Recommendations for Suicide Prevention and Related Risk Behaviors

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Introduction

According to the Colorado Department of Public Health and Environment, suicide is the second-leading cause of death for youth (ages 10-24) in Colorado.

Consider these findings from the 2011 Youth Risk Behavior Survey Results (YRBS): Colorado High School Survey:

- Percentage of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months: 21.9

- Percentage of students who seriously considered attempting suicide during the past 12 months: 14.8

- Percentage of students who made a plan about how they would attempt suicide during the past 12 months: 11.4

- Percentage of students who actually attempted suicide one or more times during the past 12 months: 6.1

- Percentage of students who made a suicide attempt during the past 12 months that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse 2.2 (Source: http://www.chd.dphe.state.co.us/topics.aspx?q=Adolescent_Health_Data)

How These Guidelines Are Organized

Current research highlights seven critical elements in a successful school-based suicide and risk prevention model. These components include:

1. Board policy and implementing procedures
2. Data collection
3. Staff development
4. Mental health promotion/suicide prevention for students
5. Interagency collaboration for prevention/intervention
6. Public awareness
7. Postvention

Accordingly, this report is organized by these components. Within each section, we offer our impressions, recommendations, and resources (where appropriate). Recommendations are underlined. The entire report is line-numbered to facilitate discussion.

Key Terms[1]

Because this report discusses highly specialized topics and necessarily requires the use of specific terms, we review these terms for the reader here.

Suicide threat – A suicide threat is a verbal or non-verbal communication that the individual intends to harm him/herself with the intention to die but has not acted on the behavior.

Suicidal act (also referred to as suicide attempt) – a potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries.

Suspected suicide (also referred to as suicide completion or death by suicide) – death from injury, poisoning, or suffocation where there is initial indication or evidence that a self-inflicted act may have led to the person's death. **Note:** Only a coroner or medical examiner can confirm that a death was caused by suicide.[2]

Background Information on Youth Suicide

To aid the reader in understanding the context for the recommendations that follow, this section first offers a brief review of research on youth suicide, including risk factors that contribute to suicidal behavior.[3]

> Suicide is the third leading cause of death for young people aged 10 to 14 and 15 to 19 years, killing 1,600 teenagers each year in the United States. The rapid increase of suicide deaths from the 1950s to the mid-1980s led to a national clarion call for more effective prevention. Thereafter, the general rate of youth suicide declined dramatically. Nevertheless, 5% to 8% of teenagers attempt suicide, and one in five teenagers seriously considers suicide each year (Gould, 2003).[4] In this section, we provide a general

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[1] Because such terms can be hurtful to loved ones and also imply that the individual was making a rational decision, we recommend that the following terms not be used in policies and other communications:
"The individual *committed* suicide, *killed* him/herself, *took* his/her own life." See also: Suicide Prevention Resource Center. (2004). *After a suicide: Recommendations for religious services and other public memorial observances*. Newton, MA: Education Development Center, Inc.

[2] Definitions from *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2001.

[3] This section is excerpted from Kerr, M.M. (2009). *School crisis prevention and intervention.* Upper Saddle River, NJ, Pearson Education, Inc. and is based in part on Kerr, M.M. (2009) , Kerr, M.M. & Traupman, E. (2003).*Youth suicide prevention: Risks, implications, and strategies.* Publication Series. Harrisburg, PA: PA CASSP Training and Technical Assistance Institute.

[4] Gould, M. S., Jamieson, P. & Romer, D. (2003). Media contagion and suicide among the young. *American Behavioral Scientist*, *46*(9), 1269-1284

understanding of the risk factors for youth suicide completion and attempts, and we highlight the implications of these risk factors for prevention efforts.

Age

The rates of completed youth suicides are low (1.5 per 100,000 among 10- to 14-year-olds and 8.2 per 100,000 among 15- to 19-year-olds). However, the Youth Risk Behavior Survey reported that 19% of high schoolers seriously considered a suicide attempt during the past year; 15% made a specific suicide plan, 8.8% reported a suicide attempt, and 2.6% made an attempt that required medical treatment (Grunbaum et al., 2002)[5]. Completed suicide is rare in children under the age of 10 because children in this age group lack the access to, or information about, lethal methods. Accordingly, most prevention strategies focus on adolescents.

Gender, Race, and Sexual Orientation

Females experience suicidal ideation (thoughts about suicide) and make more suicide attempts than males, although completed suicide is more common among males (Grunbaum et al., 2002). In the United States, youth suicides are more common among whites than African Americans, highest among Native Americans, and lowest among Asian/Pacific Islanders (Anderson, 2002)[6]. A review of research on sexual orientation and youth suicide found higher rates of attempted suicide among homosexual youths compared to their heterosexual counterparts (Remafedi, 1999)[7]. Studies that are more recent have identified "a two-to six-fold increased risk of non-lethal suicidal behavior for homosexual and bisexual youths" (Gould, Greenberg, Velting, & Shaffer, 2003, p. 390)[8].

Method

Firearms, the leading cause of suicide completion in the United States, account for almost 60% of all suicides in both males and females. For those aged 15 to 19, suicide by firearms accounted for 63% of the increase in the overall rate from 1980 to 1996 (U.S. Public Health Service, 1999)[9]. Other methods include hanging and overdose. Some

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[5] Grunbaum, J.A., Kann, L., Kinchen, S.A., et al. (2002). Youth risk behavior surveillance—United States, 2001. MMWR CDC Surveillance Summary 51 (SS4), 1-64.

[6] Anderson, T. (2002) Commentary: Owl pellets and crisis management. Legacy: The Journal of the National Association for Interpretation, vol.13, number 2, pp. 22-24.

[7] Remafedi, G. (1999) Sexual orientation and youth suicide. Journal of the American Medical Association, 282(13):1291.

[8] Gould, M., Greenberg, T., Velting, D.M., and Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. American Academy of Child & Adolescent Psychiatry, 42(4), April.

[9] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. Child Health USA 2005. Rockville, Maryland: U.S. Department of Health and Human Services, 2005.

prevention approaches have as their goal the reduction of access to lethal means such as firearms.

Risk Factors and Precipitants[10] Associated With Youth Suicide

Mental Illness

Without a doubt, mental illness is the most significant risk factor for suicidal behavior. Psychiatric diagnoses, often in combination, are present in about 90% of teen suicide completions. This dramatic link between mental illness and suicidal behavior explains why many prevention approaches have screening as a part of their program. For example, the *Columbia TeenScreen Program* uses a multistage screening program that (1) teaches teens about depression and treatment, to encourage them to identify and refer themselves, and (2) systematically screens each teen for anxiety, depression, substance abuse, and suicidality. The *SOS: Signs of Suicide Program* combines a curriculum for high school students with a brief screening. Help seeking is a goal of both programs.
Teens who *do* access psychiatric treatment usually find it effective. A combination of psychotherapy (e.g., cognitive behavior therapy) and medication treatment often works best. Sadly, however, in the month before suicidal behavior, many young people seek some medical care, but their need for psychiatric treatment goes unrecognized by their primary care providers.

Depression. Depression, with its accompanying hopelessness, anxiety, and cognitive distortions, is a major risk factor for suicide and suicide attempts. Consider this example:

> *A teenager has experienced repeated episodes of depression and feels hopeless, despite some sessions with a school counselor. After encountering a former romantic partner on the street, she breaks down and isolates herself for days. Ultimately, she concludes that she has nothing to live for, and would be better off dead. She then overdoses.*

Anxiety Disorders. Coexisting with a mood disorder, these conditions can interfere with a person's treatment and recovery. If not identified and treated, these disorders can increase the risk for suicidal thoughts and/or behaviors in depressed individuals. Consider this illustration:

> *A gifted teenager experienced anxiety for several years. Despite help from his family and school counselors, he continued to be self-critical and overly concerned about his performance and others' approval of him. When he was caught parking his car on school*

[10] Risk factors are conditions that increase the risk of a given disorder, illness, or---in this case---suicidal behavior or suicide. Though they are not considered to cause suicidal behavior, precipitants are events that have been shown to occur with some frequency prior to suicide attempts or deaths.

campus without a student permit, he faced a suspension. Panicked, he drove the car to a bridge and jumped.

As illustrated in this case, a significant number of suicide completers faced a pending disciplinary crisis. Discipline should occur as soon as possible after misbehavior to decrease the feelings of anticipatory anxiety. If the student in trouble is highly anxious, school or law enforcement officials should take steps to reduce anxiety and get immediate assistance.

Substance Abuse

An increased prevalence of drugs or alcohol is a factor accounting for why older adolescents are more likely to attempt and complete suicide compared with younger adolescents. Some adolescents use drugs and alcohol to cope with depressive feelings. Alcohol acts as a disinhibitor to suicidal behavior. Adolescents who are depressed and use alcohol are more than five times more likely to use a firearm. Consider this illustration:

Diagnosed at age 8 with conduct disorder and attention-deficit/hyperactivity disorder, this 16-year-old struggled academically. He compensated for his poor academic status by being the class clown and taking risks to gain the attention of his friends. One night at a friend's house, he drank with the other kids and then played a fatal game of Russian roulette.

Because suicidal individuals are often impulsive, restricting access during critical times may reduce suicides. In addition, even if means substitution does occur, the chance of survival may be greater with less lethal methods. Educating parents of high-risk youth about injury prevention may also aid in reducing access to lethal means. We examine next family characteristics that place students at risk for suicide.

Family Mental Illness

A family history of suicidality significantly increases the likelihood that a teenager will take his own life (Gould et al., 2003). Children of depressed parents appear to be at substantially increased risk for completed suicide, as do children of parents with substance abuse problems (Brent et al., 1993)[11].

Consider, for example, how a parent's own struggles might hinder attempts to help her child. A depressed parent might be overwhelmed by suggestions offered by professionals, feel anxious and guilty, lack confidence in parenting, have trouble setting limits for a teen's use of alcohol or other drugs, or lack the energy to follow through with treatment suggestions. Outreach to parents struggling with their own mental

[11] Brent, D.A., Perper, J.A., Moritz, G., Allman, C., Roth, C., Schweers, J., Balach, L., & Baugher, M. (1993). Psychiatric risk for suicide: A case control study. Journal of the American Academy of Child and Adolescent Psychiatry, 32, 521-529.

health challenges, including depression and substance abuse, is an important element of the prevention of youth suicide.

Family Discord

Child sexual or physical abuse is a significant risk factor for youth suicide. One study revealed that "discordant, hostile family interactions predisposed [youth] to suicidal thoughts" (Kosky, Silburn, & Zubrick, 1986, p. 527). [12] Gould, Fisher, Parides, Flory, and Shaffer (1996)[13] reported that suicide victims had less frequent and less satisfying communications with their parents. These findings support the need to incorporate the family in treatment efforts for a young person who is at risk for suicide.

Exposure to the Suicidality of Others

Research supports a contagion factor associated with suicidal behavior in adolescents. Exposure to TV programs and news stories on suicide may prompt suicidal behavior in vulnerable adolescents. Prevention involves educating reporters, editors, and producers about contagion to minimize harm and emphasize the media's positive role in educating and shaping attitudes about suicide.

Exposure to a classmate's suicide attempt may prompt suicidal behavior in other students. Young people most vulnerable to "contagion" immediately following a suicide generally are characterized as more isolated, not close to the suicide victims, and exhibiting the risk factors identified earlier.

Behavioral Indicators

Suicidal teens may begin writing or talking about death and suicide. Clues may also appear in art and music projects, diaries, or journals. Occasionally, suicidal teens begin giving away prized possessions, writing "wills" or suicide notes or saying "goodbye" in an untimely way. Youth considering suicide also may:

- Begin listening to music about death or suicide.
- Complain they are feeling hopeless or trapped in a bad situation.
- Become more aggressive, or texting or writing about wanting to hurt others.
- Visiting or creating web sites/profiles glorifying suicide and death.
- Begin using or increase their use of drugs or alcohol.
- Suddenly become cheerful for no apparent reason after a period of depression.
- Have just had a bad fight with their parents, boyfriend, or girlfriend.
- Have recently lost someone they cared about.

[12] Kosky, R., Silburn, S., & Zubrick, S. (1986). Symptomatic depression and suicidal ideation: A comparative study with 628 children. Journal of Nervous and Mental Disease, 174, 523-528.

[13] Gould, M.S., Fisher, P., Parides, M., Flory, M., & Shaffer, D. (1996). Psychosocial risk factors of child and adolescent completed suicide. Archives of General Psychiatry, 53, 1155-1162.

Tragically, the stigma associated with mental health problems and substance abuse problems and their treatment prevents many youth (and their parents) from seeking help (Kerr, 2009, pp. 90-93).

1. Policies and Procedures

We recommend that districts adopt a comprehensive set of procedures and a brief authorizing policy. The STAR-Center offers an example at http://www.starcenter.pitt.edu/SchoolDistrictSuicidePolicy/47/Default.aspx.

Program Policies. To reduce the risk of the well-documented phenomenon of suicide contagion[14], we recommend that districts also adopt a policy that indicates that only *research-validated* suicide-related programs will be implemented in schools.

Memorial Policies. We urge districts to adopt a policy regarding all memorials, regardless of cause of death. Memorials (including commemoration of anniversaries of deaths) often create tension between families and schools and can increase the risk of suicide contagion. [Specific guidelines for memorials and anniversaries can be found in Kerr, M.M. (2009). *School crisis prevention and intervention.* Upper Saddle River, NJ, Pearson Education, Inc.]

Media Policies. Unfortunately, local media often provide extensive coverage of suicides. Such coverage can increase the risk of suicide in vulnerable audiences. We recommend that districts and/or community leaders meet with regional media representatives to review acceptable media guidelines for reporting on such deaths. For information regarding media guidelines, see http://mentalhealth.samhsa.gov/suicideprevention/newsroom.asp.

2. Data Collection

Many districts across the US maintain little or no formal informal data on student risk behaviors or outcomes associated with classroom prevention programs. Districts cannot rely on referrals as data about prevalence, because suicidal individuals may never seek treatment or share their plans with others. Therefore, we suggest that districts use an established anonymous survey to gather information that can:

- inform districts and community agencies such as law enforcement and treatment providers regarding the risk-taking behaviors of youth.
- aid districts in successful grant applications for additional funding for prevention and intervention.
- assist districts in strategic planning and staffing of its prevention and intervention efforts.

[14] Studies have shown that suicidal behavior is contagious (See Gould, M. S., Greenberg, T., Velting, D. M., & Shaffer, D. (2003).Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry, 42* (4), 386–405.) That is, following exposure to a suicide attempt or death by suicide, vulnerable individuals are at higher risk for suicidal behaviors. Because of contagion, suicidal behavior differs from other crises.

One such example is the Youth Risk Behavior Surveillance System (YRBSS) available at no cost from the Centers for Disease Control and Prevention at http://www.cdc.gov/healthyyouth/yrbs/index.htm. Districts may modify the questionnaire depending on community needs and interests. The standard YRBSS questionnaire takes about 35 minutes to complete. According to the Utah Department of Health, the YRBSS has been used since 1991 (http://health.utah.gov/opha/publications/hsu/09Dec_YRBS.pdf YRBSS). Utah YRBSS data are available at http://ibis.health.utah.gov/query/selection/yrbs/YRBSSelection.html

3. Professional Development

Needs Assessment.

Staff involved in daily interaction with students at risk for suicide are vital in prevention efforts. If school gatekeepers are under-informed about the *indicators of suicide risk* (as studies have shown), then they may not recognize students who need help[15]. To improve this practice, schools must first assess what school employees know.

As is often seen, community members may hold different views of what leads to suicide attempts, with some endorsing a "stress model" that may not be supported by current research. So that everyone can work consistently to safeguard students, we recommend that districts undertake a survey of employees' knowledge about suicide risk and suicide behaviors, using the Scouller and Smith (2003) or comparable instrument. Based on these data, districts could plan professional development that addresses any gaps in information.

Focus of Professional Development

Training materials should explain specific suicide-related concepts such as contagion, restriction of lethal means, memorials, or risk assessment and management. All employees, whether certified or not, should know how to identify warning signs for suicidal behavior and other high-risk behavior and how to refer students for non-emergency follow-up. Employees should also learn how to respond to crisis situations. The **1-800-273-TALK** National Suicide Prevention Lifeline has free wallet cards , posters, and other materials for such dissemination.

We recommend that districts provide suicide prevention orientation for all new staff. All employees must be alerted to those at highest risk (e.g., males 16-19, teens with mental health or substance abuse problems, GLBT teens, those who have attempted suicide, and/or those with a pending disciplinary incident who have other risk factors).

[15] Scouller, K. M., & Smith, D. I. (2002). Prevention of youth suicide: How well informed are the potential gatekeepers of adolescents in distress? *Suicide and Life-Threatening Behavior, 32*, 67-79.

4. Mental Health Promotion/Suicide Prevention Efforts

Prevention models stress very different approaches, making it difficult for schools to determine the most effective ways to prevent youth suicide. Some approaches (see work by Kalafat and Lazarus) emphasize *protective factors and support networks*. Other strategies derive from mental health research on *risk factors and precipitating events* in suicide (see work by Brent, Shaffer, and Gould). Finally, a third category of suicide prevention methods stem from the direct personal experiences of those who have lost a loved one to suicide (see Jason Foundation, Yellow Ribbon Campaign).

We recommend a model that teaches adults how to identify students at risk and to make expedient and effective referrals to competent mental health specialists. We support validated mental health screening in school and *mental health promotion* curricula. We continue to be cautious about *suicide-focused* classroom instruction, given the American Academy of Child and Adolescent Psychiatry's warning:

> Because curriculum-based suicide awareness programs disturb some high-risk students, a safer approach might be to focus on the clinical characteristics of depression or other mental illnesses that predispose to suicidality. In the absence of evidence to the contrary, talks and lectures about suicide to groups of children and adolescents drawn from regular classes should be discouraged. This is because of their propensity to activate suicidal ideation in disturbed adolescents whose identity is not usually known to the instructor (American Academy of Child and Adolescent Psychiatry, 2000, pp. 27-28)[16] .

Prevention Curricula

We suggest that districts adopt Evidence-based Programs and Practices (NREPP)[17], because these programs have been shown to reduce risk behaviors when implemented as designed. A common concern about any district's prevention programs is the whether they are being implemented with fidelity[18]. We suggest that Districts formally monitor implementation of these prevention curricula. Moreover, new teachers should receive training each year in the curricula. NREPP validated programs include:

TeenScreen

The Columbia University TeenScreen Program identifies middle school- and high school-aged

[16] American Academy of Child and Adolescent Psychiatry, 2000. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Available at http://www.aacap.org/galleries/PracticeParameters/Suicide.pdf

[17] National Registry of Evidence-based Programs and Practices (NREPP), a service of the Substance Abuse and Mental Health Services Administration (SAMHSA). "NREPP is a searchable database of interventions for the prevention and treatment of mental and substance use disorders. SAMHSA has developed this resource to help people, agencies, and organizations implement programs and practices in their communities" (description taken from web site).

[18] Implementation fidelity is important, because it assures districts that the program is being implemented in the manner in which the reported positive outcomes were achieved in studies.

youth in need of mental health services due to risk for suicide and undetected mental illness. The program's main objective is to assist in the early identification of problems that might not otherwise come to the attention of professionals. TeenScreen can be implemented in schools, clinics, doctors' offices, juvenile justice settings, shelters, or any other youth-serving setting. Typically, all youth in the target age group(s) at a setting are invited to participate.

The screening involves the following stages:

1. *Before any screening is conducted, parents' active written consent is required for school-based screening sites and strongly recommended for non-school-based sites. Teens must also agree to the screening. Both the teens and their parents receive information about the process of the screening, confidentiality rights, and the teens' rights to refuse to answer any questions they do not want to answer.*
2. *Each teen completes a 10-minute paper-and-pencil or computerized questionnaire covering anxiety, depression, substance and alcohol abuse, and suicidal thoughts and behavior.*
3. *Teens whose responses indicate risk for suicide or other mental health needs participate in a brief clinical interview with an on-site mental health professional. If the clinician determines the symptoms warrant a referral for an in-depth mental health evaluation, parents are notified and offered assistance with finding appropriate services in the community. Teens whose responses do not indicate need for clinical services receive an individualized debriefing. The debriefing reduces the stigma associated with scores indicating risk and provides an opportunity for the youth to express any concerns not reflected in their questionnaire responses"* (description from NREPP Website).

SOS Signs of Suicide

"SOS Signs of Suicide is a 2-day secondary school-based intervention that includes screening and education. Students are screened for depression and suicide risk and referred for professional help as indicated. Students also view a video that teaches them to recognize signs of depression and suicide in others. They are taught that the appropriate response to these signs is to acknowledge them, let the person know you care, and tell a responsible adult (either with the person or on that person's behalf). Students also participate in guided classroom discussions about suicide and depression. The intervention attempts to prevent suicide attempts, increase knowledge about suicide and depression, develop desirable attitudes toward suicide and depression, and increase help-seeking behavior" (description from NREPP Website).

CARE (Care, Assess, Respond, Empower)--*formerly called Counselors CARE (C-CARE) and Measure of Adolescent Potential for Suicide (MAPS)--is a high school-based suicide prevention program targeting high-risk youth. CARE includes a 2-hour, one-on-one computer-assisted suicide assessment interview followed by a 2-hour motivational counseling and social support intervention.*

The counseling session is designed to deliver empathy and support, provide a safe context for sharing personal information, and reinforce positive coping skills and help-seeking behaviors.

CARE expedites access to help by connecting each high-risk youth to a school-based caseworker or a favorite teacher and establishing contact with a parent or guardian chosen by the youth. The program also includes a follow-up reassessment of broad suicide risk and protective factors and a booster motivational counseling session 9 weeks after the initial counseling session.

The goals of CARE are threefold: to decrease suicidal behaviors, to decrease related risk factors, and to increase personal and social assets. CARE assesses the adolescent's needs, provides immediate support, and then serves as the adolescent's crucial communication bridge with school personnel and the parent or guardian of choice. The CARE program is typically delivered by school or advanced-practice nurses, counselors, psychologists, or social workers who have completed the CARE implementation training program and certification process.

Although CARE was originally developed to target high-risk youth in high school--particularly those at risk of school dropout or abusing substances--its scope has been expanded to include young adults (ages 20 to 24) in settings outside of schools, such as health care clinics" (description from NREPP Website).

If a district engages in a partnership with an outside mental health provider to provide mental health services at the high schools, the following group prevention program for students at risk might be appropriate.

CAST

"CAST (Coping and Support Training) is a high school-based suicide prevention program targeting youth 14 to 19 years old. CAST delivers life-skills training and social support in a small-group format (6-8 students per group). The program consists of 12 55-minute group sessions administered over 6 weeks by trained, master's-level high school teachers, counselors, or nurses with considerable school-based experience. CAST serves as a follow-up program for youth who have been identified through screening as being at significant risk for suicide. In the original trials, identification of youth was done through a program known as CARE (Care, Assess, Respond, Empower), but other evidence-based suicide risk screening instruments can be used.

CAST's skills training sessions target three overall goals: increased mood management (depression and anger), improved school performance, and decreased drug involvement. Group sessions incorporate key concepts, objectives, and skills that inform a group-generated implementation plan for the CAST leader. Sessions focus on group support, goal setting and monitoring, self-esteem, decision-making skills, better management of anger and depression, "school smarts," control of drug use with relapse prevention, and self-recognition of progress through the program. Each session helps youth apply newly acquired skills and increase support from family and other trusted adults. Detailed lesson plans specify the type of motivational preparation, teaching, skills practice, and coaching activities appropriate for at-risk youth. Every session ends with "Lifework" assignments that call for the youth to practice the session's skills with a specific person in their school, home, or peer-group environment" (description from NREPP Website).

Health Curriculum and Classroom Instruction

We suggest that districts review outlines of health curricula and discuss with some educators how they deliver their course content. We recommend that curriculum supervisors monitor any "informal" activities that might expose students to the suicidality of others (e.g., activities in which a student might disclose suicidal ideation or attempts such as autobiographical activities used in some high school classes). While we discourage the use of a stress model to *explain* suicide, we do endorse high quality efforts to teach students healthy approaches to managing stress.

We recommend that districts pull from circulation textbooks that show the names of the deceased students (i.e., the student's name appears in the front of the textbook because the student was issued that book for the year). Districts should not, however, cover over these names, lest other students later discover them.

Libraries

We recommend that district librarians evaluate holdings of non-fiction books regarding suicide, substance abuse, and other mental health topics (for professionals as well as for students). Mental health treatment has changed dramatically during the past two decades, offering far more hope than in prior years. Older volumes may not contain accurate information or may contribute to the stigma of help seeking for mental health or substance abuse problems. Excellent texts for professionals, parents, and youth can be found on the COPE, CARE, DEAL web site (www.copecaredeal.org). This site is funded by the Annenberg Trust through its Adolescent Mental Health Initiative and is extensively peer-reviewed by experts. The website "synthesize(s) and disseminate(s) scientific research on the prevention and treatment of mental disorders in adolescents. The Initiative creates books and web materials for adolescents on topics including depression, bipolar disorder, anxiety, schizophrenia, and suicide prevention" (description from Cope, Care, Deal website).

School-based Support Services

Recommendations in this arena require a comprehensive review of district school-based student support services. However, we recommend for districts' consideration these general suggestions:

1. Often, several staff members have specialized expertise (e.g., having worked as a mental health crisis specialist, agency social worker or drug and alcohol counselor). Districts may want to survey student support (and other staff) to inventory these specialized skills and consider how best to use these individuals' talents. For example, one who has extensive work in mental health crisis intake would be an ideal member of the team writing the student assessment protocol or the crisis procedures.
2. School-based health clinics can reduce the stigma of help-seeking behavior and improve access to services. We encourage districts to consider partnering with local providers to

create school-based mental health clinics staffed by mental health specialists. These should operate at low or no cost to districts.

3. Not surprisingly, schools sometimes experience redundancy in services, with counselors, social workers, and the child study or student assistance teams each seeing students seeking or needing support. This "multiple–pathways" approach is not necessarily a problem and does offer students multiple sources of aid. Indeed, staff members should be encouraged to have genuine connections with students and their families and to be available to youth throughout the school day. Given the complexity and number of communications regarding at-risk students, however, each school might remind its staff, parents, and students annually of the steps they can take to make a referral or get help for a student of concern. Parents and students must have non-school hour contacts and numbers to call as well, because often crises occur during nights, weekends, and school breaks.

Often, we find that staff members use different (or no) interview questions when faced with an at-risk student. We recommend that districts review screening protocols and consider adopting a uniform protocol for interviewing students at risk for suicide and also for substance use and abuse.

Drug and Alcohol Services

Many students are struggling with drug and alcohol problems themselves or within their families. Support groups for students who are in recovery or who are coping with substance issues in their families are important to recovery and can be hosted in the community.

In addition, we suggest that districts consider designating a drug and alcohol coordinator (typically someone already on staff) for each of its middle and high schools.

A district may want to institute and disseminate a directory of families who pledge not to serve alcohol to minors. Families who participate or read about this may feel strengthened in their attempts to limit their children's under-age use of alcohol.

Parent Education

District communications with parents constitute an opportunity for important psychoeducation. We recommend that districts draft consistent language in communications[19] regarding suicide prevention, referencing the research cited in this report, to outline safeguards parents can implement, including lethal means restriction and warnings about the link between suicide and substance abuse.

[19] Communications include conversations with parents, parent forums, parent handbooks, parent letters, and communications to the public that may be heard or read by parents. See sample suicide policy and procedure for examples.

Despite outreach efforts, we often find that parents do not know how to access quality mental health services. We recommend that community providers work with districts to provide parents information on when and how to access mental health services, for crisis and non-crisis situations, including nights, weekends, and school breaks. This may require collaboration with commercial insurers as well.

Actions to Avoid

Districts should *avoid* some approaches, including those that:

- heighten the risk of contagion among vulnerable youth. Every suicide-related event and communication should be "vetted" with mental health professionals who can evaluate the risk of contagion
- may promote discrimination or cultural bias.
- depict suicide through a videotape or personal message that has not been reviewed and endorsed by experts in suicide treatment and prevention.
- deliver the message that teenagers are responsible for "saving their friends."
- involve large student assembly formats and public address announcements, because a) they are perceived as impersonal and b) they do not allow a competent adult to look for signs of distress in students.

5. Interagency and Community Collaboration

Interagency Council

Many districts have worked hard to create ties to the community, as evidenced by formal and informal collaborations. Yet, it can be difficult to convene so many providers and to problem-solve specific situations. To make optimal use of those connections and to strengthen community prevention and intervention efforts, we recommend that districts and community leaders convene a problem-solving group comprised of local agencies that respond to youth, including:

- juvenile court and district courts
- child protective services*
- police forces
- hospitals providing mental health and pediatric services
- drug and alcohol treatment providers
- faith-based leadership
- county department of health
- emergency responders*
- coroner's office/child death review team*
- organizations representing local health care providers (e.g., American Academy of Pediatrics chapter)

(* indicates group who may need to join the meetings for particular discussions only.)

We recommend that this group meet monthly with *tightly structured agendas* to a) review available risk data, b) anticipate situations or events that indicate heightened risk-taking behavior (e.g., proms, introduction of choking game to the region, and increases in use of particular drugs in the area), c) form action plans for preventing risk, d) forge stronger alliances

for sharing information and expediting services, and e) seek additional funding and/or resources for prevention and intervention efforts.

The *community* may want to consider adoption of an asset building such as the SEARCH Institute to support youth (http://www.search-institute.org/developmental-assets-are-free), and programs that limit access to lethal means such as firearms, drugs, and alcohol.

Emergency Department Means Restriction Protocol

We recommend that community treatment providers, including emergency department of hospitals, consider using the protocol outlined in *Emergency Department Means Restriction* (SPRC Classification: Effective)

> *"The goal of this intervention is to educate parents of youth at high risk for suicide about limiting access to lethal means for suicide. Education takes place in emergency departments and is conducted by department staff (an unevaluated model has been developed for use in schools). Emergency department staffs are trained to provide the education to parents of children who are assessed to be at risk for suicide. Lethal means covered include firearms, medications (over-the-counter and prescribed), and alcohol. To help with the safe disposal of firearms, collaboration with local law enforcement or other appropriate organizations is advised.*
>
> *The content of parent instruction includes:*
>
> *1. Informing parent(s), apart from the child, that the child was at increased suicide risk and why the staff believed so;*
>
> *2. Informing parents that they can reduce risk by limiting access to lethal means, especially firearms; and,*
>
> *3. Educating parents and problem solving with them about how to limit access to lethal mean" (description from: http://www.sprc.org/featured_resources/bpr/ebpp_PDF /emer_dept.pdf).*

Contact the author of this protocol for a copy: Markus J. Kruesi, MD , (843) 792-0135.

Substance Abuse in the Community

Many staff and community members express serious concern about community youth engaged in significant substance abuse, including alcohol served in family homes (sometimes with parent knowledge), use and sale of prescription drugs that youth access at home, and the use of highly addictive illegal drugs.

Substance abuse prevention is not the sole responsibility of a school district. Substance abuse prevention requires a community to undertake "environmental change" including changes in the supervision of its youth, the norms of the community, the sanctions for violations, and supports for assessment, treatment, and aftercare. Nevertheless, districts' concerns regarding suicide cannot be addressed adequately without a major *community substance abuse prevention* effort, given the general link between substance abuse and youth suicide. The Interagency Council proposed above may improve some of these communications and norms.

6. Public Awareness

There are many *community-based approaches* for suicide prevention. These programs are appealing to lay people in part because they do not require high levels of expertise. They often convey a personal connection through a survivor of suicide and tend to be compelling and engaging. Such grass-roots efforts are usually low-cost and lend themselves to trainer of trainers and other rapid dissemination.

Yellow Ribbon Program

Gatekeeper programs train individuals to recognize warning signs of risky behavior and to seek help for the individual of concern. One such program is the Yellow Ribbon program (Yellow Ribbon International Suicide Prevention Program, 2008). This program promotes help-seeking behavior through increasing awareness on suicide prevention, training gatekeepers, and facilitating the behavior by distributing "ask for help" cards. Yellow Ribbon leaders hold planning sessions with school and community leaders. They provide training for staff and youth leaders, followed by school-wide assemblies as well as booster training. Training for new staff members and students is also provided. Community task forces are established to ensure on-going resource connections, awareness reminders, event coordination, and expanded gatekeeper training.

Despite its popularity, the Yellow Ribbon program has not been systematically evaluated. Correspondence with the U.S. Substance Abuse and Mental Health Services Agency (SAMHSA) confirmed this. Concerns about the Yellow Ribbon Campaign include its potential to increase suicide contagion[20] and the tendency of groups to misunderstand its acknowledged limited mission.

In lieu of the Yellow Ribbon Program, districts may want to involve the community in promoting a research-validated program (See information regarding *SafeTALK* below), and/or other approaches such as stigma reduction, such as "Stigma-busters" (National Alliance for Mental Illness (NAMI)). Another focus might be the promotion of the 1-800-273-TALK service known as the National Suicide Prevention Lifeline. Students in crises (or concerned individuals) can call this number free of charge to speak immediately with a local counselor. The SEARCH Institute's community asset building might be a focus for a school-community effort, as might one of the research-validated mental health screening programs discussed below.

[20]Beautrais, A. A Framework for Selecting Prevention Approaches for the New Zealand Suicide Prevention Strategy. Available from http://www.chmeds.ac.nz/research/suicide/Framework_Nz_Prevention_Strategy.pdf.

Other Gatekeeper Programs

Gatekeeper training programs can be an effective part of a suicide prevention plan when these practices are put into place. The following section describes a gatekeeper program supported by research.

SafeTALK is a half-day training program that teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention. SafeTALK stresses safety while challenging taboos that inhibit open talk about suicide. The program recommends that an ASIST-trained resource or other community support resource be at all trainings. The 'safe' of safeTALK stands for 'suicide alertness for everyone'. The 'TALK' letters stand for the practice actions that one does to help those with thoughts of suicide: Tell, Ask, Listen, and KeepSafe.

The safeTALK learning process is highly structured, providing graduated exposure to practice actions. The program is designed to help participants monitor the effect of false societal beliefs that can cause otherwise caring and helpful people to miss, dismiss, or avoid suicide alerts and to practice the TALK step actions to move past these barriers. Six 60-90 second video scenarios, each with non-alert and alert clips, are selected from a library of scenarios and strategically used through the training to provide experiential referents for the participants" (description from US Suicide Prevention Resource Center (SPRC) Best Practice Registry).

7. Postvention

Postvention efforts help to meet the immediate needs of schools and communities in crisis after a tragic loss, such as a sudden death. In addition, postvention allows for face-to-face screenings of those at risk and provides a timely response to survivors. This approach was designed to assist survivors with the grieving process, while limiting the risk of suicide contagion and reducing the harmful effects in the aftermath of a suicide.

Although postvention can be an opportunity to improve the school's prevention approaches, it can be quite variable from one school/provider to another. Because there is very limited research and evaluation on postvention, schools and community must use approaches that are conceptually grounded and comprehensive.

We recommend that districts and collaborating providers consider adopting the STAR-Center's guidelines for postvention,[21] available from http://www.starcenter.pitt.edu/Manuals/6/Default.aspx. This guide, based on clinical research, is extensively peer-reviewed.

[21] Kerr, M.M., Brent, D.A., McKain, B., & McCommons, P.S. (2004). *Postvention standards manual: A guide for a school's response in the aftermath of a sudden death, 4th Edition.* University of Pittsburgh, Services for Teens at Risk (STAR-Center).

We also recommend that **districts** adopt and disseminate the guidelines included in Safe and Effective Messaging for Suicide Prevention, available at http://www.sprc.org/sites/sprc.org/files/library/SafeMessagingrevised.pdf.

In Conclusion

This document offered guidelines for prevention of suicide and related youth risk behaviors, based on our understanding of the research and our experience in working with school districts, with those who have lost a loved one to suicide, and with those at risk for suicide. We hope that readers will find the suggestions helpful.