	Alabama [ESC] (25T)	673	14.3
19	Vermont [NE] (15T)	87	14.0
20	West Virginia [SA] (7)	253	13.9
20	North Dakota [WNC] (11T)	90	13.9
22	Washington [P] (23)	921	13.8
23	Kentucky [ESC] (10)	592	13.7
24	Kansas [WNC] (19)	382	13.6
24	South Carolina [SA] (29T)	619	13.6
26	Hawaii [P] (39T)	175	13.5
27	Mississippi [ESC] (22)	381	12.9
27	Indiana [ENC] (27)	828	12.9
27	Pennsylvania [MA] (32)	1,631	12.9
30	Wisconsin [ENC] (264)	724	12.8
31	New Hampshire [NE] (29T)	166	12.5
31	North Carolina [SA] (31)	1,174	12.5
33	Virginia [SA] (33)	963	12.2
34	Delaware [SA] (36T)	107	12.1
	United States - Total	**36,909**	**12.0**
35	Iowa [WNC] (38)	361	12.0
36	Michigan [ENC] (35)	1,169	11.7
37	Georgia [SA] (39T)	1,134	11.5
38	Texas [WSC] (41T)	2,809	11.3
39	Rhode Island [NE] (45)	118	11.2
40	Minnesota [WNC] (36T)	584	11.1
41	Louisiana [WSC] (28)	490	10.9
42	California [P] (43)	3,823	10.3
43	Ohio [ENC] (34)	1,176	10.2
44	Maryland [SA] (44)	551	9.7
45	Nebraska [WNC] (41T)	170	9.5
46	Illinois [ENC] (46)	1,177	9.1
47	Connecticut [NE] (48)	316	9.0
48	Massachusetts [NE] (47)	530	8.0
49	New York [MA] (49)	1,417	7.3
50	New Jersey [MA] (50)	557	6.4
51	District of Columbia [SA] (51)	29	4.8

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

Division [Abbreviation]	Rate	Number
Mountain [M]	17.9	3,965
East South Central [ESC]	14.2	2,593
South Atlantic [SA]	13.0	7,688
West North Central [WNC]	12.7	2,576
Nation	**12.0**	**36,909**
West South Central [WSC]	12.0	4,288
Pacific [P]	11.5	5,706
East North Central [ENC]	10.9	5,074
New England [NE]	9.8	1,414
Middle Atlantic [MA]	8.8	3,605

Region [Subdivision Abbreviations]	Rate	Number
West (M, P)	13.5	9,671
South (ESC, WSC, SA)	12.9	14,569
Nation	**12.0**	**36,909**
Midwest (WNC, ENC)	11.5	7,650
Northeast (NE, MA)	9.1	5,019

Source: Highlights section and Detailed Tables for the NVSR (2012, January). Deaths: Final Data for 2009. *National Vital Statistics Reports*, *60*(3). obtained 5 January 2012; released with the appearance of the 2009 Mortality Multiple Cause Micro-data files. Additional data will be obtained when the NVSR final publication is released. [Note: divisional and regional figures were calculated from state data; state mortality data appear in Table 19 and population data are from Census Bureau Vintage 2009 estimates]

[data are by place of residence]

[Suicide = ICD-10 Codes X60-X84, Y87.0, U03]

Note: All rates are per 100,000 population.

* Including the District of Columbia.

Suicide State Data Page: 2009
12 January 2012

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

Visit the AAS website at:

http://www.suicidology.org

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Youth Suicide Prevention School-Based Guide ©

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Overview/Issue Briefs

Youth Suicide Prevention School-Based © Guide

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Checklists/Programs/Resources

Youth Suicide Prevention School-Based © Guide

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