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Youth Suicide Prevention Programs:
A RESOURCE GUIDE

SEPTEMBER 1992

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Youth Suicide Prevention Programs: A Resource Guide

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Executive Summary

Background and Approach

Given the continued high rates of suicide among adolescents and young adults (15-24 years of age), it is more urgent than ever that we apply our limited resources for prevention in the most effective manner possible. To that end, we developed this resource guide to describe the rationale and evidence for the effectiveness of various youth suicide prevention strategies and to identify model programs that incorporate these different strategies. The guide is for use by persons who are interested in developing or augmenting suicide prevention programs in their own communities. Because the diagnosis and treatment of mental disorders is so widely accepted as a cornerstone of suicide prevention, we excluded from this guide programs that provide mental health services in traditional health service delivery settings. We did include, however, programs that were designed to increase referral to existing mental health services.

We developed this resource guide through networking. Initially, 40 experts in youth suicide prevention around the country were asked to identify exemplary youth suicide prevention programs. Representatives from these programs were then contacted and asked to describe their activities and to identify other programs that they considered exemplary. The list was supplemented by contacting program representatives who participated in the 1990 national meeting of the American Association of Suicidology (AAS) and by soliciting program identification through *Newslink*, the newsletter of AAS. The resulting list of programs is not meant to represent all exemplary youth suicide prevention programs, but it does characterize the diversity of existing programs and can serve as a resource guide for those interested in learning about the types of prevention activities in the field.

For this guide, we delineated eight different suicide prevention strategies, most of which were incorporated in some combination into the programs we reviewed. These were:

- **School Gatekeeper Training**. This type of program is directed at school staff (teachers, counselors, coaches, etc.) to help them identify students at risk of suicide and refer such students for help. These programs also teach staff how to respond in cases of a tragic death or other crisis in the school.
- **Community Gatekeeper Training.** This type of gatekeeper program provides training to community members such as clergy, police, merchants, and recreation staff. This training is designed to help these people identify youths at risk of suicide and refer them for help.
- **General Suicide Education.** These school-based programs provide students with facts about suicide, alert them to suicide warning signs, and provide them with information about how to seek help for themselves or for others. These programs often incorporate a variety of self-esteem or social competency development activities.
- **Screening Programs.** Screening involves administration of an instrument to identify high-risk youth in order to provide more thorough assessment and treatment for a smaller, targeted population.
- **Peer Support Programs.** These programs, which can be conducted in either school or non-school settings, are designed to foster peer relationships, competency development, and social skills as a method to prevent suicide among high-risk youth.

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- **Crisis Centers and Hotlines.** These programs primarily provide emergency counseling for suicidal people. Hotlines are usually staffed by trained volunteers. Some programs offer a "drop-in" crisis center and referral to traditional mental health services.
- **Means Restriction.** This prevention strategy consists of activities designed to restrict access to firearms, drugs, and other common means of committing suicide.
- **Intervention After a Suicide.** Strategies have been developed to cope with the crisis sometimes caused by one or more youth suicides in a community. They are designed in part to help prevent or contain suicide clusters and to help youth effectively cope with feelings of loss that come with the sudden death or suicide of a peer. Preventing further suicides is but one of several goals of interventions made with friends and relatives of a suicide victim—so-called "postvention" efforts.

Findings

Overall, we noted that:

- **Despite many differences, the various prevention strategies incorporated into current youth suicide prevention programs have two common themes.** As noted above, we delineated eight different strategies for youth suicide prevention that were generally incorporated in some combination into the programs we reviewed. Despite their obvious differences, these eight strategies may be considered to constitute just two conceptual categories: (1) strategies to enhance the recognition of suicidal youth and their referral to existing mental health resources, and (2) strategies designed to directly address known or suspected risk factors for youth suicide.
  - *Strategies to enhance recognition and referral.* This category includes active strategies to identify and refer suicidal youth (general screening programs, targeted screening in the context of an apparent suicide cluster) as well as passive strategies to increase referrals (training school and community gatekeepers, general education about youth suicide, establishing crisis centers and hotlines). Some of the passive strategies are designed to lower barriers to self-referral for those with suicidal feelings; others are designed to increase referrals by persons who recognize suicidal tendencies in someone they know.
  - *Strategies to address known or suspected risk factors.* This category includes interventions designed to promote self-esteem and build competency in stress management (general suicide education, peer support programs); to develop support networks for youths who have attempted suicide or who are otherwise thought to be at high risk (peer support programs); and to provide crisis counseling or otherwise address the proximal stress events that increase the risk of suicide among susceptible youths (crisis centers and hotlines, interventions to minimize contagion in the context of suicide clusters). Although means restriction may be critically important in reducing the risk of youth suicide, none of the programs we reviewed placed a major emphasis on this prevention strategy.
- **Most programs focus on teenagers, with little emphasis given to suicide prevention among young adults.** With a few important exceptions, most programs designed to reduce youth suicide were developed with high school-aged youth in mind. This may be due to the fact that adolescents in high school are easier to reach than young

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adults 20-24 years of age. But it may also be due to a failure to appreciate that the suicide rate is generally twice as high among persons 20-24 years of age as among adolescents 15-19 years of age. More prevention efforts need to be targeted toward young adults at high risk of suicide.

- **Current programs are sometimes inadequately linked with existing community mental health resources.** Some programs, notably the Pennsylvania Student Assistance Program, have deliberately worked to develop very close ties with community mental health resources. In a substantial number of other programs, however, linkages with existing mental health resources have been somewhat tenuous. We believe that strengthening these ties would substantially enhance suicide prevention efforts.

- **Some strategies are applied very infrequently—despite great apparent potential for success—whereas others are very commonly applied.** In particular, despite evidence that restricting access to lethal means of suicide (e.g., firearms and lethal dosages of drugs) may prevent some youths from completing suicide, none of the youth suicide prevention programs we reviewed incorporated this strategy as a major focus of their efforts. Parents should be educated in suicide warning signs and encouraged to restrict their teens' access to lethal suicide means. Other promising strategies, such as peer support programs for previous suicide attempters or high-risk youth, might also be more widely incorporated into current suicide prevention programs, but great care should be taken to ensure that there are no adverse consequences from involving peers in such activities.

- **Certain potentially effective programs targeted at high-risk youth are not thought of as "youth suicide prevention" programs.** Alcohol and drug abuse treatment programs and programs that provide help and services to runaways, pregnant teens, or school dropouts are examples of programs that address risk factors for suicide and yet are rarely considered to be suicide prevention programs. Few of the programs we reviewed had any formal ties with such programs.

- **There is very little evaluation research in this area—indeed, there is very little data collected that would facilitate such research.** The tremendous dearth of evaluation research stands as the single greatest obstacle to improving current efforts to prevent youth suicide. In the final analysis, despite many years of experience and hard work, all we can say—and scientifically defend—is that every one of the eight strategies described herein, as currently implemented, may or may not prevent youth suicide. Clearly, this is an unsatisfactory state of affairs. We urgently need to evaluate existing suicide prevention programs wherever possible and to incorporate the potential for evaluation into all new prevention programs. Moreover, whenever possible, the outcome measure for such evaluations should be changes in suicidal behavior. After all, it is the level of suicidal behavior—not attitudes toward suicide or knowledge of warning signs—that we are ultimately working to change. When measuring a program's effect on the level of suicidal behavior is not feasible, the outcomes measured should be those that are closely associated with actual suicidal behavior.

  In this regard, it is worth noting that *any* health intervention may have unforeseen negative consequences; suicide prevention efforts are no exception. This is another, even more important reason why evaluation must be built into every youth suicide prevention program. Regardless of the prevention strategy employed, we must be vigilant to ensure that efforts to prevent suicide do not result in untoward consequences.

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Recommendations

Although we do not have sufficient information to recommend one suicide prevention strategy over another at this stage, the following recommendations seem prudent:

- **Ensure that new and existing suicide prevention programs are linked as closely as possible with professional mental health resources in the community.** As noted, many of the strategies are designed to increase referrals of at-risk youth—this approach can be successful only to the extent that there are appropriate, trained counselors to whom referrals can be made.
- **Avoid reliance on one prevention strategy.** Most of the programs we reviewed already incorporate several if not all of the eight strategies we described. However, certain strategies tend to predominate, despite limited evidence of their effectiveness.
- **Incorporate promising but underused strategies into current programs where possible.** The restriction of lethal means by which to commit suicide may be the most important candidate strategy here. Peer support groups for those who have felt suicidal or have attempted suicide also appear promising.
- **Expand suicide prevention efforts for young adults 20-24 years of age,** among whom the suicide rate is twice as high as for adolescents.
- **Incorporate evaluation efforts into all new and existing suicide prevention programs,** preferably based on outcome measures such as the incidence of suicidal behavior, or measures closely associated with such incidence. Be aware that suicide prevention efforts, like all health interventions, may have unforeseen negative consequences. Evaluation measures should be designed to identify such consequences, should they occur.

Like many prevention programs, the suicide prevention programs described in this resource guide are evolving. They are subject to changes in staff, funding, and program emphasis. Hence, readers should contact programs directly to obtain current information on their activities.

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Chapter 1
INTRODUCTION AND SUMMARY

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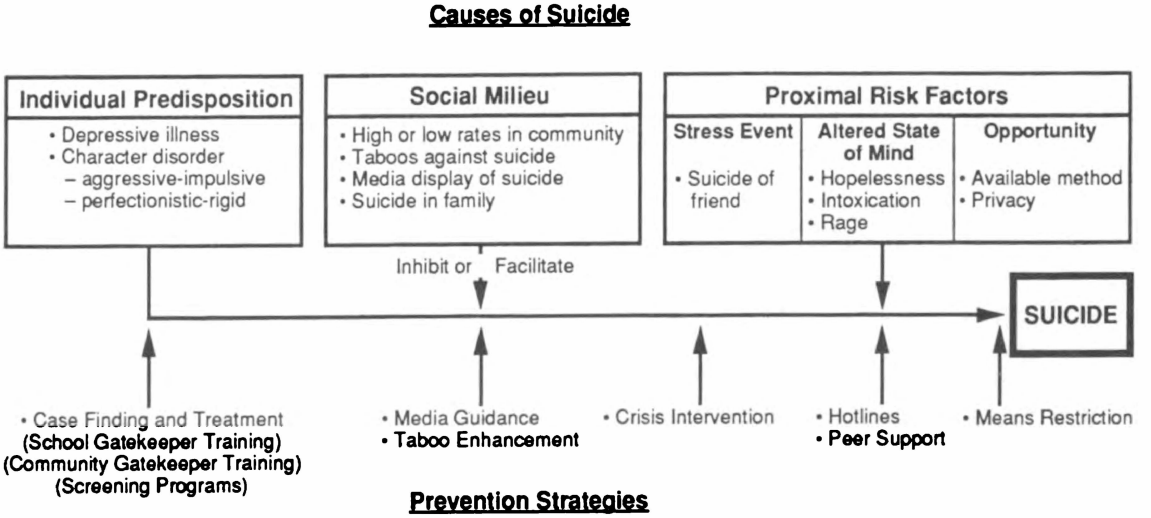
Chapter 1
Introduction and Summary

Background

For many years, we have known that persons suffering from mental disorders, particularly affective illnesses, are at markedly increased risk of committing suicide. In past decades, most people who died from suicide were older adult males who appeared to have been suffering from clinical depression or other treatable mental disorders at the time of their death. As a consequence, suicide prevention was viewed primarily as a problem of identifying and treating persons with mental disorders associated with increased risk of suicide. Mental illness is not, of course, a sufficient cause of suicide in itself; if it were, everyone who suffered from mental illness would die from suicide. There are, in fact, a variety of other factors that contribute to any given suicide and, consequently, a variety of potential points for preventive intervention (Figure 1). Nevertheless, identifying and treating persons with mental disorders remains an important mainstay of suicide prevention.

In recent years, however, there has been increasing evidence that we need to go beyond this paradigm for suicide prevention, particularly for young people (CDC, 1986). In 1950, the rate of suicide among adolescents (15-19) was 2.7 per 100,000; among young adults (20-24), the rate was 6.2 per 100,000. By 1980, the rate among both adolescents and young adults had tripled, to 8.5 and 16.1 per 100,000, respectively (Table 1). This alarming increase in the rate of youth suicide was accompanied by research indicating that only about one-third of adolescent suicide victims appeared to satisfy clinical criteria for depression or other treatable mental illness (Shaffer, et al., 1988).

FIGURE 1.
Conceptual Model of Factors Influencing Youth Suicide



Adapted, with permission, from the *Journal of the American Academy of Child and Adolescent Psychiatry.* Shaffer, D., Garland, A., Gould, M., Fisher, P., and Trautman, P. Preventing Teenage Suicide: A Critical Review, 1988, 27:675–687.

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TABLE 1.
Suicide Rates Among 15- to 24-Year-Olds in the United States, by Race and Sex (Rates Per 100,000)

Group	1950	1960	1970	1980	1988
15–19					
White Male	3.7	5.9	9.4	15.0	19.6
Black Male	—	2.9	4.7	5.6	9.7
White Female	1.9	1.6	2.9	3.3	4.8
Black Female	—	1.1	2.9	1.6	2.2
All Youth	2.7	3.6	5.9	8.5	11.3
20–24					
White Male	9.4	11.9	19.3	27.8	27.0
Black Male	—	5.8	18.7	20.0	19.8
White Female	3.5	3.1	5.7	5.9	4.4
Black Female	—	1.5	4.9	3.1	2.9
All Youth	6.2	7.1	12.2	16.1	15.0
15–24					
White Male	6.6	8.6	13.9	21.4	23.4
Black Male	4.9	4.1	10.5	12.3	14.5
White Female	2.7	2.3	4.2	4.6	4.6
Black Female	1.8	1.3	3.8	2.3	2.6
All Youth	4.5	5.2	8.8	12.3	13.2

— Data not available from National Center for Health Statistics.
Source: National Center for Health Statistics, Centers for Disease Control. Published and unpublished data.

In response to these findings, concerned people began to implement a variety of innovative programs they believed might help to reduce the rate of youth suicide. Many such programs were designed to enhance the ability of people to recognize signs of suicidal tendencies, either in themselves or in others, and to increase referrals of adolescents and young adults with psychiatric disorders to existing mental health services. Other programs tried to interrupt the chain of suicide causation at another point, by focusing on the social milieu in which suicide occurs, or on so-called "trigger factors" for suicide, such as a stressful event or the loss of a loved one.

Despite these efforts, the rate of youth suicide remains high: in 1988, the rate among adolescents was 11.3 per 100,000; among young adults, the rate was 15.0. Faced with these continuing high suicide rates, it is more urgent than ever that we determine which of the current prevention strategies are effective and, in particular, which are most effective relative to their cost. Over the years, a great variety of suicide prevention programs have been implemented, incorporating many different strategies. Despite this experience, there is still (1) no ready way to identify model programs for others who are interested in developing suicide prevention programs in their own communities, and (2) no consensus as to the relative effectiveness of particular suicide prevention strategies. In the absence of this information, people interested in suicide prevention have had no choice but to employ whatever strategies seemed most appealing, often requiring them to "re-invent the wheel" in their community and, at least potentially, leading them to expend scarce prevention resources on ineffective or relatively less effective strategies.

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Development of CDC Resource Guide for Youth Suicide Prevention

We developed this resource guide to address these two needs. It is intended as an aid to those who are interested in developing or augmenting youth suicide prevention programs in their own communities. To gather information for the guide, we contacted a wide variety of suicide prevention experts and asked them to identify and describe "exemplary" youth suicide prevention programs (i.e., programs that in their judgment were likely to be effective in the prevention of suicide).

When we cast our net for youth suicide prevention programs, we deliberately excluded programs designed to deliver mental health services in traditional health service delivery settings. As mentioned previously, the diagnosis and treatment of mental disorders has been and continues to be a cornerstone of suicide prevention. Even among teenagers, at least 1 in 5 suicide victims appears to have been suffering from clinical depression when he or she committed suicide; almost 4 in 10 appear to have had a diagnosable drug abuse disorder (Shaffer, et al., 1988). In addition, the evidence is clear that current treatment for clinical depression and certain other mental disorders is effective in reducing the duration of mental illness. Although there is surprisingly little objective evidence that treating persons with mental disorders actually reduces the overall rate of death from suicide, no one doubts that we must continue our efforts to diagnose and treat persons with mental disorders as part of any larger effort to prevent suicide. Because this approach to suicide prevention is so widely accepted, we excluded traditional mental health service delivery programs from our review. We did include, however, programs that were designed to increase referral to existing mental health services.

Study Approach

This study was designed to help clarify the issues involved in preventing suicide by describing the types of youth suicide prevention programs that are in operation or that have been proposed. We began by reviewing research studies on youth suicide prevention. We then attempted to identify and describe exemplary youth suicide prevention programs around the United States. Our general approach was, first, to identify a wide variety of suicide prevention programs that suicide prevention experts considered most likely to be effective and that might be evaluated and replicated. These judgments were made on the basis of a number of broad criteria, including the number of persons exposed to the intervention, the number of years of program operation, the nature and intensity of the intervention, and the availability of data to facilitate evaluation. After identifying these reportedly exemplary programs, we contacted the various program directors to gather further information that we believed would be valuable to others in the suicide prevention community and valuable to us in identifying programs that might be amenable to scientific evaluation. Finally, in compiling this information, we attempted to identify knowledge gaps and the kinds of evaluation questions that, if addressed, would increase our understanding of the effects of youth suicide prevention activities.

We identified the programs described in this report by contacting more than 40 experts in youth suicide prevention around the country and asking them to identify exemplary youth suicide prevention programs. Directors of these programs were then asked to describe their activities and send us any written material about their operations. We expanded our list of contacts by asking the director of each program to identify other programs that they considered exemplary. We supplemented our list by contacting participants in the 1990

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national meeting of the American Association of Suicidology (AAS) and by soliciting responses from program staff in *Newslink*, the newsletter of AAS.

Staff in suicide prevention programs rarely identified more than one or two other exemplary programs. Moreover, the programs nominated were typically in other areas of the country rather than in the same state. This leads us to speculate that the resource network that would allow programs to provide advice to one another and share information is not as well developed as it might be.

Programs in the resulting list are described in this report. This list is not meant to represent all exemplary youth suicide prevention programs, nor does the Centers for Disease Control endorse this list of programs as being the most effective or worthy of emulation. Rather, the programs we describe are intended to characterize the diversity of programs that exists and to serve as a resource guide for those interested in learning about the various types of suicide prevention activities in this field.

Youth Suicide Prevention Programs

There is a broad spectrum of youth suicide prevention programs ranging from general education about suicide to crisis center hotlines. The different prevention strategies are designed to prevent suicide in various ways (Figure 1). For example, gatekeeper training and screening programs are designed to identify people at risk of suicide and refer them to mental health services. Conversely, hotlines are intended to help people who are experiencing a crisis.

This report focuses on eight different kinds of program activities representing different strategies for suicide prevention. However, suicide prevention programs are typically quite comprehensive, incorporating several different strategies. For example, general suicide education programs in schools are almost always associated with gatekeeper training for school personnel. Similarly, in many communities, general suicide education programs are conducted by crisis center personnel. Many suicide prevention programs include several of these components in their activities, and many in the field believe that comprehensive programs offering multiple components facilitate the type of synergy and coordination that is more effective than any individual component.

Still, in planning, implementing, or evaluating suicide prevention efforts, we need to think about individual program components and prevention strategies. Although prevention programs are typically comprehensive, many program directors recommend implementing one component at a time, in order to get the activity fully operational before new program components are added. In addition, the types of evaluation questions that need to be asked will be quite different for various types of prevention strategies. Therefore, this report has been organized according to major program components and strategies.

School Gatekeeper Training. This type of program is directed at school staff (teachers, counselors, coaches, etc.) to help them identify students at risk of suicide and refer such students as appropriate. These programs also teach staff how to respond in cases of a tragic death or other crisis in the school.

Community Gatekeeper Training. This type of gatekeeper program provides training to community members, such as clergy, police, merchants, and recreation staff, as well as physicians, nurses, and other clinicians who see youthful patients. This training is designed to help these people identify youth at risk of suicide and refer them as appropriate.

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General Suicide Education. These programs provide students with facts about suicide, alert them to suicide warning signs, and provide information about how to seek help for themselves or for others. These programs often incorporate a variety of self-esteem or social competency development activities.

Screening Programs. Screening involves the administration of an instrument to identify high-risk youth in order to provide more targeted assessment and treatment. Repeated administration of the screening instrument can also be used to measure changes in attitudes or behaviors over time, to test the effectiveness of an employed prevention strategy, and to obtain early warning signs of potential suicidal behavior.

Peer Support Programs. These programs, which can be conducted in either school or non-school settings, are designed to foster peer relationships, competency development, and social skills among youth at high risk of suicide or suicidal behavior.

Crisis Centers and Hotlines. Among other services, these programs primarily provide telephone counseling for suicidal people. Hotlines are usually staffed by trained volunteers. Such programs may also offer a "drop-in" crisis center and referral to mental health services.

Means Restriction. This prevention strategy consists of activities designed to restrict access to handguns, drugs, and other common means of suicide.

Intervention After a Suicide. Strategies have been developed to cope with the crisis sometimes caused by one or more youth suicides in a community. They are designed in part to help prevent or contain suicide clusters and to help youth effectively cope with feelings of loss that come with the sudden death or suicide of a peer. Preventing further suicides is but one of several goals of interventions made with friends and relatives of a suicide victim—so-called "postvention" efforts.

Report Organization

In the chapters that follow, we describe and present the rationale for various types of suicide prevention strategies, review the research on these strategies, provide a brief summary of our judgments concerning the potential and pitfalls of these approaches, and then present brief descriptions of programs that might serve as a resource or guide for others. When program descriptions were sent out for review, program staffers were asked what advice they would share with others who might want to implement that type of program. When supplied, these comments are reported as well.

Summary of Overall Findings

Several important conclusions may be drawn from an overall consideration of the information we gathered and collated in this resource guide:

- **Despite many differences, the various prevention strategies incorporated into current youth suicide prevention programs have two common themes.** As noted previously, we delineated eight different strategies for youth suicide prevention that were generally incorporated in some combination into the programs we reviewed. Despite their obvious differences, these eight strategies may be considered to constitute just two conceptual categories: (1) strategies to enhance the recognition of suicidal youth and their referral to existing mental health resources, and (2) strategies designed to directly address known or suspected risk factors for youth suicide.

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- *Strategies to enhance recognition and referral.* This category includes active strategies to identify and refer suicidal youth (general screening programs, targeted screening in the context of an apparent suicide cluster) as well as passive strategies to increase referrals (training school and community gatekeepers, general education about youth suicide, establishing crisis centers and hotlines). Some of the passive strategies are designed to lower barriers to self-referral for those with suicidal feelings; others are designed to increase referrals by persons who recognize suicidal tendencies in someone they know.
- *Strategies to address known or suspected risk factors.* This category includes interventions designed to promote self-esteem and build competency in stress management (general suicide education, peer support programs); to develop support networks for youths who have attempted suicide or who are otherwise thought to be at high risk (peer support programs); and to provide crisis counseling or otherwise address the proximal stress events that increase the risk of suicide among susceptible youths (crisis centers and hotlines, interventions to minimize contagion in the context of suicide clusters). Although means restriction may be critically important in reducing the risk of youth suicide, none of the programs we reviewed placed a major emphasis on this prevention strategy.

- **Most programs focus on teenagers, with little emphasis given to suicide prevention among young adults.** With a few important exceptions, most programs designed to reduce youth suicide were developed with high school-aged youth in mind. This may be due to the fact that adolescents in high school are easier to reach than young adults 20-24 years of age. But it may also be due to a failure to appreciate that the suicide rate is generally twice as great among persons 20-24 years of age as among adolescents 15-19 years of age (Table 1). More prevention efforts need to be targeted toward young adults at high risk of suicide.

- **Current programs are sometimes inadequately linked with existing community mental health resources.** Some programs, notably the Pennsylvania Student Assistance Program, have deliberately worked to develop very close ties with community mental health resources. In a substantial number of other programs, linkages with existing mental health resources have been somewhat tenuous. We believe that strengthening these ties would substantially enhance suicide prevention efforts.

- **Some strategies are applied very infrequently—despite great apparent potential for success—whereas others are very commonly applied.** In particular, despite evidence that restricting access to lethal means of suicide (e.g., firearms and lethal dosages of drugs) may prevent some youths from completing suicide, none of the youth suicide prevention programs we reviewed incorporated this strategy as a major focus of their efforts. Parents should be educated in suicide warning signs and encouraged to restrict their teens' access to lethal suicide means. Other promising strategies, such as peer support programs for previous suicide attempters or high-risk youth, might also be more widely incorporated into current suicide prevention programs, but great care should be taken to ensure that there are no adverse consequences from involving peers in such activities.

  In contrast, school-based general suicide education is a commonly employed youth suicide prevention strategy (Appendix B). This is probably because it is a fairly easy and inexpensive way to reach a large audience. In addition, school-based educational efforts

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may be an intuitively appealing approach to addressing any problem among adolescents. In this case, however, there is little evidence to support school-based education as a predominant approach to adolescent suicide prevention. In many instances (not necessarily in the programs described herein, but in many other programs of which the authors are aware), the educational intervention consists of a very brief, one-time lecture on the warning signs of suicide, a method which seems unlikely to have any substantial or lasting impact on a student's risk of suicide. Moreover, general school-based suicide curricula may not be effective for those adolescents whom one most wishes to reach: those who have attempted suicide or have considered suicide as a solution to their problems in the past. Students who have previously attempted suicide may react more negatively to such curricula than students without a history of attempted suicide. While the effects—positive or negative—of such general educational approaches are still unclear, many suicide researchers believe that broader curricula that address suicide prevention in the context of other adolescent health issues are preferable to curricula that only address suicide.

- **Certain potentially effective programs targeted at high-risk youth are not thought of as "youth suicide prevention" programs.** Alcohol and drug abuse treatment programs and programs that provide help and services to runaways, pregnant teens, or school dropouts are examples of programs that address risk factors for suicide and yet are rarely considered to be suicide prevention programs. Few of the programs we reviewed had any formal ties with such programs.

- **There is very little evaluation research in this area— indeed, there is very little data collected that would facilitate such research.** The tremendous dearth of evaluation research in this area stands as the single greatest obstacle to improving current efforts to prevent youth suicide. In the final analysis, despite many years of experience and hard work, all we can say—and scientifically defend—is that every one of the eight strategies described herein, as currently implemented, may or may not prevent youth suicide. Clearly, this is an unsatisfactory state of affairs. We urgently need to evaluate existing suicide prevention programs wherever possible and to incorporate the potential for evaluation into all new prevention programs. Moreover, whenever possible, the outcome measure for such evaluations should be changes in suicidal behavior. After all, it is the level of suicidal behavior—not attitudes toward suicide or knowledge of warning signs—that we are ultimately working to change. When measuring a program's effect on the level of suicidal behavior is not feasible, the outcomes measured should be those that are closely associated with actual suicidal behavior.

  In this regard, it is worth noting that *any* health intervention may have unforeseen negative consequences; suicide prevention efforts are no exception. This is another, even more important reason why evaluation must be built into every youth suicide prevention program. Regardless of the prevention strategy employed, we must be vigilant to ensure that efforts to prevent suicide do not result in untoward consequences.

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Recommendations

Although we do not have sufficient information to recommend one suicide prevention strategy over another at this stage, the following recommendations seem prudent:

- **Ensure that new and existing suicide prevention programs are linked as closely as possible with professional mental health resources in the community.** As noted, many of the strategies are designed to increase referrals of at-risk youth—this approach can be successful only to the extent that there are appropriate, trained counselors to whom referrals can be made.
- **Avoid reliance on one prevention strategy.** Most of the programs we reviewed already incorporate several if not all of the eight strategies we described. However, as noted, certain strategies tend to predominate, despite limited evidence of their effectiveness.
- **Incorporate promising but underused strategies into current programs where possible.** The restriction of lethal means by which to commit suicide may be the most important candidate strategy here. Peer support groups for those who have felt suicidal or have attempted suicide also appear promising, but great care should be taken to ensure that there are no adverse consequences from involving peers in such activities.
- **Expand suicide prevention efforts for young adults 20-24 years of age,** among whom the suicide rate is twice as high as for adolescents.
- **Incorporate evaluation efforts into all new and existing suicide prevention programs,** preferably based on outcome measures, such as the incidence of suicidal behavior, or measures closely associated with such behavior. Be aware that suicide prevention efforts, like all health interventions, may have unforeseen negative consequences. Evaluation measures should be designed to identify such consequences, should they occur.

When developing a youth suicide prevention program in a particular community, the needs and resources of the community must be identified to determine which strategy or combination of strategies is most appropriate. We hope that the information in this document will help communities make this determination. Finally, like many prevention programs, the suicide prevention programs described in this resource guide are evolving. They are subject to changes in staff, funding, and program emphasis. Hence, readers should contact programs directly to obtain current information on their activities.

References Used in the Introduction

Centers for Disease Control. *Youth Suicide in the United States, 1970-1980.* Atlanta: Centers for Disease Control, 1986.

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Chapter 2
SCHOOL GATEKEEPER TRAINING

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Chapter 2
School Gatekeeper Training

Overview and Rationale

Gatekeeper training programs are designed to help members of the community identify youth with a high potential for suicide and refer them to appropriate sources of help. A "gatekeeper" can be anyone who has significant contact with youth during the course of the day, such as coaches, clergy, police, or volunteers. A particularly important group of gatekeepers is school personnel. Because of their importance and the effort that has been devoted to developing programs for school personnel, these programs are described in this chapter. The next chapter, "Community Gatekeeper Training," focuses on programs for gatekeepers who can reach youth in other settings.

School gatekeeper training programs are school-based programs designed to help school staff identify students at risk of suicide and to refer them for help. School gatekeepers may include any adult in the school (e.g., counselors, teachers, coaches, administrators or cafeteria staff) in a position to observe and interact with students.

Gatekeeper training usually consists of learning about warning signs of suicide, what referral sources exist and how to contact them, and what the school policy is for handling crisis situations. Other topics include legal issues involved with suicide and how to communicate with at-risk students. As illustrated in Figure 2, knowledge of these topics enhances the ability of school staff to handle potentially suicidal students and to refer them to appropriate sources of help.

School gatekeeper training is primarily intended to educate staff on how to identify students with emotional or other problems who may also be potentially suicidal. It is not meant to replace professional mental health care or to empower school staff to act as counselors but is simply meant to enable staff to "sound the alarm." Combined with appropriate professional treatment, this intervention may help prevent suicides.

School gatekeeper programs may also help school staff recognize and take action to reduce sources of stress in the social environment of the school system, such as adjustment to a new school (Caplan, 1964, Kelly, 1979), and to develop relationships with students at times of transition or vulnerability that can help them in their subsequent functioning (Hersey, 1977).

Research Findings

School gatekeeper training programs have been well received by teachers and school staff. Staff have reported these programs as helpful in California (Nelson, 1987), Colorado (Barrett, 1985), and Rhode Island (Spirito, et al., 1988). For example, as shown in Table 2, researchers evaluating the school gatekeeper education component of the New Jersey Adolescent Suicide Prevention Project found that school personnel who participated in a 2-hour training program showed increased awareness of suicide warning signs, knowledge of treatment resources, and willingness to make referrals to mental health professionals (Shaffer, Garland, and Whittle, 1988). Improvements in knowledge were also observed in the evaluation of a gatekeeper education program in Colorado (Barrett, 1985). In addition, Barrett found that referrals for

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FIGURE 2.
Rationale for School Gatekeeper Training Programs to Prevent Youth Suicide

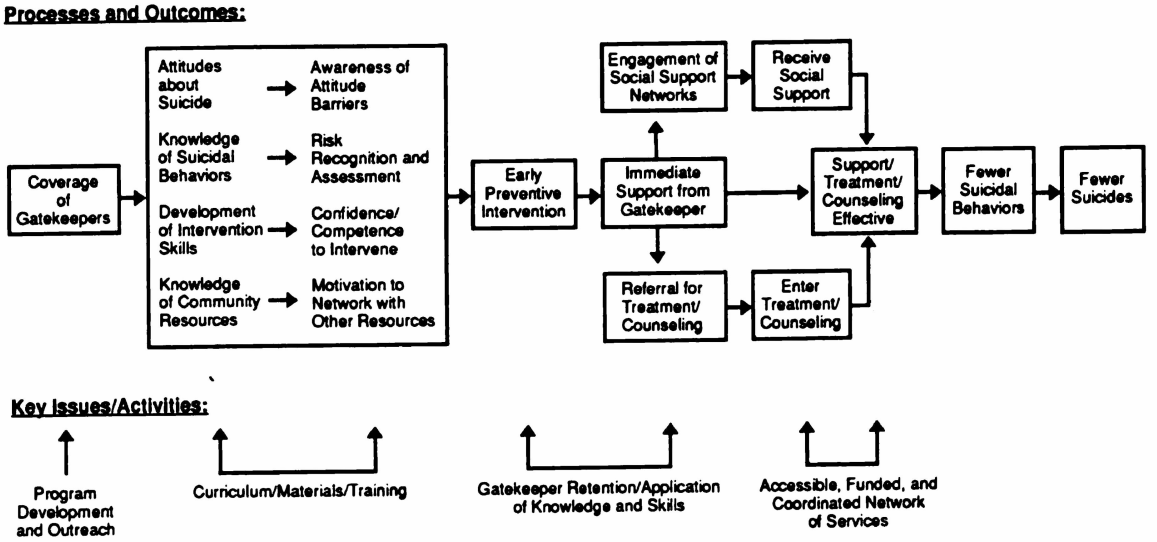

TABLE 2.
Changes in Knowledge Among School Gatekeepers After Training

Issue	Before	After
Mean Number of Warning Signs Listed	3.6	6.1
Percentage of Gatekeepers Listing Specific Warning Signs		
Making Final Arrangements	24%	53%
Nonspecific Change	34%	50%
Specific Suicidal Threat/Warning	27%	50%
Depression	57%	49%
Social Withdrawal	46%	35%
Changed Eating Habits/Weight Gain or Loss	11%	31%
Decreased School Performance	20%	29%
Engaging in Risky Behavior	2%	29%
Apathy/Indifference	22%	22%
Knowledge of Treatment Resources		
Know where to refer a troubled student	45%	68%
Willingness to Make Treatment Referrals		
Believe that they should be responsible for contacting a mental health professional (outside school) about a student who may be at risk for suicidal behavior	46%	62%

Note: Analyses are based on a sample of approximately 307 educators who completed questionnaires before and after the program. This represented 72% of educators who attended the program.

Adapted from: Shaffer, D., Garland, A., and Whittle, R. New Jersey Adolescent Suicide Prevention Project: Final Project Report, pp.28-29.

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counseling increased after a school gatekeeper training program. A delphi panel of experts estimated that school gatekeeper programs could reduce youth suicide by about 12 percent (Eddy, Wolpert, and Rosenberg, 1989). We are not aware, however, of any formal evaluation of the effect of school gatekeeper training on changes in the behavior of trainees.

Illustrative Programs

This report lists eight programs as examples of school gatekeeper training programs. These programs were selected because of their substantial time in operation, the extensiveness of the training they provided, and their tie-in with mental health or other more comprehensive youth suicide prevention programs. These programs are included:

Program	Rationale for Inclusion
East:	
BRIDGES Piscataway, New Jersey	• Comprehensive program • Plans for evaluation
Pennsylvania Network for Student Assistance Services (PNSAS) Pittsburgh, Pennsylvania	• Extent of training • Linkage with mental health agencies • Statewide operation
STAR Pittsburgh, Pennsylvania	• Strong community outreach • Linkage with mental health
Midwest:	
Suicide Prevention Center Programs Dayton, Ohio	• Comprehensive programs • Length of operation
South:	
Crisis Intervention Dade County, Florida	• Use of tools to help identify at-risk students • High minority population
Project SOAR Dallas, Texas	• Comprehensive program • Three years in operation
Adolescent Suicide Prevention Program Fairfax County, Virginia	• Eight years in operation • Extensive documentation
West:	
Weld County Suicide Prevention Program Johnstown, Colorado	• Extent of training • Coverage of grades

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The school gatekeeper programs in Dayton, Ohio, in Dallas, Texas, and in Fairfax County, Virginia, provide examples of well-crafted school gatekeeper training programs in large school systems, and the program in Weld County, Colorado, offers an example in a smaller community. These programs are relatively inexpensive to implement and maintain.

The BRIDGES program in Piscataway, New Jersey, is listed because of its active work in evaluation research. Program officials are planning to assess how well the ratings of youth provided by gatekeepers coincide with more extensive assessments by mental health professionals.

The Dade County, Florida, program is listed because it provides a quarterly "screening tool" of "at-risk" students based on such easily accessible factors as absences and poor school performance.

The Pennsylvania Network for Student Assistance Services (PNSAS) is listed not only because of its statewide implementation but also because of the extensive training it provides to key personnel in each school and the strong linkages it seeks to build with community mental health services.

Evaluation Needs

The following questions are appropriate to ask in the evaluation of school gatekeeper training programs:

- How many students are identified as being at risk?
- How accurate are the identifications?
- How many students are referred to intervention or treatment programs?
- How many students follow through on the referrals?
- Does the overall incidence of suicidal ideation and suicidal behavior decline in response to gatekeeper training and referrals?
- Do gatekeepers identify other factors that create stress in the lives of students, factors that could lead a youth to consider suicide?

The data needed to answer questions about the number of referrals and follow-ups should be relatively easy to obtain, and many of the programs listed here are collecting this information as part of internal evaluations. The questions about the appropriateness of referrals and about treatment effectiveness would probably require assistance from qualified mental health professionals as well as a more extensive evaluation effort.

Summary

School gatekeeper training programs are relatively common, though they vary in the extent of training and the strength of linkages to mental health programs. We view this linkage as fundamental to the success of these programs. Evaluation studies indicate that gatekeeper training programs are effective at educating participants and increasing their willingness to refer at-risk students for appropriate help. The effects of school gatekeeper training programs on the subsequent *behavior* of gatekeepers is unknown.

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Two potential negative consequences should be guarded against in implementing school gatekeeper training programs. First, school personnel should be sensitive to the feelings of individuals referred for help lest they feel bad about being singled out. Second, program officials should seek to minimize inappropriate referrals, which might needlessly burden the mental health system, causing delays in treatment for those truly in need.

References About School Gatekeeper Training Programs

Barrett, T.C. *Youth in Crisis: Seeking Solutions to Self-Destructive Behavior*. Longmont, CO: Sopris West, 1985.

Caplan, G. *Principles of Preventive Psychiatry*. New York: Basic Books, 1964.

Eddy, D.M., Wolpert, R.L., and Rosenberg, M.L. Estimating the effectiveness of interventions to prevent youth suicides. In: Alcohol, Drug Abuse, and Mental Health Administration. *Report of the Secretary's Task Force on Youth Suicide*. DHHS Pub. No. (ADM)89-1624, Vol 4. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1989:37-81.

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Shaffer, D., Garland, A., and Whittle, R. 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, 1988.

Spirito, A., Overholser, J., Ashworth, S., Morgan, J., and Benedict-Drew, C. Evaluation of a suicide awareness curriculum for high school students. *Journal of the American Academy of Child and Adolescent Psychiatry* 1988;27:705-711.

Suggested Additional Reading

The County School Board of Fairfax County, Virginia. *The Adolescent Suicide Prevention Program: A Guide for Schools and Communities*. Fairfax, VA, 1987.

Davidson, L.E., Rosenberg, M.L., Mercy, J.A., Franklin, J., and Simmons, J.T. An epidemiologic study of risk factors in two teenage suicide clusters. *Journal of the American Medical Association* 1989;262:2687-2692.

Garland, A., Whittle, B., and Shaffer, D. A survey of youth suicide prevention programs. *Journal of the American Academy of Child and Adolescent Psychiatry* 1988;28:931-934.

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School Gatekeeper Training: Program Descriptions

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BRIDGES: Building Skills to Reach Suicidal Youth

Location: Piscataway, New Jersey
Contacts: Charlsetta Sutton, ACSW, BCD; Karen Dunne-Maxim, R.N., M.S., (908) 463–4109

Targets:
- School personnel (guidance staff, teachers)
- Agency staff who work with youth

Years in operation: 7
Source of funding:
- New Jersey Department of Education
- Participating school systems
- Per diem from various agencies

Amount of funding (per year): Varies.

Program description: BRIDGES is a training program for selected school personnel (e.g., guidance staff, child study teams, personnel from student assistance programs, and teachers working with emotionally disturbed adolescents) to help them to develop skills in assessing suicide risk, to intervene in the crises of suicidal youth, to intervene with families and peers of suicidal youth, to follow referral procedures, and to develop school policies and procedures for suicide prevention and postvention.

Exposure: School personnel training lasts 16 hours (2 days).

Coverage: The BRIDGES program has been provided to 594 participants since 1986.

Content/topics: BRIDGES trains school personnel to accurately distinguish students at risk for suicidal behavior from those who are depressed. Personnel learn to assess students' risks, to intervene when appropriate, to work with families and peers, to follow referral procedures, and to develop school policy and procedures with regard to suicide prevention and postvention.

Referral/selection procedures: Appropriate school personnel (guidance staff, child study team members, student assistance counselors) are referred to BRIDGES by school administrators.

Evaluation: Evaluation studies are being developed. Officials are particularly interested in conducting an impact evaluation of the BRIDGES program. This evaluation would determine the efficacy of the BRIDGES program in training school personnel to accurately identify suicidal youth. Some of their ideas for evaluation include collecting data on the functioning of students at risk, the school climate, and teachers' feelings immediately after and 2 weeks after a suicide takes place to:

- Check for risk of suicide contagion
- Do assessment of risk of suicides
- Evaluate the effectiveness of the postvention program

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BRIDGES staff want to collect data on how many students are targeted and how many are identified correctly as being suicidal. If a student is accurately identified, they would then collect information on referrals and follow-ups to see if the student was making progress. Assessments would be made by readministering tests and interviewing school staff or the student. Periodic follow-ups would be conducted as long as the individual was in the school system. BRIDGES staff would look for changes in test indices and in suicide and suicide attempt rates as indicated by hospital records.

Data available: Process evaluation data have been collected for the last five years. Data have also been collected on participants' pre- and post-training knowledge of suicide risk factors. Results have demonstrated significant gains in participants' knowledge.

Special population outreach: None.

Related components:

- Postvention
- Screening
- Survivors' support groups

Address: BRIDGES: Building Skills to Reach Suicidal Youth
Charlsetta Sutton, ACSW, BCD
Karen Dunne-Maxim, R.N., M.S.
UMDNJ—CMHC
671 Hoes Lane
Piscataway, NJ 08855–1392

Reports: Brief descriptive brochure.

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Pennsylvania Network for Student Assistance Services (PNSAS)

Location: Pittsburgh, Pennsylvania
Contact: Roberta Chuzie, (412) 394-5837

Targets: All buildings at the secondary level in all school districts.
Years in operation: 6
Source of funding: Collaborative effort among the following:

- Governor's Drug Policy Council
- Department of Public Welfare, Office of Mental Health (MH)
- Department of Education
- Department of Health, Office of Drug and Alcohol Abuse
- Pennsylvania Masonic Foundation for the Prevention of Drug & Alcohol (D/A) Abuse Among Children

Amount of funding (per year): $11.5 million (this includes core team training, D/A & MH treatment, consultation and education, and administrative costs for the Commonwealth).

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

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

Coverage: Five hundred of the 501 school districts in Pennsylvania have had representatives trained in student assistance at the secondary level, which means a total of 1,039 buildings have representatives trained in SAP to date.

Content/topics: Adolescent development, suicide, depression and other mental health problems, chemical dependency, family dynamics, treatment, continuity of care, group process, and action planning.

Referral/selection procedures: Students can be referred to the team through a variety of sources: administrators, teachers, counselors, nurses, child study teams, parents or guardians, peers, and the students themselves. Reasons for a student being referred vary from violation of school policy, behavioral concerns (D/A & MH), suicidal ideation, other mental health concerns, self-reported problems, and recovery and transition back into school after treatment.

Evaluation: Preliminary data are available on the following two evaluations:

- *An Evaluation of Student Assistance Programs in Pennsylvania.* Conducted by Pennsylvania State University, Department of Counselor Education, Counseling Psychology, and Rehabilitation Services Education.

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- *Student Assistance Program Evaluation.* Conducted by the Human Organization Science Institute, Villanova University.

Findings: The 1989-90 SAP aggregate student tracking data indicate an increase in the number of students referred from 10,480 in 1988-89, to 26,739 in 1989-90, and to 41,399 in 1990-91. The number of disciplinary referrals to the core teams has decreased, indicating that a more positive approach is being taken to the program, and classroom teacher, parent, student, and self referrals have all increased. The information on the percentage of referred students who complete treatment has been difficult to track statewide. SAP does not have a mechanism to collect those data but can use a tracking form to track the students until they leave the school for services. SAP is looking into cross-referencing data collection forms with the Department of Health and the Department of Public Welfare in order to track the students once they begin treatment following a SAP referral.

Data available: The program collects data on the number of students processed by core teams during the year, referrals by grade and by race, number of referrals by source and by reason for referral, and the numbers of students in different types of treatment programs. Standardized forms are used to collect the following required data:

- The student's recent history of absences and tardiness
- Academic performance data
- Information on in-class behavior—from teachers
- Performance on standardized tests and special areas of concern
- Health information, including frequency of visits to the health office
- Information from other individuals who may have close contact with the student

Special population outreach: All at-risk students.

Related components: Postvention.

Address: Roberta Chuzie
Student Assistance Services
Station Square
200 Commerce Court Building, 2nd Floor
Pittsburgh, PA 15219

Reports:
- Annual statistical report
- Program curriculum and description
- Evaluation—preliminary data available

Advice to others interested in starting this type of program: All interested parties should network: schools, mental health agencies, drug and alcohol agencies, parents, and any other interested people. Each department at the state level (Education, Health, Public Welfare) and the governor's office should work collaboratively towards the same goal.

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Services for Teens At Risk (STAR)

Location: Pittsburgh, Pennsylvania
Contact: Dr. David Brent, (412) 624-5211

Targets: School personnel, at-risk youth.
Years in operation: 4 (for both the Outreach and Outpatient Clinic programs).
Source of funding: Pennsylvania.
Amount of funding (per year): The Outreach program has 5 full-time employees and the Outpatient Clinic has 33 full-time employees of different disciplines. Additionally, STAR has an annual budget of $170,000 for expenses other than salaries.

Program description: STAR Center offers three programs designed specifically to help school personnel identify and refer at-risk youths.

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

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

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

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

Exposure: Varies (see program description above).

Coverage: Not described.

Content/topics: Identification of potentially suicidal students, risk assessment, and referral procedures.

Evaluation: The Outreach program screens children identified during postvention sessions. The Outpatient Clinic provides a day-long clinical evaluation that combines both structured and unstructured assessment tools.

Data available: The Outreach program has data regarding the number and types of people trained in the various levels. Additionally, the number of children screened during postvention is also available.

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Related components:

- Clinical treatment
- Postvention
- Screening

Address: Dr. David Brent, Director
Services for Teens At Risk (STAR)
WPIC
Pittsburgh, PA 15213

Special population outreach: None.

Reports: Brochures and articles about the activities of STAR.

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Suicide Prevention Center Programs

Location: Dayton, Ohio
Contact: Linda Mates, LPCC, (513) 297-9096

Targets: Students (junior high and high school), gatekeepers.
Years in operation: 10
Source of funding: United Way, and state and community taxes.
Amount of funding (per year): $50,000.

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

Staying Alive: A program that targets minorities and uses nontraditional gatekeepers, such as barbers and hairstylists.

Finding Hope: Training program for parents.

Life Saver III: A 3-year pilot program training undergraduate, graduate, and postgraduate students (teachers, administrators, school counselors, and nurses).

Exposure: Not described.

Coverage: Teachers in all county schools and youth leaders and special gatekeepers (three selected each year).

Evaluation: Several are ongoing: quality assurance, client satisfaction, and client outcome.

Data availability: Participant feedback. Intervention, referral, and follow-up information may be available.

Special population outreach: African-Americans.

Related components:

- General suicide education
- Crisis center and hotline
- Parent programs
- Postvention

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Address: Linda Mates, LPCC
Executive Director
Suicide Prevention Center, Inc.
PO Box 1393
Dayton, OH 45401

Reports: Program manuals and pamphlets, and evaluation materials.

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Crisis Intervention
Dade County Public Schools

Location: Miami, Florida
Contact: Dr. J. L. DeChurch, (305) 995-7315

Targets: All students.
Years in operation: 5
Source of funding: Dade County school district and grant.
Amount of funding (per year): $120,000.

Program description: Dade County established a Department of Teenage Pregnancy and Suicide Prevention in 1987, which in turn became the Department of Crisis Intervention, whose purpose is to prepare staff at the district, region, and school levels to identify, assist, and refer students at risk. The department trains "crisis care core teams" in every school to counsel staff and the community in times of crisis. A hotline is available to assist administrators, counselors, and other support staff.

Exposure: Training of crisis core teams in the schools is done by the District Crisis Team, which consists of one counselor and one psychologist. Training consists of a 3-hour program, and so far approximately 1,000 individuals have been trained.

Coverage: Crisis teams are present in all schools; this is a county-mandated requirement. School staff includes counselors, teachers, social workers, occupational specialists, college advisors, psychologists, bus drivers, cafeteria workers, students, peer counselors, and parents.

Content/topics: How to identify, assist, and refer students at risk; suicide prevention, intervention, and postvention.

Evaluation: Participant written and verbal feedback, which has been positive.

Findings: There were 19 suicides in 1988 and only 7 in 1989, but program staff members are not sure whether to take credit for this apparent decline. They found students in middle school to be most at risk and also found a link between suicidal tendencies and a history of sexual abuse.

Data available: Program staffers are building a data base and want to use it for research and evaluation, but it is not yet operational.

Special population outreach: Not described.

Related components:
- General suicide education
- Means restriction

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- Parent education
- Postvention
- Screening

Address: Dr. J. L. DeChurch
Executive Director
Division of Student Services
Dade County Public Schools
1444 Biscayne Boulevard, Suite 202
Miami, FL 33132

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Project SOAR (Suicide: Options, Awareness, Relief)
Dallas Independent School District

Location: Dallas, Texas
Contact: Judie Smith, MA, (214) 565-6700

Target: Teachers, staff, and counselors.
Years in operation: 3
Source of funding: Local school district funds.
Amount of funding (per year): $90,000, which provides the salary for three professionals. The costs of clerical help, office supplies, and training materials are absorbed by the Psychological/Social Services Department budget.

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

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

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

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

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

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Referral/selection procedures: One counselor was selected from each school to receive training in crisis intervention and become the designated crisis counselor for his or her campus.

Evaluation: No written evaluations or tests are done at this time.

Data available: Verbal feedback from students, teachers, and parents. Reports have been entered into a new computer system, but no in-depth analysis has been completed. On file for each student seen by the program is a written summary of each year's records describing sex, age, race, grade, schools, risk assessment, sources of stress, warning signs, and action plans. The director keeps records of high-risk youths in her office. The records consist of reports filed by whoever did the risk assessment or intervention, whether the primary caregiver or a staff member of Psychological/Social Services. To evaluate the effectiveness of Project SOAR, project officials established an accurate reporting and recordkeeping system of all suicide threats, attempts, and completions to compare with past records kept by the county medical examiner. From this data system, officials hope to chart and analyze trends and determine whether the training and the procedures are effective.

The suicide records kept by the county medical examiner indicate many suicides in the Dallas area are committed by school-age teenagers who are not enrolled in school. The school drop-out rate is about 15 percent. They also discovered a ruling of suicide for a death that had been reported to the school as a homicide.

Special population outreach: The Dallas Independent School District serves a population that is 80 percent black and Hispanic. Most suicides are committed by whites.

Related components:

- General suicide education
- Parent programs
- Peer support
- Postvention

Address: Project SOAR
Judie Smith, MA
Specialist in Psychological Social Services
Dallas Independent School District
1401 South Akard
Dallas, TX 75215

Reports: Program manual.

Advice to others interested in starting this type of program: Begin by forming a joint school district/community task force to conduct a needs assessment and to review existing school suicide prevention programs and make a recommendation to the school board. The

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American Association of Suicidology would be a resource for this information. A school policy should be developed that spells out the procedures that primary caregivers would follow in the event of a suicide threat, attempt, or completion. The next step would be to assign the responsibilities of training to a facilitator who is knowledgeable in the field of suicide prevention and to review approved training material. A directory of appropriate community referral resources should be made available to all primary caregivers and crisis counselors who work with suicidal students.

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Adolescent Suicide Prevention Program

Location: Fairfax, Virginia
Contact: Myra Herbert, LICSW, (703) 246-7745

Targets: Gatekeepers (primarily school personnel).
Years in operation: 8
Source of funding: Fairfax County School Board.
Amount of funding (per year): Funding is invisible. The program provides an organized, systematic method for improving services that are in place. Fairfax County spends between $6,000 and $10,000 on printing material that is helpful with workshops, but this is not essential.

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

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

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

Coverage: Faculty and staff in all intermediate and high schools.

Content/topics: Suicide awareness and prevention techniques, profile of the suicidal youngster, how to help a suicidal youngster, assessing suicidal potential in young people (signs and symptoms), typical reasons why young people commit or attempt suicide, helpful responses, and organizing a referral network that includes community agencies and mental health resources.

Evaluation: None.

Data available: Not described.

Special population outreach: None.

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Related components:

- General suicide education
- Parent programs
- Peer support
- Postvention

Address: Adolescent Suicide Prevention Program
Myra Herbert, LICSW
Coordinator, Social Work Services
Special Education Department
Fairfax Public Schools
10310 Layton Hall Drive
Fairfax, VA 22030

Reports:

- Program Manual: Adolescent Suicide Prevention Program — A Guide for Schools and Communities
- Adolescent Suicide Prevention In-service Guide for Faculty and Staff
- Responding to Adolescent Suicide

Advice to others interested in starting this type of program: The best programs are achieved through the collaboration of schools and community agencies. Schools need to be more open and accepting of other professionals, and agencies need to learn the contingencies of educational institutions. Successful networks are only possible through combining efforts and services.

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Weld County Suicide Prevention Program

Location: Johnstown, Colorado
Contact: Susy Ruof, M.A., (303) 587-2336

Targets: Students, school staff, parents, community members.
Years in operation: 6
Source of funding: Weld Board of Cooperative Educational Services (BOCES) and local school district.
Amount of funding (per year): The start-up cost in 1984 was $1,000 (today, it would be about $2,500). Additional yearly cost is about $500 for additional training and materials, since all program functions are carried out by in-place staff.

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

Exposure: The crisis team members undergo extensive training (30 hours) in suicide awareness, counseling techniques, and methods and resources for help and referral. A 1-hour training session is provided each year to *all* school staff to give them a basic understanding and an awareness of the issue and of what they can do. An additional 4-hour training session is given to all administrators on legal issues, policies, and procedures.

Coverage: All school staff (about 170).

Content/topics: For the general staff, the program provides handouts on myths and facts, behavioral and verbal warning signs, legal issues, and what to do when students exhibit warning signs. The presenters discuss legal rationales for suicide prevention training, referral procedures, and school district and school staff responsibilities.

Evaluation: Program evaluation consists of feedback from teachers, administrators, crisis team members, and community members; statistics on referral rates after student, staff, and community education sessions; information from other county crisis teams program instructors have trained; and information on suicides committed since crisis teams have been in place in most districts in the county. (Weld County's adolescent suicide rate is now about half the state rate.)

Data available: Information is available on the number of students referred and the number of suicide attempts or gestures made. Detailed and longitudinal information is available on each student referred (stressors, symptoms, resources, history, family information, plan of

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action, follow-up). Also available are notes on all interventions done following unintentional deaths of students, parents, or staff, and suicide attempts or gestures. No suicides have occurred in the district since the program was instituted in 1984.

Special population outreach: Potentially at-risk students at grades K-2 (about one-tenth of the student body) are seen weekly in small counseling groups. At grades 3-12, outreach for these students includes ongoing counseling, being paired with teachers for individual attention, crisis intervention as needed, and long-term follow-up by the district crisis team (through graduation).

Community outreach includes training crisis intervention teams in many neighboring school districts, starting a countywide suicide prevention coalition, establishing a monthly support group for survivors of suicide, and receiving a Comprecare grant to reduce suicides among the elderly in Weld County.

Related components:

- General suicide education
- Parent programs
- Postvention
- Community gatekeeper training

Address: Weld County Suicide Prevention Program
Susy Ruof, M.A.
5290 Mesquite Court
Johnstown, CO 80534

Reports: Program manual and descriptive articles.

Advice to others interested in starting this type of program: Programs that use and train in-place staff rather than rely on outside expertise are not only much cheaper but are more effective (education of all students and staff can be done in-house as needed, referrals are made earlier, interventions can be immediate, follow-up can be ongoing and extensive). In addition, such programs seem to be much longer lived because the district staff takes ownership of the program. The crisis team needs to be a generic one, dealing with *all* deaths. Administrative and board support and good agency relationships are crucial.

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Chapter 3
COMMUNITY GATEKEEPER TRAINING

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Chapter 3
Community Gatekeeper Training

Overview and Rationale

The goal of these programs is to train community members to identify young people at risk of suicidal behaviors and to refer them to appropriate sources of help. This triage or "gatekeeping" function can be undertaken by anyone who has significant contact with youth in the course of professional or volunteer activities. Examples of gatekeepers include coaches, clergy, police officers, health care professionals, hairdressers and barbers, and bartenders. (Gatekeepers also include school personnel; however, because of their frequency and special administrative requirements, gatekeeper training programs designed specifically for school personnel were described in Chapter 2.) Gatekeeper programs have two kinds of activities: media campaigns and training programs at various levels of intensity/expertise directed at specific types of gatekeepers, such as the police or clergy.

The rationale for community gatekeeper programs is illustrated in Figure 3. The fundamental idea behind these programs is that people at risk of suicide often come into contact with police, clergy, doctors, friends, or others who do not recognize the risk of suicide and therefore do not act to access, obtain, or arrange appropriate help for them. These programs are designed to increase a potential gatekeeper's sense of confidence and competency in helping a person at risk of suicide. There are several core objectives of community gatekeeper programs: to increase gatekeepers' knowledge of suicide warning signs; to increase knowledge of referral sources in the community; and to foster a greater willingness to refer high-risk youths to mental health or other appropriate services. Some gatekeeper programs also stress the need to build confidence and a broader competency for directly helping suicidal youths among community gatekeepers. Some community gatekeeper programs also help community people recognize and take action to reduce sources of stress for youth in the community. Examples of this might include efforts to improve employment opportunities for young people or to improve access to recreational facilities for high-risk youth. For instance, one prevention program in New York provided a drop-in setting for youth in shopping malls.

One of the challenges to community gatekeeper training programs is to provide psychologists, nurses, primary care physicians, psychiatrists, and other traditional caregivers with needed suicide prevention training. Many studies demonstrate that approximately 50 percent of suicide victims had seen a physician during the month before their death (Johnson, Ferrence, and Whitehead, 1973). The assumption that these helpers are adequately prepared to manage the issue of suicide or even to perform the basic gatekeeper role has been questioned. Bongar and Harmatz (1991) surveyed psychology training facilities and report that only 40 percent of all graduate programs in clinical psychology offer formal training in the study of suicide. Medical students receive relatively little training about the warning signs of suicide and the role of physicians in helping to prevent a suicide.

Research Findings

Three kinds of evaluation should be considered: (1) assessment of the degree to which these programs have sensitized "gatekeepers" to their role in identifying and appropriately helping those youths who might be at risk of suicidal behaviors; (2) assessment of the degree to which these programs result in appropriate identification and disposition of suicidal persons; and (3)

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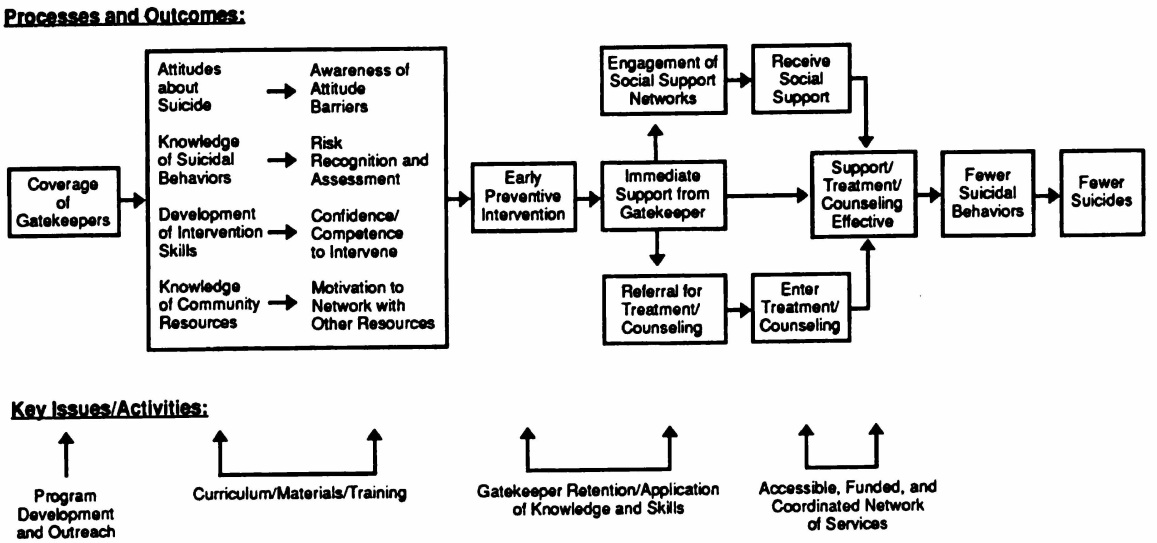
FIGURE 3.
Rationale for Community Gatekeeper Training Programs to Prevent Youth Suicide



assessment of the impact of these programs on youth suicides or suicide attempts. Very little has been done in any of these areas. In one study, the investigator assessed how community gatekeepers responded to simulated cases 6 months after completion of a 2-day workshop in suicide intervention skills; the results showed that most workshop participants retained the skills they were taught in the program (Tierney, 1988).

Results of a follow-up survey in California (McConahay, G. Suicide Intervention Training Effectiveness, Garlington Center N/NE Community Mental Health Center, Portland (OR), unpublished manuscript, 1990) showed that, 6 months after a 2-day intervention skills workshop, most participants reported that they felt more capable of dealing with a person they thought was suicidal. The participants reported that they drew on a greater number of mental health resources when dealing with individuals who were potentially suicidal. However, the number of people with whom they intervened did not increase.

Illustrative Programs

This report lists seven programs as examples of community gatekeeper programs, two of which are in a single agency. Most of these programs provide both training and informational materials for parents, teachers, counselors, health-care professionals, clergy, policemen and the general public. One is exclusively a media program. These programs are described below.

Adolescent Suicide Awareness Program (ASAP) "Don't Say Goodbye" Media Campaign Lyndhurst, New Jersey

This is an extensive program with training initiatives directed at a variety of professionals, such as teachers, emergency room staff, clergy, and policemen. Methods and training materials for this program are increasingly sought by other communities that are developing similar

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initiatives. Part of this program, a multimedia public education campaign titled "Don't Say Goodbye," encourages teens and adults to recognize high-risk people and to refer them to a county psychiatric crisis phone line. An evaluation of the impact of the campaign on the use of the crisis phone line was to be completed by the Rutgers School of Applied Psychology in the fall of 1991.

Youth Suicide Prevention Program
Manassas, Virginia

This is a comprehensive community-based program operated by a community coalition that seeks to disseminate information on youth suicide and to train school personnel to identify high-risk teens. Print and broadcast media and special events are used to provide information. This program has not been evaluated, but findings from an ongoing study monitoring suicide attempts and gestures in Prince William County will provide input to further program development.

LivingWorks Education, Inc.
Calgary, Alberta

The core component of this comprehensive, community-focused program is a 2-day Intervention Workshop offered to a wide variety of gatekeepers. It provides training in "Suicide First Aid" skills. More than 50,000 people in the United States and Canada have participated. An evaluation indicates that people retain the skills they were taught for up to 6 months after they complete the workshop. Further evaluations confirm the effectiveness of the strategy used to ensure widespread community use of the training materials. Introductory sensitization and awareness programs, as well as advanced and specialized treatment seminars, are other program components integrated with and reinforcing the Intervention Workshop objectives. These objectives focus on the helping competencies of gatekeepers and aim to strengthen community resource networks.

Suicide Intervention Skills Workshop
California Department of Mental Health
Sacramento, California

Identical to the Calgary, Alberta, "LivingWorks Education, Inc.," program described above, this Suicide Intervention Skills Workshop offers an intensive 2-day workshop in suicide intervention skills. More than 10,000 people throughout the state have been trained in the program. A helper's handbook reinforces workshop learning. The Trainer Corps has developed as a strong community advocacy group for local and statewide suicide prevention activities.

Center for Indian Youth Program Development
Albuquerque, New Mexico

This community-based program targeted to Native Americans is directed toward the prevention of a variety of violent behaviors, one of which is youth suicide. The center provides support and technical assistance to community coalitions seeking to establish youth suicide prevention programs.

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Jail Suicide Prevention Program
National Center on Institutions and Alternatives (NCIA)
Mansfield, Massachusetts

NCIA develops training materials to support jail staff in screening and providing appropriate monitoring for incoming detainees. The jail population overlaps but is not the same as the youth target group under consideration here. This program, however, is included because it has implications for increasing the sensitivity of support staff to high-risk young people in stressful environments.

Evaluation Needs

Assessing the impact of these programs on the rate of youth suicide in the community is extremely difficult. Intermediate outcomes that are easier to assess include changes in peoples' knowledge of suicide warning signs, their attitudes toward seeking or providing help, and their referral of high-risk youth to counseling or treatment. Another way to evaluate any type of suicide prevention program is by assessing changes in suicide attempts and gestures, either over time in one community or by comparing these events in experimental and control communities. These endpoints will reflect both the effectiveness of this strategy and the degree of program penetration (i.e., the extent to which the information generated by the program has reached members of the community who are likely to be in a position to encounter and help teens at high risk of suicide). Some questions that might be addressed in an evaluation are—

- Are gatekeepers accurately identified? Have significant groups been overlooked?
- How appropriate is the message? Does it reflect current knowledge of who is at high risk, how they can be identified, and what interventions are likely to work?
- Have those who operate support services to which young people are referred observed a change in the number or appropriateness of such referrals since the training program began?
- Are referrals made by trained gatekeepers appropriate? Specifically, are the people referred truly at high risk of suicidal behavior? Are the referrals made to appropriate helping resources, given the particular characteristics and situations of the suicidal youths?
- How long-lasting is the effect of the program? Do the gatekeepers remain aware of appropriate identification and referral procedures over time? Is reinforcement of the message needed, and is it provided?

Many of these questions could be answered by evaluation studies without much disruption of program operation. The youth suicide prevention workers we talked with over the course of this investigation were strongly convinced of the importance of what they are trying to accomplish and were very interested in evaluation. The development of mechanisms capable of evaluating the effectiveness of these programs in training gatekeepers would help the programs improve their efforts.

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Summary

Community gatekeeper training programs are designed to teach people likely to come in contact with young people how to recognize, handle, and refer for assistance youths who exhibit warning signs of suicide. Prospective gatekeepers include coaches, police, clergy, and health-care staff. A number of training programs exist and have been successfully adapted to specialized settings. In implementing these programs, officials should ensure that referrals are appropriate, since inappropriate referrals could make it more difficult for the mental health system to respond to those truly in need.

References About Community Gatekeeper Training Programs

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

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

Suggested Additional Reading

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

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Community Gatekeeper Training: Program Descriptions

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Adolescent Suicide Awareness Program (ASAP) "Don't Say Goodbye" Media Campaign

Location: Lyndhurst, New Jersey
Contact: Diane Ryerson, MSW, (201) 935-3322

Adolescent Suicide Awareness Program (ASAP)

Targets: Police, clergy, emergency room personnel, staff of pediatricians' and family practice physicians' offices.
Years in operation: 9
Source of funding: United Way, state and local government.
Amount of funding (per year): Varies.

Program description: ASAP sponsors a basic training curriculum for police recruits, a 1.5-hour awareness program for all municipal and county police, and an intensive program for juvenile officers. A multitiered training program will be established for clergy, involving seminarians, parochial school teachers, funeral directors, and youth ministers. To supplement instructional units, a "Clergy Specific" information package will be developed and widely distributed.

Exposure:

- Police recruits: 2.5-hour awareness program
- Police: 1.5 hour awareness program
- Police: 7-hour skill-building program for juvenile officers
- Emergency room and medical office staff: informational packet to help first responders identify and manage suicidal children and adolescents

Coverage:

- Police: Training is being implemented as part of the Prosecutor's Mandatory In-Service Training Program. By 1989, 2,300 police officers in Bergen County had received instruction; 180 rookies and 75 juvenile officers per year are also recipients of training.
- Clergy: In April 1990, 800 information packages were distributed to county clergy and funeral directors.

Content/topics:

- Police: Police were trained in identifying, managing, and obtaining professional help for suicidal teenagers. Specific operating procedures were provided.
- Clergy: Crisis intervention skills and increased information, especially in regard to identifying warning signs, will equip clergy with a focused, more effective approach to counseling troubled teens and their families.

Evaluation: Participant evaluation forms.

Data available: None.

Special population outreach: Out-of-school youth.

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"Don't Say Goodbye" Media Campaign
Bergen County Taskforce on Youth Suicide Prevention

Targets: Middle school and high school students, parents, educators, general public, dropouts.
Years in operation: 1
Source of funding: United Way, corporate and foundation grants, state and county government.
Amount of funding (per year): $20,000 for original production of print ads and $2,000 for external evaluation of the program's impact; $60,000 is being sought to fund production of TV and radio spots. All development work was done pro bono by a local ad agency.

Program description: Multimedia public mental health education campaign encourages teens and adults to recognize youths at risk and get them professional help by calling a county psychiatric crisis phone number.

Phase 1: Set of six posters, wallet cards, brochures, print ads, and bill boards.
Phase 2: Six TV and four radio spots.

Exposure: General public through print and electronic media.

Coverage: Pilot program directed to 850,000 Bergen County residents.

Content/topics: Viewers are encouraged to recognize warning signs and take action to save a life by calling the county psychiatric emergency service for advice, evaluation, and/or outreach and screening.

Evaluation: The Rutgers School of Applied Psychology is evaluating the impact of the campaign on the use of the countywide psychiatric emergency service program, whose phone number appears on all campaign material. Data was to be available in the fall of 1991.

Related components:

- General suicide education
- Parent programs
- Postvention
- School gatekeeper training
- Screening

Address: Adolescent Suicide Awareness Program (ASAP)
Diane Ryerson, MSW
Director, Counseling and Education Services
South Bergen Mental Health Center
516 Valley Brook Avenue
Lyndhurst, NJ 07071

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Youth Suicide Prevention Program

Location: Manassas, Virginia
Contact: Evelyn Hatfield, (703) 792-7730

Targets: Students, parents, professionals, and the general public of Prince William County.
Years in operation: 4
Source of funding: State and local sources.
Amount of funding (per year): $50,000 for staff support.

Program description: This is a comprehensive community program aimed at promoting positive mental health attitudes. Program staff members train school personnel how to identify and help suicidal youths and help them to develop crisis teams. They will also conduct suicide prevention classes and provide postvention support when asked. Program staffers already work with junior and senior high schools and are starting to move into elementary schools.

There is also a community group on suicide prevention called the "Prince William Youth Suicide Prevention Coalition," whose activities include an annual "Love Life Day" and the providing of grants to schools to establish prevention activities. Another component is a student group ("Friends Are Needed" (FAN) Club) concerned with suicide prevention. School representatives attend training sessions to learn how to initiate suicide prevention programs in their schools. In addition, the coalition produces parent and teen directories of warning signs, actions to take, and sources of help, and is involved in legislative efforts to limit methods of committing suicide.

Coverage: Countywide.

Evaluation: None.

Data available: The Community Service Board is collecting data on the number of suicide attempts, gestures, and ideations among Prince William County youth from a variety of sources, including schools, local hospitals, detention centers and hotlines. The information gathered will be used for program development.

Related components:
- General suicide education
- Intervention after a suicide
- Means restriction
- School gatekeeper training

Address: Youth Suicide Prevention Program
Evelyn Hatfield
Youth Suicide Prevention Specialist
Prince William County Community
Services Board—Prevention Branch (PWCCSB-PB)
8033 Ashton Avenue
Manassas, VA 22110

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Special population outreach: High-risk youth and minorities. A Minority Issues Task Force works to identify appropriate ways to reach minority youth.

Reports:

- Pamphlets describing the program
- Youth Suicide Prevention Coalition Newsletter
- Suicide Prevention Training Evaluation Training Form

Advice to others interested in starting this type of program: Offering comprehensive services is very important because techniques helpful to some youths may not be appropriate for others. Programs will be more effective if a variety of approaches is used.

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LivingWorks Education, Inc.

Location: Calgary, Alberta
Contact: Bryan Tanney, M.D., (403) 242-3397; FAX (403) 268-9201

Targets: Community gatekeepers, employee assistance staff, mental health caregivers, police, corrections agency personnel, school personnel (at all levels of expertise).
Years in operation: 10
Source of funding: University of Calgary, grants, community support, strategic partnerships with other helping agencies, royalties from workshop presentations.
Amount of funding (per year): Varies.

Program description: The core of this program is the Intervention Workshop, originally modeled after the American Heart Association's 'Heart Saver' Program. Based on an adult education model of continuing professional education, the program is designed for all caregiver groups, including, but not limited to, often under-served community "gatekeepers." Its content is fully described in the Suicide Intervention Skills Workshop of the California Department of Mental Health also included in this chapter. A "Training for Trainers" course certifies trainers to present the workshop and other components of the program. Other activities are integrated with the workshop presentation and include sensitization and awareness education, bereavement intervention training, advanced treatment seminars, and refresher training.

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

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

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

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

The bereavement training and the advanced treatment seminars and workshops are 1-day sessions. Refresher training incorporates workshop activities, a helper's handbook, and various self-directed learning activities using audiovisuals.

Coverage: More than 50,000 participants in the United States, Canada, and parts of Europe and Australia have taken the Intervention Workshop. A network of over 600 certified trainers is available. Several teams of senior trainers are available to present "Training for Trainers" courses.

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Content/topics: The integrated components of this program meet a wide spectrum of community needs concerning suicidal behaviors: information on general suicide awareness, emergency intervention methods, care and support for the bereaved, and ongoing treatment for suicide risk patients. Each component also addresses the importance of developing community-based, comprehensive, coordinated, and integrated approaches to suicide prevention.

Evaluation: Evaluation studies have found high levels of participant satisfaction, statistically significant improvements in suicide intervention skills, knowledge and skill retention over time, and improved community service profiles for sponsoring agencies.

Data available: Program brochures, published material, program evaluation references, and access to trainer contacts are available upon request.

Special population outreach: None.

Related components:

- School gatekeeper training
- Intervention after a suicide

Address: Bryan Tanney, M.D.
LivingWorks Education, Inc.
Suite 704
300 Meredith Road, NE
Calgary, Alberta T2E 7A8
Canada

Reports: Written and audiovisual materials are available as self-learning tools to reinforce the skills presented in the Intervention Workshop.

Advice to others interested in starting this type of program: This program is a long-term commitment with as many as 10 separate components. Delivering some or all of these programs to *all* potential caregivers in the community takes time and planning, perhaps over several years. If you can present one Intervention Workshop as a demonstration, you always receive invitations to do more. Each program can be flexibly adapted to "feel" as if it fits the needs of the community. If you can get administrators or policymakers involved, they often "champion" the program within their own and other agencies with a sense of commitment and ownership.

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Suicide Intervention Skills Workshop
California Department of Mental Health

Location: Sacramento, California
Contact: David Neilsen, MSW, Program Coordinator, (916) 323-9296

Targets: Community gatekeepers, mental health personnel, school personnel, social services personnel, and law enforcement officers.
Years in operation: 5
Source of funding: California, community support.
Amount of funding (per year): $150,000.

Program description: The "Suicide Intervention Skills Workshop" is identical to the "Intervention Workshop" of LivingWorks Education, Inc., Calgary, Alberta, also described in this chapter. The curriculum features a series of large and small group activities, minilectures, audiovisuals, and role playing exercises designed to help people increase both their abilities and level of confidence when working with suicidal individuals.

Exposure: The workshop includes 14 hours of learning experiences. The first day focuses upon the examination of caregivers' attitudes and specific assessment skills. The second day concentrates upon intervention strategies and skill building through the use of large group simulations and small group role plays that involve all participants.

Coverage: The program is targeted at mental health professionals, probation and law enforcement staff, social services personnel, and educators—all of the front-line gatekeepers in the community that a child or an adult would encounter. The original program focus was upon youth; community demand and the demographics of suicidal persons has required the Department to broaden the focus. Service providers to the elderly, persistently mentally ill, and institutional settings have been included.

More than 330 presenters have completed the 5-day "Training for Trainers" program, which certifies persons to present the workshop within their communities. Fifty-five of California's 58 counties have active training teams, the majority of which feature multidisciplinary teams. Over 15,000 persons have attended the 14 hours of training in the past 5 years.

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

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

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Evaluation: Limited. Results of a follow-up evaluation in Canada, using simulated cases, showed that workshop participants retained specific intervention skills 6 months after completing the workshop. Results of a smaller study in Yolo County, California, did not show an increase in the number of suicidal persons that trainees dealt with. This lack of increase may be due to more accurate identification of persons who were at risk for suicide. Another follow-up study conducted by San Francisco County Mental Health showed a tremendous interest in additional or refresher workshops with more role plays and specific content for specific high-risk groups.

Data available: Trainer materials include a handbook and manual. Participant materials include surveys, questionnaires, worksheets, posters, two audiovisuals, and numerous transparencies as learning aids.

Special population outreach: None: open to all groups.

Related components:

- School gatekeeper training
- Intervention after a suicide

Address: California Department of Mental Health
Suicide Prevention Project
Division of Community Programs, Room 250
1600 Ninth Street
Sacramento, CA 95814

Reports:

- The California Helper's Handbook for Suicide Intervention
- Suicide Prevention Project Summary (6 pages)
- "The Suicide Prevention Project—Five-Year Report" (unpublished draft)

Advice to others interested in starting this type of program: Staffers of the Suicide Intervention Skills Workshop submitted the following comment in addition to the above that may be relevant to others developing similar programs: "The workshop has connected the entire state and brought about the beginnings of a standardized approach to training that includes an expectation that competency and skills will be imparted to participants. This network, made up of crisis centers, county offices of education, mental health and social services, now serves to advocate for continued funding and programming for this at-risk group of persons. Secondly, and more importantly, it functions to bring together at a local level the necessary partners for improved community responses and services for suicidal persons. The team-building outcome, while not evaluated in the previous studies, continues to be a primary comment of those who have participated in the workshop."

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Center for Indian Youth Program Development

Location: Albuquerque, New Mexico
Contact: Sally Davis, Director, (505) 277-4462

Targets: Native American youth.
Years in operation: 8
Source of funding: Indian Health Service (IHS).
Amount of funding (per year): Varies.

Program description: The health status of Native American teenagers in the United States is below that of the general population. The usual barriers to the use of health care services by young people (including young Native Americans) are compounded in rural areas by distance, isolation, and lack of appropriate services.

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

Exposure: Not reported.

Coverage: Center services are available on-site at four rural New Mexico high schools. In addition, the program provides technical assistance to other schools and community groups.

Content/topics: Services provided by the Center include:

- Mental health counseling
- Alcohol abuse evaluation, counseling, and education
- Suicide prevention
- Health education and promotion
- Physical examinations
- Pregnancy testing
- Family planning
- Programs to reduce school absenteeism and truancy

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Evaluation: At four sites, data gathered through surveys and interviews of students and adults are being used for planning and evaluation.

Findings: Center staffers have received positive feedback on their services in terms of teacher satisfaction and increased awareness of and knowledge about suicide. Both students and teachers reported increased opportunities to discuss suicide openly. The suicide rate has declined since the program began.

Data available: Study survey data and interviews with community gatekeepers.

Related components:

- General suicide education
- Means restriction
- Peer support
- School gatekeeper training

Address: Center for Indian Youth Program Development
Sally Davis, Director
Division of School Health
and Center for Indian Youth Program Development
University of New Mexico School of Medicine
Albuquerque, NM 87131

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Jail Suicide Prevention Program
National Center on Institutions and Alternatives (NCIA)

Location: Mansfield, Massachusetts
Contact: Lindsay M. Hayes, M.S., (508) 337-8806

Targets: Staff in jails, detention centers, and police lockups.
Years in operation: 14
Source of funding: National Institute of Corrections, U. S. Dept. of Justice, state and county contracts.
Amount of funding (per year): Not reported.

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

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

Coverage: Technical assistance is offered on a national basis.

Content/topics:

- Why jail environments are conducive to suicidal behavior
- Potential suicide predisposing factors
- High-risk suicide periods
- Warning signs and symptoms of suicidal behavior
- Suicide prevention screening
- Disposition and referral procedures
- Written rules and procedures
- Jail suicide updates
- Architectural design
- Supervision levels

Evaluation: Available from the National Institute of Corrections.

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Findings: The investigators found a direct relationship between staff training, written rules and procedures, and the reduction of jail suicides.

Data available: Data from two national studies of jail suicide are available upon request.

Special population outreach: Although jail suicide cuts across all demographic areas, a disproportionate number of the jailed population are poor or from minority groups.

Related components:

- Intervention after a suicide
- Screening

Address: Jail Suicide Prevention Program
Lindsay M. Hayes, Assistant Director
National Center on Institutions and Alternatives
40 Lantern Lane
Mansfield, MA 02048

Reports:

- Jail Suicide Update newsletters
- National Study of Jail Suicide: Seven Years Later
- And Darkness Closes in ... National Study of Jail Suicide
- Training Curriculum on Suicide Detection and Prevention in Jails and Lockups

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Chapter 4
GENERAL SUICIDE EDUCATION

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Chapter 4
General Suicide Education

Overview and Rationale

General suicide education programs are typically school-based programs that review with students the facts and myths about suicide, alert them to warning signs, and provide information about how to seek help for themselves and others. Some programs also encourage students to share their feelings and develop their interpersonal coping skills.

General suicide education programs are designed to achieve some or all of the following goals:

- **To dispel myths and increase knowledge.** The programs present facts, statistics, and myths regarding suicide to help students understand why some people become suicidal and what they can do to prevent a suicide.
- **To promote case finding.** In many instances, suicidal adolescents are more comfortable discussing suicidal feelings or intentions with other students than with adults. General suicide education programs provide descriptions of warning signs of suicide and encourage students to seek help for friends who are contemplating suicide.
- **To provide students with information about mental health resources.** Programs provide students with information about how various mental health resources operate and how to contact them.
- **To encourage students to seek help.** The programs describe methods of seeking help. Program instructors encourage students to disclose suicidal feelings by pointing out that many adolescents report having such feelings, but that suicidal feelings are temporary and help is available. The programs try to provide alternatives for solving problems other than suicide.
- **To promote the development of interpersonal and social competency.** Many suicide education programs provide training in stress management and coping skills to help students deal with their problems. Programs also promote the development of listening and interpersonal skills to help students improve their relationships with peers, parents, and others.

The rationale for school-based suicide education programs is illustrated in Figure 4. The basic premise is that, the more students know about suicide warning signs and sources of help, the more likely they will be to ask for help for themselves or refer others for help. The efforts of general suicide education programs to help students discuss feelings and promote interpersonal competence are meant to help increase their use of existing social support networks.

If successful, general suicide education programs would presumably result in an increase in calls to hotlines and higher entry rates of suicidal youth into programs that provide mental health services. Implicit in the general suicide education approach is a recognition of the difficulty of determining who, among thousands of healthy adolescents, is truly at high risk of suicide. For this reason, programs employing this strategy are given to all students, without efforts to screen and target high-risk youth.

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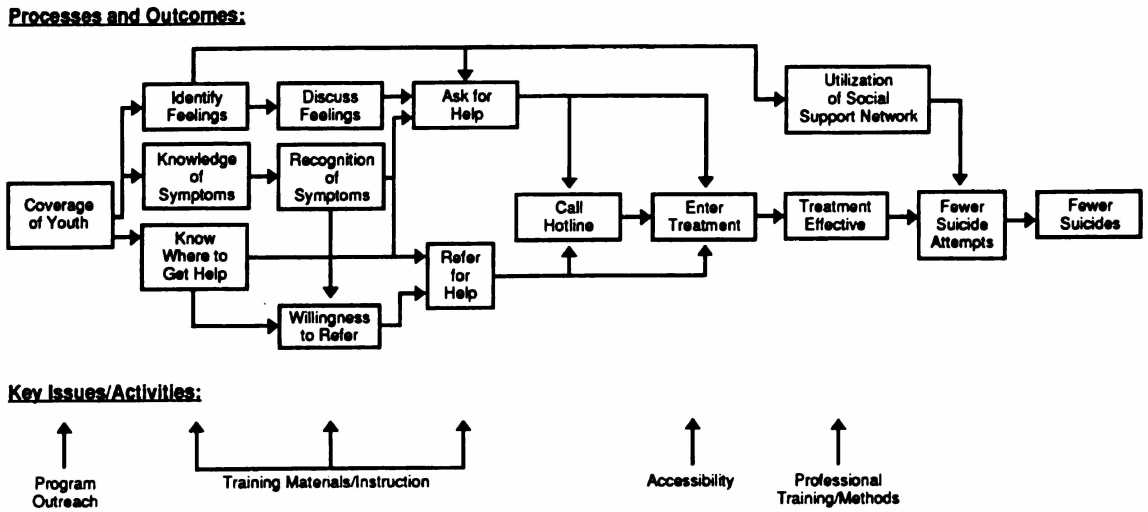
FIGURE 4.
Rationale for General Suicide Education Programs to Prevent Youth Suicide



This rationale postulates a long chain of events, and the strength of these various linkages has not been convincingly demonstrated. Using results of a survey of ninth and tenth graders in six high schools in New Jersey (Shaffer, et al., 1990), researchers compared the attitudes and beliefs of students who reported or did not report prior suicide attempts. As summarized in Table 3, they found that students who had reported a prior suicide attempt were more likely to keep feelings of depression to themselves and were more likely to think of suicide as a possible solution for someone who has a lot of problems. These are the types of attitudes and beliefs that general suicide education programs seek to change. What is not clear is how effectively general suicide education programs influence suicidal behavior.

Research Findings

In the following evaluations of school-based general suicide education programs, researchers have reached similar conclusions:

- **Participants have at least short-term increases in knowledge about suicide.** An evaluation of a youth suicide prevention program that was incorporated as part of the health curriculum in four Rhode Island high schools showed that participants increased their knowledge about suicide and suicide warning signs (Spirito, et al., 1988). In this evaluation with 291 experimental and 182 control students, researchers employed a Solomon four-groups design to control for the effects caused by pretest sensitization. They found significant differences between experimental and control groups 10 weeks after students participated in the prevention program.

  Results of an evaluation study (Table 4) showed that students who completed youth suicide prevention programs in New Jersey knew more about suicide warning signs immediately after completing the program than did students in a control group (Shaffer, Garland, and Whittle, 1988). These programs lasted an average of 3 classroom hours or less. In this evaluation, researchers surveyed some 1,000 students ages 13 to 18 in six different high schools and a similar number of students in five control schools.

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TABLE 3.
Attitudes Held by 9th and 10th Grade Students Who Did or Did Not Report Prior Suicide Attempts

Risk Factors	Males			Females		
	Attempters (n=19)	Control Subjects (n=460)	Odds Ratio	Attempters (n=44)	Control Subjects (n=450)	Odds Ratio
Acceptability of Suicide						
I think suicide is a possible solution for someone who has a lot of problems.	42.1%	10.4%	6.2	22.7%	9.3%	2.9
Willingness to Share Feelings						
If depressed, it is a good idea to keep these feelings to yourself.	36.8%	13.6%	3.7	16.3%	3.6%	5.1
If I felt like killing myself, I would not tell anyone how I felt.	36.8%	17.6%	2.7	—	—	—
When you feel very upset, sad, or unable to cope, do you talk to someone in your family?	—	—	—	18.2%	38.4%	0.4
Use of Alcohol or Drugs to Cope						
I drink alcohol or take other drugs when feeling very upset, sad, or unable to cope.	15.8%	2.4%	7.7	—	—	—
Drinking alcohol and taking other drugs are good ways to keep from feeling depressed.	26.3%	10.1%	3.2	—	—	—

— Not reported/not statistically significant.

Note: All reported odds ratios are statistically significant at an uncorrected .05 level.

Adapted from: Shaffer, D., Vieland, V., Garland, A., Rojas, M., Underwood, M., and Busner, C. Adolescent suicide attempters: response to suicide-prevention programs. *Journal of the American Medical Association* 1990;264:3151-3155. Copyright, American Medical Association.

Results of a study in California (Nelson, 1987) showed significant differences in knowledge of suicide between a sample of 95 students immediately following participation in a 4-hour curriculum on youth suicide prevention and a comparison sample of 77 high school students.

- **Participants know more about mental health referral sources.** Results of the evaluation in New Jersey showed that program participants increased their knowledge of how to contact a hotline or crisis center. The participants reported that they would be more likely to refer other students to such services than were control students (Table 5). However, there was no change in the proportion of program participants reporting they would ask a teacher, counselor, or parent about how to contact a mental health professional outside of school. Moreover, the proportion of students who indicated (in a global fashion) that they knew how to get outside help did not increase after their exposure to the program.

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TABLE 4.
Effects of a General Suicide Education Program on 9th and 10th Grade Students' Knowledge of Suicide Warning Signs

Suicide Warning Signs	Demonstration (n = 940)	Comparision (n = 1072)
Saying he wants to kill himself	85%	82%
Has tried to kill himself before	82%	82%
Using drugs a lot	74%	75%
Very bad family problems	71%*	66%
Sad or depressed	80%†	68%
Not caring about the future	74%†	51%
Joking a lot about killing self	72%†	57%
Drinking too much	64%†	58%
Keeping to himself	57%†	35%
Not enjoying anything	56%†	40%

*Difference significant at a 0.05 level.
†Difference significant at a 0.01 level

Adapted from: Shaffer, D., Garland, A., and Whittle, R. New Jersey Adolescent Suicide Prevention Project: Final Project Report, p.12.

TABLE 5.
Effects of a General Suicide Education Program on 9th and 10th Grade Students' Knowledge of How and Where To Get Help

	Demonstration		Comparison	
Issue	Before (n = 940)	After (n = 940)	Before (n = 1072)	After (n = 1072)
Knowledge About Where to Get Help				
If you needed to contact a mental health professional outside of school, how would you find out where to go or whom to call?				
Call a hotline or emergency number	24%	34%*	20%	26%
Knowledge About Helping Friends				
What should you do if a friend tells you he/she is thinking about killing himself/herself?				
Tell my friend to call a hotline or mental health center	40%	44%*	36%	36%

*Difference significant at a 0.01 level.

Adapted from: Shaffer, D., Garland, A., and Whittle, R. New Jersey Adolescent Suicide Prevention Project: Final Project Report, pp.9-10.

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- **Participants' attitudes show little change.** In evaluations of the New Jersey program (Shaffer, Garland, and Whittle, 1988; Shaffer, et al., 1990), researchers reported no statistically significant changes among participants in attitudes toward seeking help, in attitudes toward suicide, or in willingness to seek help (Table 6). There was no evidence of these types of changes either among all students or among the subset of students who had reported a prior suicide attempt. Results of a subsequent study showed no evidence of attitude change among participants in an additional New Jersey program that employed better trained instructors and used more varied teaching techniques (Shaffer, et al., in press).

TABLE 6.
Effects of a General Suicide Education Program on the Attitudes of 9th and 10th Grade Students Who Reported or Did Not Report a Prior Suicide Attempt

	Demonstration		Comparision	
Issue	**Before**	**After**	**Before**	**After**
Willingness to Give Advice				
What should you do if a friend tells you he or she is thinking about killing himself/herself?				
Tell friend to call a suicide hotline.				
Nonattempters	39%	43%	35%	37%
Attempters	29%	37%	27%	20%
Willingness to Seek Help				
I would not be willing to go to a mental health professional if I were having a personal problem.				
Nonattempters	32%	32%	32%	33%
Attempters	43%	47%	47%	35%
If I felt I wanted to kill myself, I would not tell anyone.				
Nonattempters	15%	15%	15%	16%
Attempters	30%	20%	29%	41%
Acceptability of Suicide				
For people who have a lot of problems in their lives, I think suicide is never a solution.				
Nonattempters	89%	85%	91%	86%
Attempters	66%	72%	63%	60%

Note: These analyses are based on approximately 563 students in demonstration schools and 487 students in the control schools who participated in both the pretest and posttest surveys. Approximately 9% of the respondents in both sites reported prior suicide attempts. Both for attempters and nonattempters, none of the changes in proportions from surveys at Time 1 and Time 2 were statistically significant, either at demonstration schools (in which there was a suicide prevention education program between Time 1 and Time 2) or at control schools (in which no program was given).

Adapted from: Shaffer, D., Garland, A., and Whittle, R. New Jersey Adolescent Suicide Prevention Project: Final Project Report, pp.21-23.

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Likewise, no evidence for changes in participants' attitudes about suicide was found 10 weeks after their exposure to a suicide education program in Rhode Island (Spirito, et al., 1988). This was the case even though the program had a 4-hour curriculum, and the four-point scales employed in the evaluation may have been more sensitive to change than the "True/False" scales used in the New Jersey study.

The Rhode Island program did, however, appear to help students cope with general problems. Students who participated in the program were less likely to believe that social withdrawal was an effective way to solve problems and were less apt to report engaging in wishful thinking or blaming others when encountering problems. Participation in the program was also associated with decreased feelings of hopelessness.

Participants in a general suicide education program in Mankato, Minnesota (Dennis Blomquist, Guidance Director, Mankato Public Schools), had lower depression scores after a series of classes that dealt with suicide and building self-esteem. However, because no comparison group data were provided, it cannot be determined whether these changes were due to the program, to sensitization caused by repeated testing, or to some other factor(s).

- **There is no evidence of increased suicidal ideation or behavior among program participants.** Some researchers have voiced concerns that general suicide education programs might "de-stigmatize" suicide, resulting in increased suicidal behavior. Data from the New Jersey evaluation, however, do not support that concern. Results of the study, as shown in Table 6, indicate no significant changes in the proportion of students who felt that suicide might be an acceptable solution for a person with problems (either among the general student body or among students who had made prior suicide attempts). There was also no evidence of an increase in the number of students who reported thinking about suicide (Shaffer, Garland, and Whittle, 1988).

  Similarly, results of the Rhode Island study (Spirito, et al., 1988) showed no differences in the proportion of students who agreed with the statement that "teenagers who try to kill themselves are weak or very disturbed," though the proportion of students agreeing with this statement (about 5 percent of both the experimental and control groups) was quite small. The Rhode Island study also included a "hopelessness scale" to examine the possibility that the suicide awareness curriculum had a negative effect on emotional status. Instead, researchers found that students participating in the suicide awareness curriculum had significantly lower scores on hopelessness; this was particularly the case for female students.

  However, Overholser, et al. (1989), who studied a "suicide awareness curriculum," reported mixed results: significant positive program effects among female students but small negative effects among male students. Specifically, male students had "small but statistically significant increases in the level of hopelessness [as measured by the Hopelessness Scale for Children (HSC)], less appropriate evaluative attitudes, and an increase in maladaptive coping responses." Overholser, et al., also stated, however, "Whether such a small increase on the HSC has any practical significance is questionable, since the mean scores at posttesting were lower than scores obtained by suicide attempters on the HSC and are still within the normal range."

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- **The highest risk students may react negatively.** In the New Jersey evaluation reported in JAMA (1990), students who reported a prior suicide attempt rated the program more negatively than other students (Table 7). Specifically, students who reported a prior suicide attempt were significantly less likely to feel that other students should participate in such a program; were significantly more likely to believe that talking about suicide in the classroom might precipitate suicide; and were significantly more likely to report knowing someone who was "upset a lot" by the program. None of the attempters reported that they themselves found the programs upsetting. However, Shaffer, et al. (1990), speculated that the two suicide attempters who reported knowing others who were upset may in fact have been attributing their own feelings to others.

  The meaning of these findings is not yet clear. One interpretation is that, although students in general may like these programs, those who are actively suicidal may find the programs unsettlingly trivial. On the other hand, students with a history of attempted suicide may be more apt to speak negatively of *any* type of intervention, including psychotherapy. This does not necessarily mean that their risk of suicide is increased. Indeed, Shaffer, Garland, and Whittle (1988) note that their findings "provide no evidence for an increase in suicidal behavior or ideation following the [New Jersey] suicide prevention programs" (p.19).

  Given these preliminary findings, prudence suggests that **schools which undertake general suicide education programs should have in place staff and resources to recognize and deal with students who might be upset by participation in these programs.**

  Persons considering school-based general suicide education as a prevention strategy should also recognize that not all curricula are necessarily well-conceived. Some curricula are quite sensational, and thus may foster suicide contagion. Other curricula tend to "normalize" suicide in a manner that some researchers fear will promote suicidal thinking by lessening whatever protective effects may derive from the social "taboo"

TABLE 7.
Ratings of General Suicide Education Programs by 9th and 10th Grade Students Who Did or Did Not Report a Prior Suicide Attempt

Statement	Percent (Number) Agreeing	
	Attempters	Nonattempters
(4 schools; 35 attempters, 469 nonattempters)		
Other students should participate in the same program	74.3% (26)	89.0% (435)
Talking about suicide in the classroom makes some kids more likely to try to kill themselves	26.7% (9)	11.5% (56)
(2 schools; 14 attempters, 236 nonattempters)		
I know someone who was upset a lot by the program	14.3% (2)	2.2% (5)

Adapted from: Shaffer, D., Vieland, V., Garland, A., Rojas, M., Underwood, M., and Busner, C. Adolescent suicide attempters: response to suicide-prevention programs. *Journal of the American Medical Association* 1990;264:3151-3155.

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associated with suicide. Still other curricula inadvertently provide teens with clear "how-to" instructions for committing suicide. In considering this issue, Dunne-Maxim (1991) has written:

> While well-intentioned, some curricula addressing suicide prevention address the topic in a sensationalized way...[O]ne film that is shown depicts two attractive teenagers climbing into a car with their cat to kill themselves by carbon-monoxide poisoning...Showing movies of attractive kids on tall buildings with highly emotional music to prevent suicide is similar to the way drug prevention programs began. The latter graphically showed youngsters the range of possibilities in available drugs.

In light of these concerns, persons considering school-based general suicide education as a prevention strategy should seriously consider incorporating the goals and objectives of general suicide education programs into traditional school health curricula rather than holding special, highly visible classes on suicide prevention. Many suicide researchers believe that broad-based primary prevention programs focusing on health enhancement may be of greater value than programs that address only suicide.

- **Researchers have not sought to measure changes in behavior.** In none of the evaluation studies we surveyed did researchers report looking at changes in the behavior of students, such as changes in the number of students seeking help or the number of students referring others for assistance. Program staffers have reported increased uses of hotline services following general suicide education programs in schools (Barbara Blanton, Director, Crisis Center of Collin County), but no formal evaluation has been done in this area. Often, the programs have been too small to reliably demonstrate changes in suicide attempts or suicide, even if these had been measured.

A common element of the programs that were evaluated was their limited duration and intensity. Most programs were 1 to 3 hours long and were often held in a classroom setting that might not have been conducive to discussion. It is not clear how much we can expect from such modest interventions.

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Illustrative Programs

School-based general suicide education programs are numerous. The 13 programs listed below are included on the basis of their time in operation. A brief description of each of these programs is provided at the end of this section.

Program	Rationale for Inclusion
East:	
Adolescent Suicide Awareness Program (ASAP) Self Esteem For Life Fitness (SELF) "Getting to Know Me" Lyndhurst, New Jersey	• Nine years in operation • Strong ties to community program
New Jersey Adolescent Suicide Prevention Project Trenton, New Jersey	• Multischool program • Evaluation study
Samaritans of Rhode Island Providence, Rhode Island	• Statewide program • Evaluation data
Midwest:	
Suicide Prevention Center Program Dayton, Ohio	• Ten years in operation • Comprehensive program
South:	
Delaware Youth Suicide Prevention Wilmington, Delaware	• Eight-day lesson program • Multischool program
Jewish Family Service New Orleans, Louisiana	• Four-day program by nonschool group • Large minority population
Project SOAR Dallas, Texas	• Comprehensive program • Large minority population
Crisis Center of Collin County Plano, Texas	• Eight years in operation • Strong link with hotline
West:	
California School Suicide Prevention Los Angeles, California	• Large school program • Minority population
Weld County Suicide Prevention Johnstown, Colorado	• Comprehensive program • Rural youth
Suicide Prevention and Crisis Call Center Reno, Nevada	• Comprehensive program • High suicide-risk area

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Evaluation Needs

Our review of research suggests that the following are important research issues to be investigated in future studies:

- Do program participants change their attitudes toward the acceptability of suicide?
- Do the people at highest risk benefit from such programs? Does this approach actually **increase or decrease** suicidal ideation or behavior?
- Do program participants improve their interpersonal skills and ability to disclose feelings?
- Are program participants less likely to use alcohol and drugs to cope?
- Do program participants use referral sources more often?
- Do the number and type of referrals change? Are the new referrals appropriate?

Scientific evidence documenting positive changes in attitudes and behaviors relating to suicide among program participants and addressing concerns about potential adverse consequences from such programs would help enormously to encourage continued support of general suicide education programs.

Summary

General suicide education programs represent a relatively popular and intuitive approach to youth suicide prevention. These programs can reach substantial numbers of young people, but the programs are typically limited in duration. Results of evaluation studies indicate that the programs can increase the knowledge of students about suicide warning signs and (to some extent) about sources for help and referral. Evidence that the programs influence participants' attitudes about suicide or willingness to seek help is, however, scarce. In one study, students who reported a prior suicide attempt were more likely than other students to react negatively to the program. Prudence suggests that schools which undertake general suicide education programs should have in place staff and resources to recognize and deal with students who might be upset by participation in these programs. Researchers have not yet examined the impact—positive or negative—of general suicide education programs on suicidal behavior.

References about General Suicide Education Programs

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Overholser, J., Hemstreet, A., Spirito, A, and Vyse, S. Suicide awareness programs: effects of gender and personal experience. *Journal of the American Academy of Child and Adolescent Psychiatry* 1989;28:925-930.

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Suggested Additional Reading

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Garland, A., Whittle, B., and Shaffer, D. A survey of youth suicide prevention programs. *Journal of the American Academy of Child and Adolescent Psychiatry* 1988;28:931-934.

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General Suicide Education: Program Descriptions

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Adolescent Suicide Awareness Program (ASAP)
Self Esteem For Life Fitness (SELF)
"Getting to Know Me"

Location: Lyndhurst, New Jersey
Contact: Diane Ryerson, MSW, (201) 935-3322)

High school program: Adolescent Suicide Awareness Program (ASAP)

Targets: High school students (9th and 10th grade).
Years in operation: 9
Source of funding: State and local government, school contacts, foundations.
Amount of funding (per year): $2,000-$3,000 the first year for training and supplies; $100-$500 in subsequent years for training materials.

Program description: ASAP, a joint effort between local mental health providers and the schools, is a comprehensive school-based program for raising knowledge and awareness levels of youth suicide in the schools and in the community. ASAP is one of three developmentally related school-based mental health education programs. "Getting to Know Me" targets elementary school students and Self Esteem For Life Fitness (SELF) is targeted at the middle school population. ASAP consists of three interrelated segments:

- The Educators' Seminar: A 3-hour awareness and skill-building workshop for faculty administration and support staff.
- The Parents' Program: An informational program that can vary from a 30-minute overview to an intensive 2-hour workshop.
- The Students' Workshop: A workshop at which specially selected school personnel are trained to teach the ASAP student curriculum to 9th or 10th graders.

Programs for educators and parents should be implemented first to prepare adults to deal with students who may need help.

Exposure: ASAP presentations are conducted as either two 2-hour sessions or six 40-minute lessons in 9th or 10th grade health classes.

Coverage: About 5,000-6,000 students per year in Bergen County. An additional 50 schools are reached annually through the ASAP Professional Seminar.

Content/topics:
- Facts about and warning signs of suicide
- Where to get help for oneself or a friend
- How to help a suicidal friend
- Building working relationships between schools and local mental health service providers

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Evaluation: No formal evaluation other than student and teacher rating surveys, which have been consistently positive. Funding is being sought to conduct a retrospective study of the impact of the ASAP program since its inception in 1982.

Data available: The program administers a written questionnaire that serves to help identify at-risk youths.

Middle school program: Self Esteem For Life Fitness (SELF)

Targets: Middle school students (grades 6-8).
Years in operation: 4
Source of funding: United Way, private industry.
Amount of funding (per year): $40,000 program development; one-time cost of $1,500 per school to implement; $100 per year after training completed.

Program description: SELF is a comprehensive school-based program in which participants learn techniques for developing positive self-images and healthy coping skills. It is a cooperative project between local mental health providers and the schools. The student curriculum is delivered by a SELF staff member to selected school personnel, who in turn deliver the material to the students. The material can be used at all grade levels with minor adjustments, although it was primarily designed for middle school students.

The SELF training teaches selected faculty to implement the SELF curriculum in the classroom. There are companion workshops for faculty and parents.

Exposure: The Educators' Seminar can be presented as either a half- or full-day workshop. The Parents' Program is 1.5 to 2 hours. The Student Curriculum training for school staff requires 3 full days of training.

Coverage: Varies according to school personnel trained. Now reaches 1,000-2,000 students annually. Can conceivably reach an entire school population.

Content/topics:

- Understand the sources of self-esteem
- Evaluate present levels of self-esteem
- Implement techniques to increase self-esteem in the classroom
- Develop effective problem-solving strategies
- Encourage appropriate help seeking behavior
- Reduce the self-destructive behavior of youth
- Increase self-awareness and appreciation of others
- Forge closer bonds among teachers, students, and parents
- Identify and refer troubled middle school children for appropriate help
- Improve communications between school and community agencies

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Evaluation: No formal evaluation other than narrative comments by parents and teachers.

Data available: None.

Elementary school program: "Getting to Know Me"
Bergen County Task Force on Youth Suicide Prevention

Targets: Elementary school students (grades 4 and 5).
Years in operation: 1
Source of funding: County government.
Amount of funding (per year): Program was developed and piloted with $20,000 Freeholder funding. Program trainers teach elementary faculty how to present the student curriculum. Cost is about $3,500 annually to implement in each school, once faculty members are trained. Teachers are paid to undergo training.

Program description: "Getting to Know Me" is a mini-curriculum consisting of 10 lessons, each 50 minutes long. The goal is to reduce self-destructive behavior in adolescence by teaching elementary school children to deal with loss constructively and to develop good coping, problem-solving, and decision-making skills before the teen years. The focus is on enhancing self-esteem and relationship skills.

Exposure: Elementary school teachers are taught to present the curriculum in two half-day training sessions. As of the fall of 1990, teachers from eight schools have received the training.

Coverage: 1990—a minimum of 650-800 children during first-year pilot.

Content/topics:
- Change and stress
- Self-esteem
- Feelings
- Coping with loss
- Developing control

Evaluation: Researchers from Fairleigh Dickinson University are conducting an external evaluation of the pilot project. Preliminary data on the pilot will be available soon.

Special population outreach: The programs have been modified for urban inner-city schools with large black and Hispanic populations.

Related components:
- Community gatekeeper training
- Parent programs
- Postvention

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- School gatekeeper training
- Screening

Address: Adolescent Suicide Awareness Program (ASAP)
Diane Ryerson, MSW
Director, Counseling and Education Services
South Bergen Mental Health Center
516 Valley Brook Avenue
Lyndhurst, NJ 07071

Reports:

- A Cry For Help That's Dying To Be Heard: The First Annual Report (1988) of the Bergen County Task Force on Youth Suicide Prevention.
- Description of programs (packet).
- Teens in Crisis: Preventing Suicide and Other Self-Destructive Behavior (by Tom Barrett).

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New Jersey Adolescent Suicide Prevention Project

Location: Trenton, New Jersey
Contact: Maureen Underwood, A.C.S.W., (609) 777-0717

Targets: Selected school staff, mental health professionals, community crisis team members.
Years in operation: 5
Source of funding: New Jersey.
Amount of funding (per year): Varies.

Program description: Initial project goals were to increase awareness of adolescent suicide among school administrators, teachers, parents, and students; to teach them to identify high-risk teens and refer those teens to appropriate help; and to ensure a coordinated, easily used system for referral of identified teens to local mental health resources. The initial student programs were delivered either by experienced mental health professionals or by regular teachers who had been especially trained for this purpose. Although the student programs had little apparent effect, the programs for educators were effective, and most schools that participated in the initial study were encouraged to either develop or promulgate more effective policies and procedures for responding to suicide emergencies.

Current project activities include in-service training for selected school staffers on the management of suicide risk and responses to suicide crises; consultation with school administrators on the development and implementation of appropriate policies and procedures; training for mental health professionals in intervention following a suicide; and technical assistance to communities trying to develop crisis response teams that are capable of managing mental health emergencies, including suicides and threats of suicide.

Exposure: The original school-based program consisted of 1.5- to 4-hour sessions in 9th- or 10th-grade health classes. Current sessions for selected school staff (e.g., nurses, child study team members, guidance staff, and administrators) usually consist of 1-day workshops, and those for mental health professionals are usually 2-day workshops. Community crisis team sessions vary on the basis of community needs.

Content/topics: Students in the original program learned facts about and warning signs of suicide; where to get help for oneself or a friend; and how to help a suicidal friend. Content of the current program is related to preparing targeted audiences for responding to student and community needs in the event of intentional death (i.e., suicide or homicide).

Evaluation: Findings from the initial school-based demonstration programs, carried out in 1985-1987, indicated that there was an increase in students' knowledge of suicide warning signs and sources of help. In general, however, there was no significant change in students' attitudes about suicide or their willingness to seek help after attending prevention programs. Student assessments were made by using precoded self-report forms administered 1 or 2 days before the students participated in the program and repeated about a month later. Most students were fairly knowledgeable and held relatively sensible attitudes about suicide. There was no evidence from this limited study that the programs increased suicidal preoccupations or behavior among participating students. Most educators indicated that their knowledge about suicide, treatment programs, and suicide warning signs increased dramatically after they participated in the programs.

Data available: Pre-post youth attitudes/knowledge survey.

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Related components:

- School gatekeeper training
- Intervention after a suicide

Address: New Jersey Adolescent Suicide Prevention Project
Maureen Underwood, A.C.S.W., Coordinator
Dept. of Human Services
Division of Mental Health and Hospitals
CN727—Capital Center
Trenton, NJ 08625

Reports:

- *Youth Suicide Prevention: Meeting the Challenge in New Jersey Schools*. New Jersey Department of Human Services, Division of Mental Health and Hospitals, 1989.
- Shaffer, D., Garland, A., and Whittle, R. 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, 1988.
- Shaffer, D., Vieland, V., Garland, A., Rojas, M., Underwood, M., and Busner, C. Adolescent suicide attempters: response to suicide-prevention programs. *Journal of the American Medical Association* 1990;264:3151-3155.

Advice to others interested in starting this type of program: Community involvement is critical, since it disperses responsibilities that are often dumped on the school or mental health system. Under the leadership of one key agency (e.g., school, municipal government, or mental health department), organize a task force of all community groups and agencies involved in providing services to children and try to insure participation by agency heads or community leaders, since high level support is key to task force success. To help all community groups "buy into" the task force mission, provide a workshop or training seminar that communicates the necessity of addressing the needs of the entire community in a mental health emergency. To increase the likelihood of speedy task completion, designate subgroups to work on aspects of organization and implementation, and impose a deadline for their deliberations. Once the task force is organized, schedule regular meetings to review its status and update agendas on the basis of community needs.

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The Samaritans of Rhode Island

Location: Providence, Rhode Island
Contact: Sally Ashworth, (401) 272-4243

Targets: Teachers, students (grades 9 to 12), and school gatekeepers.
Years in operation: 5
Source of funding: Funds are allocated by the state legislature for the Samaritans to develop and provide in-service workshop training for health curriculum teachers.
Amount of funding (per year): $35,000.

Program description: In 1986, the Rhode Island legislature passed a law mandating suicide education as part of the school health curriculum for all ninth graders. The Samaritans of Rhode Island developed separate programs for school personnel, parents, and students. The Samaritans of Rhode Island also consults in the development of crisis intervention and postvention protocols.

Exposure: Five lessons, lasting a minimum of one class period each, are recommended, but teachers are only required to present the information during one class period. Lessons cover suicide awareness and how to "befriend," plus some questionnaires to assess students' knowledge of and attitude toward suicide.

Coverage:
- Student workshops: 64 workshops reaching 2,719 students
- Health fairs: 7 fairs reaching 3,900 students
- College presentations: 9 presentations reaching 391 students

Content/topics: "Befriending" skills, factual information about suicide, and available resources.

Evaluation: Studies have been conducted on the efficacy of the suicide awareness curriculum.

Findings: Knowledge about suicide was found to increase slightly as a function of not only the suicide curriculum but also of having taken a suicide knowledge pretest. Students participating in the curriculum were found to have the lowest scores on hopelessness as measured by the Hopelessness Scale for Children (HSC). Attitudes about suicide were found to improve mainly as a function of the students having completed a baseline rating of attitudes rather than of having completed the curriculum itself. Some marked differences in attitude were found between the sexes.

Data available: Above-mentioned test scores.

Special population outreach: Not described.

Related components:
- Crisis center and hotline
- Postvention
- School gatekeeper training
- Screening

Address: Samaritans School Program
Sally Ashworth
School Program Coordinator for Samaritans
2 Magee Street
Providence, RI 02906

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Reports:

- *Teachers Manual for the Prevention of Suicide Among Adolescents.*
- Spirito, A., Overholser, J., Ashworth, S., Morgan, J., and Benedict-Drew, C. Evaluation of a suicide awareness curriculum for high school students. *Journal of the American Academy of Child and Adolescent Psychiatry* 1988;27:705-711.

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Suicide Prevention Center Programs

Location: Dayton, Ohio
Contact: Linda Mates, LPCC, (513) 297-9096

Targets: Junior high and high school students, school and community gatekeepers.
Years in operation: 10
Source of funding: United Way, the state, and community taxes.
Amount of funding (per year): $75,000.

Program description: The general suicide education program is part of a comprehensive program. The Suicide Prevention Center (SPC) provides a broad range of crisis support services, including a 24-hour crisis hotline, training for professionals (e.g., teachers, service providers, clergy, physicians, and police), and a crisis response team for postvention work with individuals or groups.

There is a junior high program (grades 7-9) that is one-to-three sessions long and a high school program (grades 10-12) that lasts 10 days. School programs are not mandatory, since the SPC does not want to force teens to go to sessions; attendance depends on school policy.

Coverage: Countywide.

The numbers by age are as follows:

Grades K-6:	1,600 or more students per year
Grades 7-12:	3,100 or more students per year
Adults:	1,000 or more per year

Content/topics: Topics include stress management and coping skills as well as facts about suicide. Students are also assessed with a scaled survey to (1) compare potentially suicidal students with other adolescents, and (2) check on the progress of at-risk students over time.

For elementary students, the focus of both the assessments and classroom programs was on sharing feelings frequently associated with grief and loss and developing a circle of adult resources. Secondary level assessments and classroom programs highlighted recognition of suicidal behavior, adult resources, and factual information about suicide.

Evaluation: An evaluation was conducted in two different school systems (K-12, all adults) by means of a pretest and posttest of the programs. The results indicated that programs did not lead to an increase in suicide nor were they otherwise harmful; but the number of referrals did increase. The following evaluations are ongoing: quality assurance, client satisfaction, and client outcome.

Data available: Pretest and posttest surveys on knowledge and attitudes. Intervention, referral, and follow-up information may also be available.

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Related components:

- Crisis center and hotline
- Parent programs
- Postvention
- School gatekeeper training

Address: Linda Mates, LPCC
Executive Director
Suicide Prevention Center, Inc.
PO Box 1393
Dayton, OH 45401

Reports: Program manuals and pamphlets and evaluation materials.

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Delaware Youth Suicide Prevention Pilot School Program

Location: Wilmington, Delaware
Contact: David L. Jefferson, Ph.D., (302) 645-6288

Targets: Students (grades 8 to 12).
Years in operation: 2
Source of funding: Department of Services to Children, Youth and their Families.
Amount of funding (per year): The annual cost was about $9,000; however, first year costs were greater because of expenses for the trainer, substitute teacher salaries, and stipends paid to parent and school board member participants. The actual maintenance cost of the program was $900 per year for each of the six participating school districts.

Program description: In response to recommendations from the Delaware Youth Suicide Task Force, the state piloted a general suicide education program in 20 schools in 6 school districts. The program was conducted in the spring and fall of 1989 and the winter of 1990, with a total of 2,200 students. The program, patterned after the California School Suicide Prevention Program, was instituted in response to a suicide rate among Delaware youths that was greater than the national average. The program also conducts 2 or more hours of training for all school faculty, a 1-hour parent awareness program, and a peer counseling program.

Exposure: Eight 1-hour classes are conducted with students in grades 8 to 12. Classes are conducted in health education, psychology, or sociology classes. Over the 8-day sequence, classes are conducted by the regular teacher who has been trained in the suicide prevention curriculum or by a two-person team consisting of the regular teacher and a teacher trained in youth suicide prevention.

Coverage: 2,200 students in 20 schools in 6 school districts.

Content/topics: Using materials from the California School Suicide Prevention Program, the course covers how to deal with stress and depression, how to communicate feelings, how to listen better, and where to go for help.

Evaluation: A prepost evaluation was conducted with 1,650 exposed and unexposed students in 20 schools. The evaluation, conducted by Stephanie Henson of the Center for Education Research and Evaluation, University of Delaware, was a simplified adaptation of the instrument used in the New Jersey evaluation project.

Findings: Students who take the course refer their peers for help more often than students who do not take the course. The school psychologist indicates that student referrals are often more accurate than referrals by teachers.

Data available: Prepost survey data on students as described in the report, "Delaware Youth Suicide Prevention Program: Summary of Survey Results."

Special population outreach: None.

Related components:

- Parent education
- Intervention after a suicide
- School gatekeeper training

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Address: Delaware Youth Suicide Prevention Pilot Project
Dr. David L. Jefferson
2 Texas Avenue
Broadkill Beach, DE 19968

Reports:

- Evaluation report
- Task force report

Audiovisual materials and instructional or learning aids were taken from the California School Suicide Prevention Program for California Public Schools. Additional films or learning aids were selected by teachers as needed.

Advice to others interested in starting this type of program: Limit the number of agencies (departments or divisions of departments) that are to be responsible for program implementation. Designate one person as overall program coordinator, and when more than one agency must be involved, use liaison persons to maintain effective networking. Program training should involve policymakers (i.e., administrators and school board members) and parents, as well as the staff who will provide the training. Peer counselors should also be involved in the program training.

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Jewish Family Service (JFS)

Location: New Orleans, Louisiana
Contact: Susan Daube, (504) 524-8475

Targets: Junior high and high school students.
Years in operation: 6
Source of funding: United Way, Freeport-McMoRan, Inc.
Amount of funding (per year): $40,000.

Program description: JFS staffers have developed and present a four-part curriculum for area private, parochial, and public schools. The curriculum is delivered by the staff and a trained corps of 32 volunteers. JFS staff are available to volunteers and school counselors to assist with referrals, problem situations, and to answer questions pertaining to suicide prevention, statistics, and postvention. In addition, all counselors, social workers, nurses, and designated teachers from every public middle, junior, and high school in Orleans parish have received training in recognizing adolescent depression and suicide and in referring at-risk students for professional help.

Exposure: The curriculum in its standard form is 4 days long, but can be adapted to a 3- or 5-day session. It is presented by a trained volunteer during class periods, which typically last for 50 minutes. The curriculum consists of a word-by-word, action-by-action text. It allows for flexibility in working with adolescents so that they acquire safe problem-solving skills. At the end of the 4-day program, students are able to recognize the warning signs of depression and suicide, know what to do if they or someone they know is in crisis, apply safe problem-solving skills, and know how to get help from adults. Grades 7 through 12 receive the curriculum. Newspaper articles, spots on local news broadcasts, and presentations by the JFS staff to the New Orleans community are other means of reaching the public.

Coverage: 5,000 students in 29 schools each year.

Content/topics: Discussion of attitudes towards suicide, warning signs, how to help someone in crisis, and safe problem-solving skills (how one can get help with a problem one is having trouble solving).

Evaluation: Each student attending a presentation fills out an evaluation form. The presenter of each program also fills out an evaluation.

Data available: JFS staff keeps records of students' and counselors' responses to the program and of referrals made.

Special population outreach: None described.

Related components:

- Peer support programs
- School gatekeeper training

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Address: Susan Daube
Family Life Education Coordinator
Jewish Family Service
2026 Saint Charles Avenue
New Orleans, LA 70130-5319

Reports:

- Adolescent Suicide Prevention Program Manual
- Videotape shown to students

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Project SOAR (Suicide: Options, Awareness, Relief)
Dallas Independent School District

Location: Dallas, Texas
Contact: Judie Smith, MA, (214) 565-6700

Targets: Teachers and staff, students (10th graders).
Years in operation: 3
Source of funding: Dallas Independent School District (DISD).
Amount of funding (per year): $90,000, salary for three professionals. Clerical work, office supplies, and training materials are absorbed by Psychological/Social Services Department budget.

Program description: SOAR is a comprehensive program that covers prevention, intervention, and postvention. Prevention consists of suicide awareness lessons for teachers and staff. There is a peer support system (PAL) and a section on esteem building called Quest. School counselors in all secondary and elementary schools are trained in risk assessment, and a crisis team is available to intervene following suicides.

Exposure: Student education is conducted during required health education classes, usually taken in the 10th grade, and the curriculum was established as five 1-hour lessons. The peer helper course (PAL) is offered to a select number of juniors and seniors, and includes a unit on suicide prevention. In addition to the health curriculum lessons, the PAL curriculum emphasizes crisis intervention skills. The SOAR team has conducted suicide awareness sessions for every secondary school and most of the elementary schools. The in-service meetings include school policy and procedures, warning signs, and the do's and don'ts of general crisis intervention.

Coverage: Potential to reach all 132,000 students in the school system.

Content/topics:

- Attitudes toward suicide
- Facts and myths about suicide
- Warning signs
- Listening skills
- How to help—referrals, sources of help

Evaluation: No formal evaluation at this time. Parents have been called to see how their child was affected by the program.

Data available: Feedback is now obtained from students, teachers, and parents, so it may be possible to develop a written survey or more formal interview survey. Program officials are building a data base on those who threaten and attempt suicide that may be useful in assessing changes in these rates over time. The data that are being collected include race, age, sex, method of suicide attempt, risk assessment, history of suicidal behavior, precipitating events, behavior warning signs, and the action plan followed for each student seen by the system. The program director keeps records of high-risk students in her office. These records consist of reports filed by whoever did the risk assessment or intervention, so these persons' responses to the program could be evaluated.

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Special population outreach: In an effort to reduce the dropout rate, every DISD school has a Pupil Assistance and Support Team to identify and provide additional help for at-risk students. The team receives referrals from a behavior of concern checklist. Included in this checklist is a section of suicide warning signs. These students are then referred to the primary caregiver or member of the Psychological/Social Services Department.

Related components:

- Peer support
- Postvention
- School gatekeeper training

Address: Project SOAR
Judie Smith, MA
Specialist in Psychological Social Services
Dallas Independent School District
1401 South Akard
Dallas, TX 75215

Reports: Program manual.

Advice to others interested in starting this type of program: The National Safety Council has developed suicide prevention curriculum standards. Review these standards before setting up a curriculum for a school-based suicide prevention program.

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Crisis Center of Collin County

Location: Plano, Texas
Contact: Barbara Blanton, M.S.N., R.N., (214) 881-0088

Targets: Middle school and high school students.
Years in operation: 8
Source of funding: Grants, contracts, fund raising, donations, some city and county funding.
Amount of funding (per year): $156,000.

Program description: The Crisis Center is a telephone hotline service that also provides suicide education to middle and high school students. Center workers use a self-administered questionnaire on facts and myths about suicide to assess knowledge and attitudes. Sessions are conducted by trained volunteers (whose training consists of 16 hours of instruction plus classroom observation out in the field) working in pairs. Elements of intervention used after a tragedy include a face-to-face support group for survivors of suicide and a crisis intervention team that comes to school in response to specific incidents. Intervention team members visit at the funeral home and attend funerals with the students. Postvention services have also been developed for the local community college.

Exposure: Twice a year, program staffers conduct 55-minute sessions in required health education classes for grades 9-12. There is also a middle school program (grades 7 and 8) that focuses more on coping with stress and problems than on suicide.

Coverage: 8,000 or more students in Collin County and other areas. The program should reach every student in high schools where it is provided, since health education classes are required.

Content/topics:

High school: Students discuss suicide issues and try to assess their knowledge and feelings, why people commit suicide, warning signs, and how to help. Topics include:

- Facts and figures (quiz)
- Suicide warning signals
- Why do young people kill themselves?
- How can you help? What to do?
- Don't keep a secret! Tell an adult you trust!

Middle school: The program, titled "Coping with Depression," covers sources of depression, signs and symptoms of depression and suicidal feelings, and coping skills: how to help yourself as well as others who are having problems.

Evaluation: The program staff members administer a questionnaire evaluation to school counselors, teachers, students, and presenters about the program's presentation and content. They also collect survey data (including a knowledge quiz in the form of student pre- and posttests) from teachers and students to assess the impact of programs.

Findings: The program has always gotten positive feedback.

Data available: Knowledge and attitude questionnaire data and evaluation survey data.

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Special population outreach: Teens 12-19, teachers, counselors, and recently, the local community college staff and students.

Related components:

- School gatekeeper training (high school and college)
- Community gatekeeper training
- Postvention after a suicide, homicide, unintentional injury/death, or molestation by a teacher
- Survivors' groups

Address: Barbara Blanton, M.S.N., R.N.
Executive Director
Crisis Center of Collin County
PO Box 861808
Plano, TX 75086

Reports:

- Program description (brochures)
- High school curriculum
- Middle school curriculum
- Evaluation forms

Advice to others interested in starting this type of program: A prevention program must work in cooperation with the schools. Trust should be established between the school district, individual schools, and the center offering the prevention program. Knowledge of trauma and grief and group process is vital to both suicide prevention programs and postvention programs.

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California School Suicide Prevention Program

Location: Los Angeles, California
Contact: Alice Sesno, Ph.D., (310) 922-6333

Targets: High school students, grades 9-12.
Years in operation: 6
Source of funding: California.
Amount of funding (per year): $300,000 for the first 3 years for development of the curriculum.

Program description: The development of a statewide youth suicide prevention program was mandated in 1983 and begun in 1984. The program manual of general suicide education materials was distributed to all public high schools as required by law but, since implementation of the program was not required, the program was not always implemented. There are also programs for teachers and parents, which include suicide awareness training for school personnel and handouts on the warning signs of suicide, how to help, and sources of help. Implementation of a peer counseling program is suggested, along with a section for administrators on how to implement the program in their schools.

Exposure: Five lessons (one class period each) are suggested, to be taught to all four grades.

Coverage: Statewide. A program manual was distributed to all public high schools. Delivery of the program, however, is not mandated, so the program's coverage and extent of use are uncertain.

Content/topics: The program teaches students to cope with suicidal feelings and how to help themselves or suicidal friends. The five-lesson program covers how to deal with stress and depression and how to communicate feelings, how to listen, and where to go for help.

Evaluation: Thirty schools were selected to participate in an evaluation of the curriculum, 10 classrooms being in each of the following groups: treatment, pre-post control, and post-only control. The pre- and post-questionnaires included items to assess attitude, knowledge, and behavior related to suicide. Schools were asked to provide information on the number of suicides and attempts made during the year.

Findings: The results demonstrated that knowledge levels increased, but the numbers of suicides and attempts were too small to statistically evaluate.

Data available: Data were collected for the initial evaluation. Officials do not know whether data are still being collected.

Related components:

- Intervention after a suicide
- Parent programs
- School gatekeeper training

Address: California State School Suicide Prevention Program
Alice Sesno, Ph.D.
Los Angeles County Office of Education
9300 East Imperial Highway
Downey, CA 90242

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Reports: California State Department of Education. *Suicide Prevention Program for California Public Schools: Implementation and Resource Guide*. Sacramento, CA: California State Department of Education [ISBN 0-8011-0682-6], 1987.

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Weld County Suicide Prevention Program

Location: Johnstown, Colorado
Contact: Susy Ruof, M.A., (303) 587-2336

Targets: Students, grades 3-12.
Years in operation: 6
Source of funding: Weld Board of Cooperative Educational Services (BOCES) and the local school district.
Amount of funding (per year): The start-up cost in 1984 was $1,000 (which would be about $2,500 today). Additional yearly cost is only about $500 (for additional training and materials), since all program functions are carried out by in-place staff.

Program description: This program develops crisis teams for schools (from in-place staff) and implements a student curriculum for grades 3-12. The student curriculum varies, depending on the grade, but mainly consists of educating students about depression and its role in suicidal thoughts, about how and where to get help for oneself or a friend, and about how to develop coping and problem-solving skills. Presentations to students can be integrated into several types of ongoing classes, such as health, social studies, or home economics, with the size kept fairly small (25-30). In grades K-2, a general counseling curriculum emphasizing social skills, friend-making, and problem solving is taught; in addition, potentially at-risk students are seen weekly in small counseling groups. Teachers for grades K-5 receive training in communication, depression recognition, helpful responses to children's losses, and how to teach coping skills.

Exposure: Three 1-hour sessions, integrated every other year into regularly scheduled classes for grades 3-12, is recommended.

Coverage: This mostly rural, 40% Hispanic, school district has about 1,300 students.

Content/topics:

- Depression: causes, symptoms, coping mechanisms
- Suicide: facts and myths, warning signs, how to help a suicidal friend
- General coping skills: friend-making interpersonal problem-solving

Referral/selection procedures: Teachers, students, and community members are encouraged to refer at-risk youths to crisis team members and school staffers who have been specially trained in suicide intervention and counseling techniques as part of the BOCES program.

Evaluation: Feedback from teachers, administrators, and community members; statistics on referral rates after student and staff education sessions; and countywide tracking of suicides since crisis teams have been in place in most districts in the county. Weld County's adolescent suicide rate is now about half the state rate.

Data available: Number of students referred, number of attempts or gestures, detailed and longitudinal information on each student referred (stressors, symptoms, resources, history, family information, plan of action, follow-up). Notes on all interventions done following accidental deaths of students, deaths of parents or staff members, and suicide attempts or gestures. There have been no suicide completions in the district since the program was instituted in 1984.

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Special population outreach: Potentially at-risk students in grades K-2 (about one-tenth of the student body) are seen weekly in small counseling groups. At grades 3-12, outreach for these students includes ongoing counseling, individual attention from a teacher, crisis intervention as needed, and long-term follow-up by the district crisis team (through graduation).

Community outreach includes training crisis intervention teams in many neighboring school districts, starting a countywide suicide prevention coalition, establishing a monthly support group for survivors of suicide, and receiving a Comprecare grant to reduce suicides among the elderly in Weld County.

Related components:

- Community gatekeeper training
- Parent programs
- Postvention
- School gatekeeper training

Address: Weld County Suicide Prevention Program
Susy Ruof, M.A.
5290 Mesquite Court
Johnstown, CO 80534

Reports: Program manual and descriptive articles.

Advice to others interested in starting this type of program: Programs that use and train in-place staff rather than relying on outside expertise are not only much cheaper but are also more effective (education of all students and staff can be done in-house as needed, referrals are made earlier, interventions can be immediate, and follow-up can be ongoing and extensive). Administrative and board support and good agency relationships are crucial. For additional advice, write for reprints of our six National Association of Suicide Prevention articles.

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Suicide Prevention and Crisis Call Center (SPCCC)

Location: Reno, Nevada
Contact: Roger Simon, (702) 323-4533

Targets: Teens.
Years in operation: 4
Source of funding: Community Block Grants, E.L. Cord Foundation.
Amount of funding (per year): $12,300.

Program description: The teen suicide prevention program is conducted by the Suicide Prevention and Crisis Call Center, which also offers a 24-hour crisis line, a support group called Survivors of Suicide, elderly outreach, a 24-hour child abuse and neglect reporting hotline, a child abuse and neglect prevention program, and a face-to-face rape crisis intervention program. The goal of the education program is to provide a comprehensive approach to training and educating school staff, students, and parents on teen suicide and its prevention. The school component is modeled after Diane Ryerson's ASAP program in New Jersey. A primary reason the program is of interest is that Nevada has the highest suicide rate in the United States for both the general population and for teens.

Exposure: The program is conducted throughout the year in classrooms in the 7th through 12th grades, with no more than 35 students per class. The length of the session varies, depending on the school's schedule, from 45 to 60 minutes.

Coverage: The program is funded for the Washoe County School District (about 30,000 students) and is available on a fee-for-service basis for rural school districts.

Content/topics:

- Suicide statistics
- Myths and facts
- Warning signs
- How to help

An anonymous questionnaire about suicide and suicidal behavior can be administered before the suicide prevention and information session.

Evaluation: Students answer questionnaires, before and after participating, about their attitudes toward suicide and their knowledge of resources.

Findings: The main finding was that more students would call the hotline after the presentation than would have before the presentation.

Data available: Several studies on suicide in Nevada have been conducted, including at least one by CDC. Analyses include rates by age, race, and sex; questionnaire data on calls to the Crisis Call line; and the results of pretest and posttest surveys in different high schools. The Crisis Center is conducting a community survey regarding the entire Crisis Call program, especially the hotline. The survey is being done in conjunction with a University of Nevada-Reno student as part of his thesis.

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Special population outreach: The program is offered in rural schools on a "fee-for-service" basis, in Washoe County School District's Alternative Education program, and at the juvenile detention facility. In Reno, the low-income area schools are targeted.

Related components:

- Crisis center and hotline
- Parent programs
- Peer support
- School gatekeeper training

Address: Roger Simon
Executive Director
Suicide Prevention and Crisis Call Center
PO Box 8016
Reno, NV 89507

Reports: Program description and results of surveys are available.

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Chapter 5
SCREENING PROGRAMS

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Chapter 5
Screening Programs

Overview and Rationale

Typically, screening programs are conducted in schools and involve the administration of a screening instrument to identify high-risk youths. Persons identified by the initial screening test then receive in-person counseling and, if warranted, referral and treatment.

One model of such a program could involve multistage screening to identify students with psychological problems or personality traits that could be related to suicide, such as depression, and impulsive or aggressive behavior. Students might be identified through a general screening questionnaire; students with high scores would then consult with a guidance counselor or social worker specially trained to identify the signs of a potentially suicidal youth. Students thought to be at risk would then be given a third screening by a specialist and referred to receive treatment. This might consist of intensive psychotherapy, drug therapy, family counseling, and/or enrollment in classes intended to help students cope with their special problems.

The rationale for this type of approach is that, since suicide is a rare event, prevention efforts will be most efficient if we can identify persons who are at a high risk of suicide so that they can be referred for specific interventions. At present, for many people, depression and other psychological problems go undiagnosed, and thus these people never receive appropriate treatment. As illustrated in Figure 5, a multistage screening program would theoretically allow us to identify these youths and enroll them in a treatment program.

Research Findings

The potential of such screening protocols has been widely discussed (Yufit, 1989; Shaffer, et al., 1988; Eddy, Wolpert, and Rosenberg, 1989). Unfortunately, most screening protocols are in a developmental stage. Work on one research instrument is being done by Dr. Gail Slap and her colleagues at the Children's Hospital in Philadelphia. Without a high degree of sensitivity, however, the capability of a screening instrument to detect a potential suicide case is limited; such a limitation will, in turn, limit the potential effectiveness of a screening program. Likewise, lack of specificity (the capability of correctly identifying low-risk youth) may also compromise screening efforts.

The strongest predictor of suicide is prior suicide attempts. Adolescents who attempt suicide can be identified in emergency rooms or through school screening surveys. For instance, in the New Jersey School Evaluation, students were asked if they had ever thought about killing themselves or had tried to kill themselves. Students who answered "yes" to either question were then asked if they had stopped feeling that way. Those who said that "I haven't stopped feeling that way," along with students who said that they would like for someone to help them with their problems, were then contacted by a school guidance team. When asked later how they felt about being contacted, almost all these students said that they were pleased, although several students also felt embarrassed or angry (Shaffer, Garland, and Whittle, 1988). Identification of prior suicide attempters as high-risk students is important, but it is not

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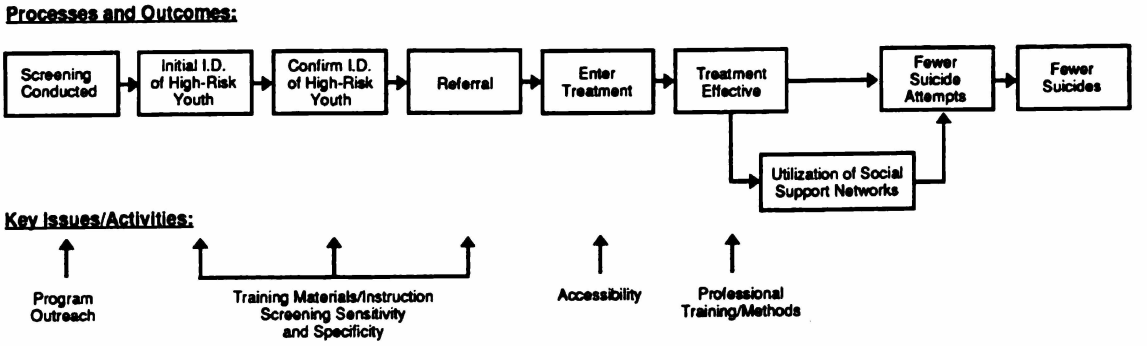
FIGURE 5.
Rationale for Screening Programs to Prevent Youth Suicide



sufficient for screening. Results of epidemiologic studies in the United States (Shaffer, et al., 1988) and in Britain (Shaffer, 1974) suggest that only 25 to 40 percent of suicide victims have made prior suicide attempts. Other predictors of completed suicide among youth include depression (Shaffer, et al., 1988); feelings of hopelessness and inability to have fun (Fawcett, et al., in press); antisocial behavior (Shaffer, et al., 1988); substance abuse (Shaffer, et al., 1988, reported this for males) and alcoholism (Robins, Murphy, and Wilkerson, 1959); and a family history of suicide (Shaffer, et al., 1988).

A similar set of risk factors has been identified for youths *attempting* suicide. Results of a case-control comparison of Philadelphia teenagers who had attempted suicide with those who had not (Slap, et al., 1989) showed that those who had attempted suicide were more likely to have (1) made a previous suicide attempt, (2) experienced school failure, (3) experienced family problems, and (4) used marijuana.

These types of factors can be included in screening tests for adolescents. A screening test has not yet been developed, however, that has both the sensitivity and specificity necessary for accurately yet efficiently identifying high-risk youth.

Another issue in the screening approach is when to screen. Adolescents at low risk of suicide today may be at high risk of suicide a month later. Yet another issue to consider is the potentially adverse consequences of referring "false positives"—teens who are not truly at high risk of suicide, but who score in the dangerous zone of the screening instrument—for more intensive counseling or screening. The screening approach is perhaps most useful and practical in a crisis situation (e.g., in the face of an apparent suicide cluster).

Illustrative Programs

We identified only a small number of screening programs in operation. Among the programs is the Rural Minnesota Program (operating in schools throughout the state) that uses a screening test to assess suicidal ideation, depression, and related problems among 8th-through-12th-grade students, followed by individual interviews with those identified as being at high risk. The screening is done along with a series of five to six class sessions on stress, depression, and coping.

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In the Crisis Intervention Program in the Dade County, Florida, schools, a very different type of screening is used. The program uses easily available school performance data to identify students who may need special attention. The program develops a computerized "Student Intervention Profile" every nine weeks that consists of seven elements based on grades, attendance, tardiness, and classroom behavior. When a student profile changes in three or more areas, a message is generated that the student may need help, and a counselor has a private meeting with the individual.

These programs are described at the end of this chapter.

Evaluation Needs

In developing an effective screening instrument, researchers must ask several key questions. One priority research area is to validate the sensitivity and specificity of various screening instruments. Given the complex web of risk factors for suicide, any sufficiently sensitive screening tool will probably refer more false positives than true positives.

For programs that choose to undertake screening programs with existing instruments, the priority evaluation issues concern the follow-up to the screening effort. In particular, it would be useful to develop a tracking system to assess:

- What proportion of students were deemed to require follow-up screening? Of these, how many actually received follow-up screening?
- Of students receiving follow-up screening, what proportion was determined to require counseling, treatment, or special competency development training?
- Of students determined to require some kind of treatment, how many actually received help? What kinds of therapy were provided? What were the reasons that therapy was not provided (e.g., failure of the student to keep appointments, lack of funds, lack of treatment space)?
- Of students receiving follow-up counseling or therapy, how many completed the treatment? What evidence exists of behavioral change as a result of the treatment?
- Was any stigma attached to follow-up? Did the follow-up screening detract from or augment the capability of mental health services to provide treatment services?

The final concern, of course, will be to determine what effect the program might have on suicide attempts. Given low incidence rates in this type of study, several years of data collection might be required before any determination can be made. Such a study might be possible by carefully instituting a system of records that would allow matching the names of students (and their screening scores and treatment status) with an independent source of records of suicide attempts.

The feasibility of such a study will vary by location. First, conducting such a survey will require the cooperation of institutions, such as hospital emergency rooms, that would identify the majority of suicide attempts in the area. Second, it will require agreements concerning confidentiality that would allow the names of youths attempting suicide to be matched with the names of youths who made previous suicide attempts or who were identified as being at risk of suicide. If the logistics of such matching can be worked out, such an evaluation would greatly facilitate an assessment of the utility of screening programs.

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Summary

Because suicide is a rare event, screening programs have been designed to identify and provide treatment or other assistance for youth at high risk of suicide. As designed, the programs typically administer an initial screening test to a large number of students, with follow-up screening of students who are identified as potentially at risk. Screening represents a potentially efficient way to focus prevention resources on those in greatest need. Unfortunately, most screening protocols are still in the developmental stage, and further research is needed before the screening programs are ready for wide implementation. Even when reliable screening instruments become available, issues of the timing of screening, the costs of follow-up, and referral of "false positives" will need to be resolved before widespread implementation becomes practical.

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Suggested Additional Reading

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Screening Programs: Program Descriptions

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Rural Minnesota Program

Location: Minneapolis, Minnesota
Contact: Barry Garfinkel, M.D., (612) 626-6577

Targets: Students (8th through 12th grade), gatekeepers.
Years in operation: 4
Source of funding: Blandin Foundation.
Amount of funding (per year): Not provided.

Program description: In this program, different education and therapy programs are used for parents, teachers, students in general, and students at risk of suicide. Program staff developed a prototype curriculum for 8th through 12th graders consisting of five to six sessions on stress, depression, and coping. Early identification and screening is done by checking rating scales to see how disturbed or how suicidal adolescents are and selecting those in need of extra education or attention. Other programs include one for parents on recognizing suicidal behavior and one for teachers that, through slides, manuals, video tapes, and other aids, shows them the warning signs of suicide and what to do when they recognize such signs.

Exposure: Five to six class sessions in 8th through 12th grades.

Coverage: Statewide.

Content/topics: Stress, depression, and coping strategies.

Evaluation: Program personnel are starting to collect data but have conducted no formal evaluation yet. Program staffers want to do follow-ups every 6 months. They used a screening questionnaire to survey an additional 3,000 youngsters to determine the occurrence of suicidal ideation, depression, and associated findings. The screening is done in the classroom, and all students between grades 8 and 12 complete the form. Program staffers are looking at a study that will measure the validity of the screening by comparing answers that at-risk students give during interviews with those of a matched control group.

Data availability: Results from screening instruments.

Special population outreach: Not described.

Related components:

- General suicide education
- Parent programs
- School gatekeeper training

Address: Rural Minnesota Program
Barry Garfinkel, M.D.
Division of Child Psychiatry
University of Minnesota Hospital
Mayo Building
420 Delaware Street, SE
PO Box 95
Minneapolis, MN 55455

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Reports: Screening instrument, Student Pictorial Attention Measure (SPAM).

Advice to others interested in starting this type of program: Communities should learn to screen students and to develop the resources for providing the appropriate follow-up to screening. Schools might need to have a crisis intervention team that can work with the youngsters once they are identified as being at risk. The cost of this type of investigation would probably be the total of the cost of the crisis interventionist and of the screening. These costs would vary from locale to locale throughout the country, but most investigations can probably be effectively done for under $50,000 per year.

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Crisis Intervention
Dade County Public Schools

Location: Miami, Florida
Contact: Dr. J. L. DeChurch, (305) 995-7315

Targets: All students.
Years in operation: 5
Source of funding: School district and grant.
Amount of funding (per year):$120,000.

Program description: This program consists primarily of training school-based staff in suicide awareness and providing classes on suicide prevention for 10th graders. Screening is done by means of computerized profiles of each student that record seven behavioral elements and monitor changes in these elements over time.

Coverage: All students in Dade County public schools.

Screening method: The "Student Intervention Profile" (SIP) is produced every nine weeks and consists of seven elements, including grades, attendance (absent, late), and classroom behavior (not doing homework, acting up). Every time a counselor intervenes, information is added to a data base, so when a counselor or teacher notices a potential needy student, he or she can check the student's record for previous problems. All information is coded to preserve anonymity.

Referral procedures: When an SIP changes in three or more areas, a message is generated that the student may need help. A counselor then has a private conference with the student or invites him or her to attend a group session.

Evaluation: Participant written and verbal feedback, which has been positive.

Findings: There were 19 suicides in 1988 and only 7 in 1989, but program staffers are not sure whether they should take credit for the apparent decline. They found students in middle school to be most at risk and also found a link between suicidal tendencies and sexual abuse.

Data available: The program is building a data base to be used for research and evaluation, but it is not yet operational.

Special population outreach: Dade County has a high black and Hispanic population. Suicide information is printed in English, Spanish, and Creole.

Related components:

- General suicide education
- Means restriction
- Postvention
- School gatekeeper training

Address: Dr. J. L. DeChurch
Executive Director
Division of Student Services
Dade County Public Schools
1444 Biscayne Boulevard, Suite 202
Miami, FL 33132

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Reports:

- State guidelines
- Student lesson plans
- Youth in crisis hotline report form
- Student intervention profile form

Advice to others interested in starting this type of program: Contact various programs to find out what has worked best in different communities.

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Chapter 6
PEER SUPPORT PROGRAMS

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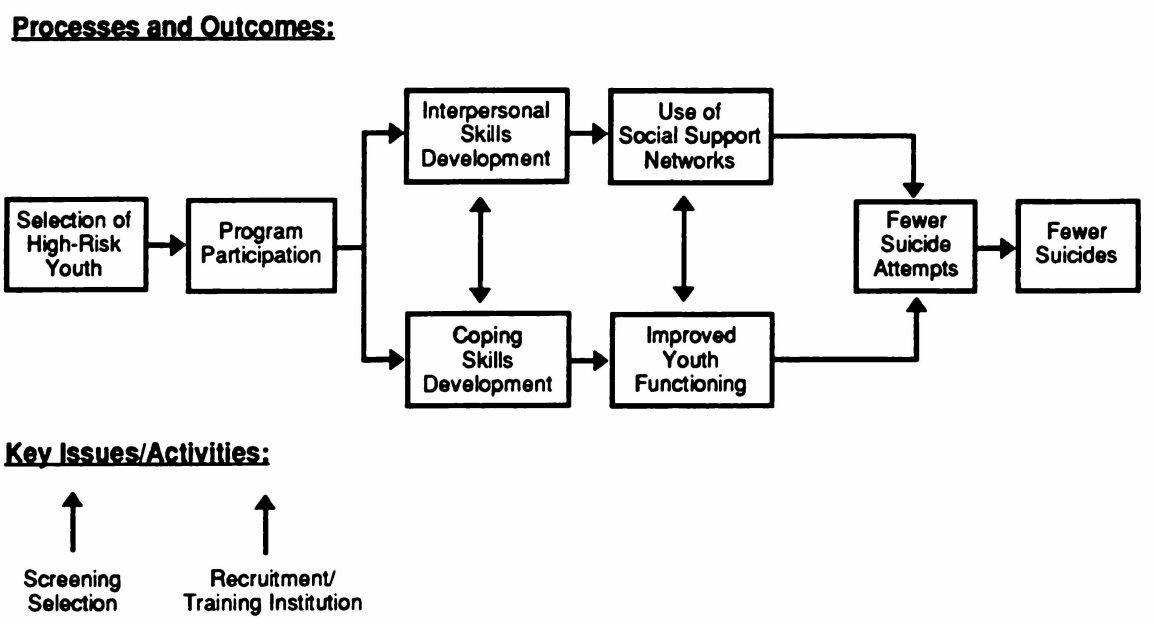
Chapter 6
Peer Support Programs

Overview and Rationale

Peer support programs, which can be conducted in either school or nonschool settings, are designed to foster peer relationships, competency development, and coping skills among high-risk youths as a method of preventing suicide among them. The goal of peer support programs is to provide a setting in which young people who may be at risk for suicide can receive the support of their peers and develop interpersonal and coping skills. (These programs are not intended to be therapeutic programs or psychiatric treatment programs, which are better considered as treatment efforts and are not covered in this document.)

The rationale for peer support programs, as illustrated in Figure 6, is to enhance the interpersonal and coping skills of participants, allowing them to increase their use of natural social support networks and to improve their school attendance and school and job performance. Peer support programs might help to reduce antisocial behavior and substance abuse, factors associated with suicide. Finally, a peer support program that improves the functioning of youths and increases their use of social support networks might be expected to reduce their rates of suicide and premature death from other causes (such as alcohol-related traffic fatalities and homicide).

FIGURE 6.
Rationale for Peer Support Programs to Prevent Youth Suicide



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Research Findings

The effect of peer support programs in preventing youth suicide has not been evaluated. Preliminary data from the Link-Up program in St. Paul, Minnesota, indicate that students who participate in the peer support program show improvement in academic performance, school attendance, and self-esteem. The relationship between these behaviors and suicide has not been established, and the effect of the Link-Up program on suicidal behavior has not been measured.

Although not designed as suicide prevention efforts, other peer support programs have been developed to prevent such adolescent problems as substance abuse, delinquency, school failure, and school dropout. Among adolescents, these various types of high-risk behaviors are often interrelated (Barnes and Welte, 1986; Donovan and Jessor, 1985; Elliott, Huizinga, and Menard, 1988; Kandel, 1978). For instance, results of a national survey of high school seniors (Johnston, Bachman, and O'Malley, 1986) showed a high incidence of delinquency and school problems among drug users. The seniors who abstained from drugs did not completely avoid other problems: a fifth of these students reported committing minor theft, receiving traffic tickets, cutting classes, or drinking heavily. These problems, however, occurred among a third of marijuana users and among almost half of students who frequently (four or more times) used illicit drugs (other than heroin). The relationship of these behaviors to youth suicide is unknown.

The results of evaluations of these programs (reviewed by Dryfoos, 1990) suggest that peer support programs may be useful in reducing high-risk behaviors among youth. For instance, in a metaanalysis of 143 adolescent drug prevention programs, Tobler (1986) found that, although programs had a greater impact on knowledge than on attitudes, they did appear to reduce the frequency of substance abuse (the reduction being much greater for cigarette smoking than for the use of other substances). Of particular interest was the finding that peer-influence programs, which focused on such areas as developing refusal skills and enhancing interpersonal competency, were more effective than other program models (such as knowledge-oriented programs and affective-education programs that focused on building self-esteem). Although all the program models appeared to reduce cigarette use, only the peer-influence programs reduced the use of alcohol and marijuana. Similarly, results of a metaanalysis of data from 14 studies of school-based drug education programs showed that programs taught by peers were more successful than those taught by adults (Bangert-Downs, 1988).

The applicability of these studies to suicide prevention needs to be established. However, the success of peer support programs with other high-risk behaviors suggests that the programs have potential as an intervention approach to preventing youth suicide.

Illustrative Programs

We identified a small number of peer support programs, though other programs may exist that were not identified as suicide prevention efforts. Two examples of peer support programs illustrate the nature of this type of suicide prevention program.

Link-Up in St. Paul, Minnesota. This school-based program is aimed at junior and senior high school students who are identified as at risk on the basis of prior problems of absenteeism, marginal academic performance, and personal problems identified by school staff. The

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program involves a series of small group sessions in which participants are taught to give each other support by listening and providing friendship. The groups help students to orient themselves with the resources of the school, to develop friends, and to better cope with a new school environment. Preliminary data indicate that students show improvement in academic performance, attendance, and self-esteem (though without a comparison group, these findings are difficult to interpret).

The Youth Suicide Prevention Project in Bothell, Washington. This is a peer support program for youths who have made a prior suicide attempt. The program offers weekly group meetings that give participants an opportunity to develop peer support and improve their coping skills. The groups are designed to reduce the alienation and isolation felt by participants. None of the 350 youths who have participated in the program have died from suicide as of the fall of 1991. This project has not been formally evaluated.

These programs are described at the end of this chapter.

Evaluation Needs

Although staff in these programs give positive reports about the effects of the programs, the efficacy of such programs in terms of suicide prevention must be formally evaluated. The most important question, of course, is whether these programs result in changes in suicidal behavior. It would also be useful to determine whether participants' levels of suicidal ideation change.

Short of measuring these changes, studies could be used to evaluate whether the program affects what are postulated as "high-risk" behaviors. Although changes in such behaviors will not necessarily reduce suicide, they do provide useful indicators of other, positive program effects. Potential indicators include:

- **Changes in school performance**
  - Changes in attendance
  - Changes in academic performance
  - Changes in antisocial behavior
  - Graduation from high school
- **Changes in vocational performance**
- **Changes in interpersonal behavior**
- **Changes in psychological mood and outlook**
  - Changes in depression
  - Changes in self-esteem
  - Changes in attitude toward the future
- **Changes in drug and alcohol use**

Almost all of these indicators are addressed by the programs mentioned, and data exists in the form of questionnaire results and personal observations. To more rigorously evaluate the effects of the programs, researchers would need to identify and collect data from a comparable group of youths who did not participate in the program and ultimately to relate changes in these intermediate indicators of risk to suicide prevention. With such a comparison group, we could better understand the cause of changes that may be observed among program participants.

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Summary

Peer support programs are designed to help youths who may be at risk of suicide develop peer relationships and coping skills. Peer support programs may also help reduce antisocial behavior and substance abuse (factors that may be associated with suicide risk). Efforts must be made to assure that youths do not feel "labeled" because they are participating in these programs. Furthermore, the programs should not be viewed as a substitute for professional counseling. Finally, we believe that great care should be taken to ensure that there are no adverse effects from involving troubled or suicidal youths, or youths with a history of such problems, in peer support programs.

In this study, we identified two peer support programs, each with a distinctly different approach to identifying at-risk youth:

- Link-Up in St. Paul, Minnesota, provides a series of small-group sessions for students identified by school staff on the basis of absenteeism, marginal academic performance, and personal problems. Preliminary evaluation data indicate improvement in attendance, academic performance, and self-esteem. The effect of the program in preventing suicide is not known.
- The Youth Suicide Prevention Project in Bothell, Washington, offers a peer support program for youths who have made a prior suicide attempt.

These programs seem promising; however, we need to evaluate whether they improve the psychological and emotional health of those participating or reduce their suicidal behavior, and whether there are any unforeseen adverse consequences from such programs.

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Peer Support Programs: Program Descriptions

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Link-Up

Location: St. Paul, Minnesota
Contact: Don L. Keys, Ph.D., (612) 699-2657

Targets: Junior and senior high school students.
Years in operation: 7
Source of funding: Schools and donations. Schools provide the initial funds; once the program is up and running, students keep it going at very low cost.
Amount of funding (per year): The initial start-up cost is $300, which includes the cost of materials for up to 16 youth facilitators and the training of 1 adult facilitator. After this initial start-up expense, the cost is about $2.50 per child per year.

Program description: This is a school-based peer support group for students perceived as potentially at risk for suicide. The focus is peer-helping and peer friendship; the goal of the program is not to build junior counselors but to help youngsters establish friends and to identify resources that are available when a friend needs more help or has problems that need adult intervention. Link-Up builds skills in three areas that are commonly lacking among high-risk youth: peer support, coping skills, and self-esteem.

Exposure: Five training sessions are conducted at the senior high level and four at the junior high level. The extra session in high school is used to identify resources outside the school setting, but at the junior high level, emphasis is on in-school resources only.

The initial training for setting the program in place includes the training of up to 16 youths and 1 adult facilitator. After this initial training, the facilitator, who will complete four to five sessions, will be able to facilitate the program.

Coverage: By 1989, several thousand adolescents in 9 Minnesota cities had participated. By 1991, Link-Up programs were operating in 26 states.

Content/topics: Many of the topics covered in the training are geared to help the participants in the group get to know each other. Group members are taught how to support each other by listening, caring, and providing friendship; they need to develop healthy self-concepts, enhance their self-esteem through positive peer support, develop coping skills, and learn how to communicate effectively with their peers and family. They need support from their peers, family, teachers, and others, and they need to learn how to ask for help when they need it. The program is designed to provide ongoing reinforcement for the youth.

Referral/selection procedures: Youths at the junior high level are selected for participation in Link-Up by the school staff in consultation with the Link-Up advocate. The class is selected to include a balance of both high academic achievers and those who are not doing as well in school. Some senior high participants are recruited during lunch periods; others are referred by school counselors, teachers, or other school personnel.

Evaluation: Students are tested at the beginning and the end of each program segment and at the beginning and end of school quarters (trimesters). Testing is done by using an instrument specifically designed for Link-Up that covers self-esteem, coping skills, and networking skills. The test measures the self-image of the students and how they believe that others see them.

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Findings: An average of at least 84 percent of the students have shown improvement in at least two of the three tested areas. Students who regularly attend Link-Up have improved their academic performance and attendance.

The University of Minnesota did an independent study of risk factors among junior and senior high school students throughout the State of Minnesota. The study covered a 5-year span that coincided with the pilot tests of the Link-Up Program at Patrick Henry Senior High School and at Franklin Junior High School. The results available for the high school indicated a 67-percent decrease in absences and school performance problems among the students who participated in the program. The Link-Up program was the only significant change in student activities during this period. Results for the junior high school are not yet available.

Data available: Data were maintained on pilot program students for 5 years. Individual schools may collect data for extended periods if the students are available and willing to provide data.

Special population outreach: The Link-Up program is especially designed to provide easy access and aggressive outreach to high-risk youngsters. It addresses the needs of gay and lesbian youth and youth who are considered "near drop-out," and it reaches those students who are perceived as "most popular" by others but who identify themselves as lonely and isolated. The program helps new and re-entering students adjust to the school environment.

Related components: None.

Address: Link-Up
Don L. Keys, Ph.D.
518 South Saratoga
Saint Paul, MN 55116

Reports: Brochure, articles, background information, and an informational VHS videotape are available on the program. (Materials are available on request, and the program manual is available for $25.00 from Don L. Keys.)

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Youth Suicide Prevention Project

Location: Bothell, Washington
Contact: Brian Jung, M.A.; Vicki Jung, M.A., (206) 487-3355

Targets: At-risk youth less than 24 years of age.
Years in operation: 5*
Source of funding: Corporations, foundations, private donations, service clubs, city and county funds, and fundraising efforts.
Amount of funding (per year): Not reported.

Program description: The agency served at-risk youths (24 years old and younger) and their families. Besides peer support groups, services provided included survivors' support groups, a parents' support group, emergency services and crisis intervention, educational presentations to schools and the community-at-large, in-service training, and phone crisis counseling during business hours.

Exposure: The following groups were ongoing and met on a regular basis: two peer groups and a parents' support group met weekly, and a survivors' support group met monthly. In addition, a newsletter for services of suicide was published monthly; a quarterly newsletter for educating and fundraising was distributed to the community-at-large. Crisis intervention was provided as needed.

Coverage: Over 350 youths have attended the peer support groups.

Content/topics: The primary topic was suicide and the problems that participants believed contributed to their suicidal ideation. Topics included self-mutilation and self-harm; the grieving process; the identification and expression of feelings; problems with parents, boyfriends or girlfriends, and peers; drugs and alcohol use; parents' drug abuse; sexual abuse; financial problems; employment; self-esteem versus self-identity; eating disorders; problems in school relating to grades, teachers, and "belonging"; and life transitions, such as moving into adulthood.

Referral/selection procedures: Groups made up of ideators (youths who held thoughts of suicide), attempters (youths who had made one or more attempt), survivors (youths who had lost a friend or family member to suicide), and concerned friends (youths who were worried about a friend who might be at risk of suicide). Referrals came from concerned friends, parents, schools, hospitals, police, and at-risk youths themselves.

Evaluation: Follow-up phone calls were done periodically to determine the suicidal ideation of group members who had not attended for several months. Records were also maintained on suicide attempts of members before and after they joined a group. Follow-up was done with the medical examiners' offices to determine whether any group members committed suicide.

*The peer support program is now being continued under private auspices rather than as part of the Youth Suicide Prevention Center.

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Findings: Information gathered from the King County and Snohomish County Medical Examiners' Offices confirmed that to date one person served through the agency's counseling and intervention program had committed suicide. Whether this represents more or fewer suicides than would otherwise be expected to occur in this high-risk population has not been determined.

Data available: Data is available on 450 youths, consisting of some or all of the following:

- Psychosocial history and demographics of client and client's family (intake)
- Risk-assessment sheet
- Suicide Ideation Questionnaire (Reynolds 1987) (intake and postgroup)
- Reynolds Adolescent Depression Scale (Reynolds 1987) (intake)
- Suicide attempt/self-harm history (both before and after joining the group)
- After-group assessment form (weekly)

Self-reports of suicidal ideation or intent were collected weekly in the peer support groups. Variable data sets are available for all participants for the duration of the program.

Special population outreach: At-risk youths (12 to 24 years old): ideators, attempters, friends or family members of someone who committed suicide, and "concerned friends."

Related components:

- General suicide education
- Community gatekeeper program
- Crisis center and hotline
- Programs for parents
- Postvention
- School gatekeeper training
- Screening
- Survivors' support program

Address: Brian Jung, M.A., Vicki Jung, M.A.
10116 Main St., Suite 201-B
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Chapter 7
CRISIS CENTERS AND HOTLINES

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Chapter 7
Crisis Centers and Hotlines

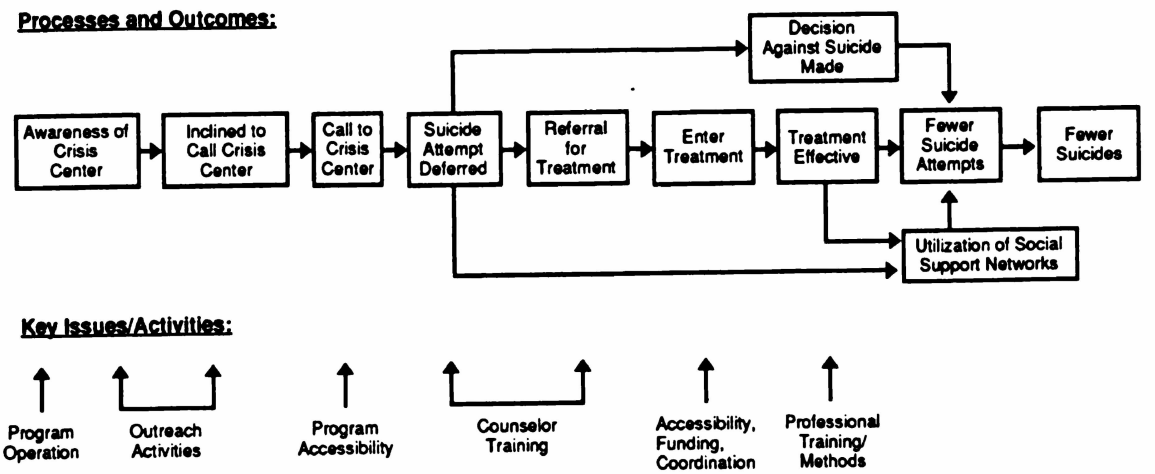
Overview and Rationale

The rationale for crisis hotlines (articulated by Litman, et al., 1965, and illustrated in Figure 7), relies on the premise that suicide attempts are often precipitated by a critical stressful event, are often impulsive, and are usually contemplated with substantial ambivalence (Shaffer, et al., 1988). Hotlines are designed to respond to the crisis and to deter a caller from self-destructive acts until the immediate crisis has passed. Crisis center hotlines offer an immediately available source of support; they do not require a trip to a clinic; and they are anonymous, allowing callers the opportunity to say anything in a context in which they may feel secure and in control.

Most crisis centers provide a telephone service that is available at least during the night (when traditional mental health services may not be available), and many operate 24 hours a day (Franklin, et al., 1989). These centers are typically staffed by volunteers. Some hotlines targeting adolescents are staffed by teen volunteers, but most hotlines serve clients of all ages, and volunteers are 18 years of age and older (Simmons, Comstock, and Franklin, 1989).

Many of the hotlines are part of a more comprehensive suicide prevention program, with strong linkages to schools and to mental health services. Many programs offer drop-in counseling services, whereas others offer only information and referrals, linking callers with existing community services.

FIGURE 7.
Rationale for Crisis Center and Hotline Programs to Prevent Youth Suicide



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Research Findings

Evidence of the effectiveness of crisis centers and hotlines in preventing suicide is scarce and somewhat inconsistent. Results of an evaluation of changes in suicide rates in two British communities provided evidence of the effect of a hotline program (Bagley, 1968). Bagley compared suicide rates in a community following the introduction of a Samaritan suicide prevention program with the rates in a community with a 24-hour telephone crisis service staffed by clergy or laymen who referred callers to a psychiatric specialist. The study results showed a 5.8 percent decrease in the average suicide rate in the community with the Samaritan suicide prevention program and a 19.8 percent increase in the control community.

Results of studies in the United States (Bridge, et al., 1977; Weiner, 1969; Lester, 1974) have not duplicated this finding. Unfortunately, such ecologic studies (typically regression designs comparing cities with and without crisis hotlines) are not designed to measure program effects at the individual level—effects that, even if real and substantial, may not be evident at the community level.

In one study (Miller, et al., 1984), researchers found a small but statistically significant difference in the rate of suicide among white women 25 years of age and younger between communities with and without crisis center hotlines. Since young women are the most frequent users of hotlines, these results suggest that hotlines can have an effect on suicide rates among people willing to make use of their services.

Although there have been few evaluations of how hotlines affect behavior, there has been considerable research on hotlines, the results of which may help others develop effective hotlines (Auerbach and Kilmann, 1977; Dew, et al., 1987; Shaffer, et al., 1988; Stein and Lambert, 1984). Here are some conclusions of this research:

- **Hotlines reach an important audience.** Hotlines appear to serve an otherwise under-served population. Results of a survey of 3,000 college freshman (King, 1977) showed that only 8 percent of hotline callers were receiving other mental health services. In a study of a communitywide hotline in Los Angeles, researchers found that the census tracts from which calls were made corresponded closely to the census tracts with the highest rates of suicide (Lester, 1971). In a follow-up study in Cleveland, researchers found that callers to hotlines are indeed at higher risk of suicide than is the general population (Sawyer, Sudak, and Hall, 1972), although only 6 percent of those who committed suicide had been in contact with a crisis center. In a statistical "synthesis" of studies of crisis intervention, Dew, et al. (1987), found that crisis center hotlines were successful in attracting the kind of persons they wanted to attract.

- **Adolescents need to be made more aware of hotlines.** In studies of general hotlines, researchers have found that adolescents constitute only a small proportion of all callers (Litman, et al., 1965) and that adolescent suicide attempters may be significantly less aware of crisis services than adult attempters (Greer and Anderson, 1979).

  There is evidence that targeted advertising can increase awareness of hotlines among particular groups. For instance, following advertisement of the services of a crisis center among the high school population, 98 percent of high school students recognized the name of a specific crisis center, and during the next 3 years, 5.6 percent of them, mostly girls, made use of its services (Slem and Cotler, 1973).

- **Hotline service to young men needs to be improved.** Results of numerous studies have indicated that young women call hotlines more frequently than do young men (King,

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1977; Morgan and King, 1975; Shaffer, et al., 1988; Slem and Cotler, 1973). Results of a survey of 3,000 college freshman to identify users of the hotline in a college community showed that young men who had used the hotline were significantly less satisfied with the service than were young women (King, 1977). This finding may have been a function of the type of problems involved in the calls. In another study (Getz, Fujita, and Allen, 1975), researchers found that callers with problems about parents felt more positively about the crisis intervention than callers who had serious mental health or drug problems. Both sexes reported greater satisfaction when their call had been taken by an opposite-sex operator.

- **Training is important.** Training appears to be important in determining the kinds of information and counseling provided by volunteer hotlines. Some researchers found that untrained volunteers were often overly directive, offering advice prematurely on the basis of inadequate information (Knowles, 1979; McCarthy and Berman, 1979). In another study, researchers found that untrained volunteers were less skilled than professionals in eliciting relevant past history and integrating caller information (Hirsch, 1981). Several researchers have found that training improved the quality of information provided and increased the frequency with which empathy and warmth were expressed in the telephone conversation (Bleach and Claiborn, 1974; France, 1975; Gentler, 1974; Kalafat, Boroto, and France, 1979). In one study, only volunteers who had received preliminary training improved with experience (Elkins and Cohen, 1982).

  These types of variables are related to the outcome of the calls. In one study of a hotline in Florida (Knickerbocker, 1972) in which researchers used independent ratings of tape-recorded calls, they found a moderate positive correlation between clinical effectiveness measures of empathy, warmth, and genuineness, and decreases in caller anxiety and depression from the beginning to the final segment of the call. (Caller segments were rated without the rater hearing the volunteer's voice.) Furthermore, in a study of a community hotline, researchers found that callers were more apt to show up at an appointment at a crisis center if the operator had given concrete directions during the initial hotline call (Slaikeu, Lester, and Tulkin, 1973; Tapp, Slaikeu, and Tulkin, 1974), or if callers rated the hotline counselor as showing greater understanding of the caller's problem (Slaikeu, Tulkin, and Speer, 1975).

- **Follow-through should be improved.** Follow-through of suggestions for action and receipt of counseling may be influenced by how much outreach the crisis center provides. Results of several studies suggest that compliance can be improved if the volunteer or clinician makes an actual appointment for the caller rather than simply providing the caller with a number to call. In one study, the compliance rate for attempters seen in an emergency room was 82 percent when an appointment was made versus 37 percent when only the name of a clinic was provided (Kogan, 1975). In another study, 55 percent of adults who called a hotline kept at least two subsequent appointments at a mental health treatment clinic when the initial appointment was made for them, compared to 37 percent of callers who were simply provided a name and phone number (Rogawski and Edmundson, 1971). Sudak, et al. (1977), reported compliance rates of 60 percent for a service in Cleveland where hotline operators routinely made clinic appointments (instead of relying on the caller's own initiative) and undertook further follow-up if an appointment was not kept.

  Training in referral procedures is important. For instance, the results of one study of typical calls to hotlines showed that 15 percent of callers were given inaccurate

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information by counselors and that callers were frequently given a wide range of alternatives without the counselors' screening the one most appropriate for the callers (Bleach and Claiborn, 1974).

Illustrative Programs

In the United States, there are several hundred telephone hotlines and crisis centers (a listing of these centers is available from the American Association of Suicidology in Denver, Colorado). The programs described in this report have been included because of their time in operation, the extent of their outreach activities, and their linkages to local mental health centers and other youth suicide prevention programs.

Program	Rationale for Inclusion
Suicide Prevention Center Dayton, Ohio	• Eight years in operation • Comprehensive program
Youth Crisis Hotline Baltimore, Maryland	• Expanding to statewide hotline with local referrals
Crisis Center of Collin County Plano, Texas	• Eight years in operation • Linkages to school-based suicide prevention programs
Suicide Prevention and Crisis Call Center Reno, Nevada	• High-risk area served • Comprehensive program • Some evaluation efforts underway

Evaluation Needs

Crisis centers and hotlines may serve a variety of important functions, only one of which is the prevention of suicide. Nevertheless, suicide prevention is one of the key reasons why many crisis centers and hotlines are established, so it is important to determine how effective they are in this regard.

The question of whether crisis centers and hotlines prevent suicide can be subdivided into several questions:

- **Are the people who use crisis centers at high risk of suicide?** As noted, the demographics suggest that crisis centers and hotlines are used by young women, a group generally at relatively low risk of suicide. The young women who use the crisis centers and hotlines may, however, be at high risk.
- **Would people who use the crisis centers and hotlines commit suicide if these centers and hotlines were not available?** Perhaps people at high risk of suicide who use hotlines would seek care through mental health centers or other mental health resources in the community if hotlines were unavailable. It is therefore important to determine whether crisis centers and hotlines increase the referrals of people who might otherwise not use community mental health resources.

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- **Do people who use crisis centers and hotlines commit suicide at a lower rate than otherwise similar people who cannot use hotlines (because this service is not available or is unknown to the suicide victim)?** Such questions might be answered by comparisons between locales with and without crisis centers or hotlines; studies of this design are, unfortunately, very challenging to conduct and interpret.

Two questions about intermediate objectives should also be addressed:

- **What encourages high-risk youth to use hotlines?** Obviously, hotlines can only be effective if they are used. Thus, we need to know what kinds of outreach activities are effective in getting high-risk youths, particularly young men, to use the hotlines.

  In this regard, it might help if hotlines around the country could periodically share information. Most hotlines keep track of the basic demographic characteristics of their callers (e.g., age category, sex, and nature of the call). If programs shared this information, hotlines that are serving a relatively high proportion of high-risk youth might be identified and the methods used by these hotlines to publicize their services could then be shared with other hotlines. At the individual program level, the demographics of callers could be monitored for changes resulting from intensified outreach or publicity efforts.

  Another way to assess the use of hotlines would be to conduct a community survey to assess people's knowledge of the hotline and factors that might influence their willingness to use it. If the survey is conducted as part of existing school-based or other community surveys, this information might be gathered at relatively little cost. Such surveys might provide information about knowledge of and perceptions about the hotline that could influence its use.

- **What makes hotlines effective in convincing callers to receive counseling?** Another important issue is how hotline programs influence the behavior of callers. The method of determining this will vary with the confidentiality procedures in place in different programs and situations.

  — *Follow-up of referrals.* Some, but not all, callers will be referred to a crisis center or a mental health clinic. In some situations, a caller will provide a name that can be used to check whether a follow-up visit was made. This will most likely be the case when callers are referred to the center or clinic that operates the hotline, thus enabling officials to determine whether a client kept an appointment without violating confidentiality procedures.

  In other programs, because callers are anonymous, follow-up by name is not possible. In such programs, data might be obtained by arranging for personnel in the treatment programs receiving referrals from the hotline to ask clients at first contact how they came to their agency. Treatment programs could then provide aggregate data on the number of new clients referred by the hotline.

  — *Follow-up of callers.* Not all callers will receive a referral to another setting. In many of these cases, callers will be asked to make a specific change or take a specific action. In these situations, studies might be conducted by asking the callers to call their counselors after a specified period to let them know how things are going.

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Summary

Many programs have crisis centers or hotlines to help deal with suicidal people. These programs are based on the premise that youth suicide can be precipitated by a stress event and that suicidal feelings are almost always temporary and accompanied by ambivalence. Hotlines offer an opportunity to help deter self-destructive acts until the immediate crisis has passed and to help callers connect with mental health resources.

Although hotlines may provide a variety of important services to callers, their effectiveness at reducing the rate of completed suicide to the community has not been established. Researchers have found that the way volunteers handle calls can influence the mood of callers and the likelihood that callers will keep appointments for counseling. The results of one study indicated that hotlines may reduce the rate of suicide among young women. On the other hand, hotlines as now constituted tend to be used by populations at relatively low risk of suicide (young women). The effectiveness of hotlines on the rates of suicides among young men has not been demonstrated.

If the rationale for this approach is sound, the effectiveness of hotlines and crisis centers for youth suicide prevention might be improved by increasing outreach to young males, requiring consistent training of volunteer staff, and taking steps to improve follow-through with callers.

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Crisis Centers and Hotlines: Program Descriptions

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Suicide Prevention Center Programs

Location: Dayton, Ohio
Contact: Linda Mates, LPCC, (513) 297-9096

Targets: Students (junior and senior high school), gatekeepers.
Years in operation: 25
Source of funding: United Way, the state, and community taxes.
Amount of funding (per year): $130,000.

Program description: The Suicide Prevention Center (SPC) provides a broad range of crisis support services, including a 24-hour crisis hotline, training of professionals (teachers, service providers, clergy, physicians, police, etc.), and a crisis response team for postvention work for individuals or groups. Specific programs are:

Child Puppet Program: Started 7 years ago, this program for younger children (grade school) helps them deal with the grief involved in the death of a loved one.

Lives In Transition: This program targets youth with physical disabilities (grades 4-6).

Besides identifying those most at risk, educating students and gatekeepers, and intervening with students after the death of a friend or family member, the SPC also works directly with students through intervention and follow-up. When necessary, adolescents may be hospitalized; child services and the police are consulted when youths are not in school.

Coverage: Countywide.

Evaluation: Several evaluations are ongoing—quality assurance, client satisfaction, and client outcome.

Data availability: Intervention, referral, and follow-up information is available. Data are being collected on calls to the hotline, and a mechanism is in place for following up referrals.

Related components:

- General suicide education
- Crisis center and hotline
- Gatekeeper training
- Parent programs
- Postvention

Address: Linda Mates, LPCC
Executive Director
Suicide Prevention Center, Inc.
PO Box 1393
Dayton, OH 45401

Reports: Program manuals and evaluation materials, pamphlets.

Advice to others interested in starting this type of program:

- Research your community
- Build coalitions
- Train adults first

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Youth Crisis Hotline

Location: Based in Baltimore but serves state of Maryland
Contact: Henry Westray, Jr., M.S.S., L.C.S.W., (301) 225-5060

Targets: Youth (ages 15-24).
Years in operation: The program has been fully operational for 2 years. The Governor's Task Force on Youth Suicide Prevention convened in 1985 for 1 year. Since October 1989, all school districts have received funding for Youth Suicide Prevention programs.

Source of funding: Money for the Task Force, the Maryland Department of Education's Youth Suicide Prevention School Program, an annual statewide conference, the Youth Crisis Hotline, and the program coordinator's salary was provided by the state. Additional resources were provided by Marylanders Against Youth Suicide (MAYS), various corporations, and a local television station.

Amount of funding (per year):

- Task force (1985 to 1986 only) — $60,000
- State coordinator's salary — $40,000
- Youth crisis hotlines — $150,000
- Maryland Department of Education (school programs and annual conference) — $161,000
- Marylanders Against Youth Suicide (MAYS) — $5,000
- Corporations and a local T.V. station (1990–1991 only) — $80,000

Program description: A new statewide hotline was implemented in August 1990. After calling an 800 number, callers are directed to the nearest of six centers. Each center issues monthly reports on the types of calls received and quarterly reports based on this information.

While the program is included in this section because of the statewide coverage of its hotline, one of the distinguishing features of the program is its involvement with a number of youth suicide prevention activities. These include formation of a task force that collected information on youth suicide prevention efforts across the state. All counties in Maryland and Baltimore City provide prevention programs for youth, parents, schools, and communities. There are youth peer leadership groups in which youth leaders are trained to assist troubled peers and make appropriate referrals. All young people receive training from the Department of Education and local prevention coordinators.

The Student Assistance Program (SAP) is in place in public schools to identify troubled youths and refer them to appropriate services. Suicide prevention education is a major component of the mandatory training for all SAP members, who are adult professionals within the school.

Colleges and universities across the state were invited to share their policies and procedures for dealing with students in emotional crisis or who are suicidal and to provide information about campus programs targeted to youth suicide prevention, intervention, or postvention. Most colleges and universities reported that they have no written suicide prevention policies, but most had a written policy for dealing with students who reported being suicidal.

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The state coordinator and the Governor's Interagency Workgroup for Youth Suicide Prevention direct and oversee youth suicide prevention activities in Maryland. The Interagency Workgroup and representatives from various county and city agencies, youth advocacy groups, and other organizations have formed four committees that focus on major areas related to youth suicide. These committees are the Community Information and Resources Committee, the "At-Risk" Populations Committee, the Grant Proposal and Research Committee, and the Cult Awareness Committee.

Outreach: With the exception of the Grant Proposal and Research Committee, each committee has conducted educational workshops around the state in order to educate professionals and the community.

- The "Lifeline, Youth Suicide Prevention Campaign" included a television special on youth suicide prevention and a year-long media campaign sponsored by the Maryland State Department of Health and Mental Hygiene, MAYS, Pizza Hut, and Fox 45 Television Station. This campaign began September 1990.
- A second media campaign was begun August 1990 in cooperation with the start-up of the Youth Crisis Hotline. Included was a "kick off" and a reception, which featured the governor of Maryland, who proclaimed August 8 as Youth Crisis Hotline Day in Maryland. Press packets were sent to the media.
- The governor proclaimed October to be Youth Suicide Prevention Month. Press packets were sent to local media outlining statewide events during this month. Two of the major events during this month were a statewide Conference on Youth Suicide Prevention and a "Kick-Off" program to start a calendar of events throughout the state.
- Numerous television and radio stations, as well as the print media, featured the Youth Crisis Hotline and Youth Suicide Prevention activities in Maryland. The State Department of Health and Mental Hygiene distributed flyers, t-shirts, and over 700,000 stickers and wallet-sized cards featuring the numbers of hotlines across the state.
- The Maryland State Department of Health and Mental Hygiene and MAYS coordinated training for various groups and organizations across the state.

Coverage: Statewide.

Evaluation: Annual programmatic and statistical review by the state.

Data availability: Governor's Task Force Report on Youth Suicide in Maryland. Selected data are collected on the youth crisis hotline. Evaluations were completed by participants of youth suicide prevention conferences held in 1989 and in 1990.

In January 1990, a statewide survey was sent to all county commissioners and executives in order to determine the prevention activities in their jurisdictions. An attempt was also made to sensitize this group to the problem of youth suicides.

In November 1990, a survey was sent to selected schools, police departments, and child care agencies across the state in order to investigate suicide and cult-related activities.

Special population outreach: Several workshops have been done to educate professionals and others concerning the problems of gay youth. The state has been working closely with various gay organizations in this regard. The "At-Risk" Populations Committee has prepared a training module related to gay youth.

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African-American Suicide. Maryland's 1990 Youth Suicide Prevention Conference included a workshop titled "African-American Suicide." The state has worked collaboratively with the Baltimore City Health Department, Baltimore City schools, and other organizations in order to focus on this increasing problem.

Related components: Youth Crisis Hotline Centers have established linkages with and referred callers to local mental health centers and to other needed community resources across the state.

Address: Henry Westray, Jr.
Coordinator for Youth Suicide Prevention
201 West Preston Street
Baltimore, MD 21201

Reports:

- Task Force Report, 1987.
- Task Force Report, 1990 Update.
- "Developing Community Resources" — Report on the Second Annual State Conference on Youth Suicide Prevention, October 9, 1990.
- Brochures and other items about and distributed by individuals and organizations involved with hotline activities.

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Crisis Center of Collin County

Location: Plano, Texas
Contact: Barbara Blanton, M.S.N., R.N., (214) 881-0088

Targets: All ages (no separate teen line).
Years in operation: 8
Source of funding: Grants, fund raising, donations, some city and county funding.
Amount of funding (per year): $156,000.

Program description: This is a 24-hour telephone hotline service staffed mostly by volunteers who have been trained in suicide prevention techniques. Established in 1984, it is certified by the American Association of Suicidology. A telephone log of all calls is maintained, and each call lasting more than 5 minutes is extensively documented. There is no separate teen line, but volunteers do request the name of the school from all young callers.

In special circumstances, follow-up on hotline calls is conducted. Calls from students who seem to be at risk of injuring themselves or others are pursued by contacting the appropriate school counselor. Hotline volunteers also network to provide emergency help for all at-risk persons. As part of the suicide prevention program in the schools, they notify school counselors of all at-risk students; they do the same in the postvention program.

Outreach: Wallet cards are handed out to students as part of the general suicide education component. Informational brochures, stickers, and posters are distributed community-wide. A Survivors of Suicide support group meets three times a month. Community education of adults is also a high priority.

Coverage: Countywide.

Referral procedures: Referrals are made to local mental health facilities and other community agencies. Staff members also receive referrals from teachers and students, especially after education presentations.

Evaluation: No specific evaluation of the hotline services has been conducted; however, the services have always gotten positive verbal feedback. A letter is being sent to all agencies to which clients are referred asking for feedback. To assess the impact of the program, hotline counselors collect survey data from callers when appropriate. School-based programs are evaluated through forms to teachers, counselors, and volunteer presenters. Pre- and posttests are given to students to evaluate knowledge and presentation.

Data available: Telephone logs are used to collect data on demographic characteristics, on referrals, on the type of or reason for the call, and on whether it is a repeat call. Volunteers are often unable to get the name and location of callers, which makes follow-up difficult.

Special population outreach: Outreach efforts are targeted at persons of all ages: teachers, counselors, school administrators, businesspersons, persons in senior citizen centers, suicide survivors, physicians, and funeral home directors.

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Related components:

- School gatekeeper training (high school and college)
- Community gatekeeper training
- General suicide education (youth, college students, adults)
- Postvention after a suicide, homicide, unintentional injury/death, or molestation by a teacher
- Survivors' groups

Address: Barbara Blanton, M.S.N., R.N.
Executive Director
Crisis Center of Collin County
PO Box 861808
Plano, TX 75086

Reports:

- Program description (brochures)
- High school curriculum
- Middle school curriculum
- Evaluation forms

Advice to others interested in starting this type of program: Begin with a survey of available services and gaps in services. Coordinate with existing programs, especially the local community mental health center. Community support must be established prior to offering services. Gather input from as many sources as possible (e.g., schools, hospitals, community agencies, community leaders, local government, and private practitioners).

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Suicide Prevention and Crisis Call Center (SPCCC)

Location: Reno, Nevada
Contact: Roger Simon, Executive Director, (702) 323-4533

Targets: Teens, school personnel, parents.
Years in operation: The SPCCC has been in operation for 24 years.
The Youth Program has been in operation for 4 years.
Source of funding: United Way, grants, and service-in-kind with University of Nevada-Reno. The Youth Program receives additional funding through community block grants and the E. L. Cord Foundation.
Amount of funding (per year): The SPCCC has a budget of $145,000 and the Youth Program has an additional $15,000.

Program description: The Suicide Prevention and Crisis Call Center offers a 24-hour crisis line, a youth suicide prevention program, a support group called Survivors of Suicide, elderly outreach, a 24-hour child abuse and neglect hotline, a child abuse and neglect prevention program, and a face-to-face rape crisis intervention program. The hotline is part of a comprehensive program offering training and education to school staff, students, and parents on teen suicide and its prevention. The hotline provides information on suicide, emotional support, crisis intervention, and referral for all callers, regardless of the type of problem. The program is especially important, since Nevada has the highest suicide rate in the United States.

Outreach: The elderly, teens, rape victims, and the general population.

Coverage: Statewide. (The center has an instate toll-free number.)

Evaluation: The center is conducting a community survey on the entire Crisis Call program, especially the hotline. The survey is being done in conjunction with a student from the University of Nevada-Reno as part of his thesis. No follow-up evaluation is planned because of Washoe County School District regulations.

Findings: None yet.

Data available: Several studies on suicide in Nevada have been conducted, including one by CDC. Analyses include rates by age, race, and sex; questionnaire data on calls to the Crisis Call line; and the results of surveys in different high schools conducted before and after training programs. Data from the hotline include the caller's age, sex, and reason for calling.

Special population outreach: Rural and low-income populations are a focus for all SPCCC programs.

Related components:

- General suicide education
- Parent programs
- School gatekeeper training
- Survivors' groups

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Address: Roger Simon
Executive Director
Suicide Prevention and Crisis Call Center
PO Box 8016
Reno, NV 89507

Reports: The program description and results of surveys are available.

Advice to others interested in starting this type of program: For a teen program, a good working relationship with the local school district is essential to developing a rapport with the schools. Our rapport is with the Office of Student Services. Start by making presentations to school staff and then getting permission to educate students. Emphasize that this type of prevention program has been proven to *reduce* the risk of teen suicide in a community. (The fear tends to be that talking about suicide in the schools will increase the number of attempts.) In Washoe County (where Reno is located), the number of teen suicides has dropped by half since 1986 when the program was implemented, even though the total number of suicides in the county has continued to rise.

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Chapter 8
MEANS RESTRICTION

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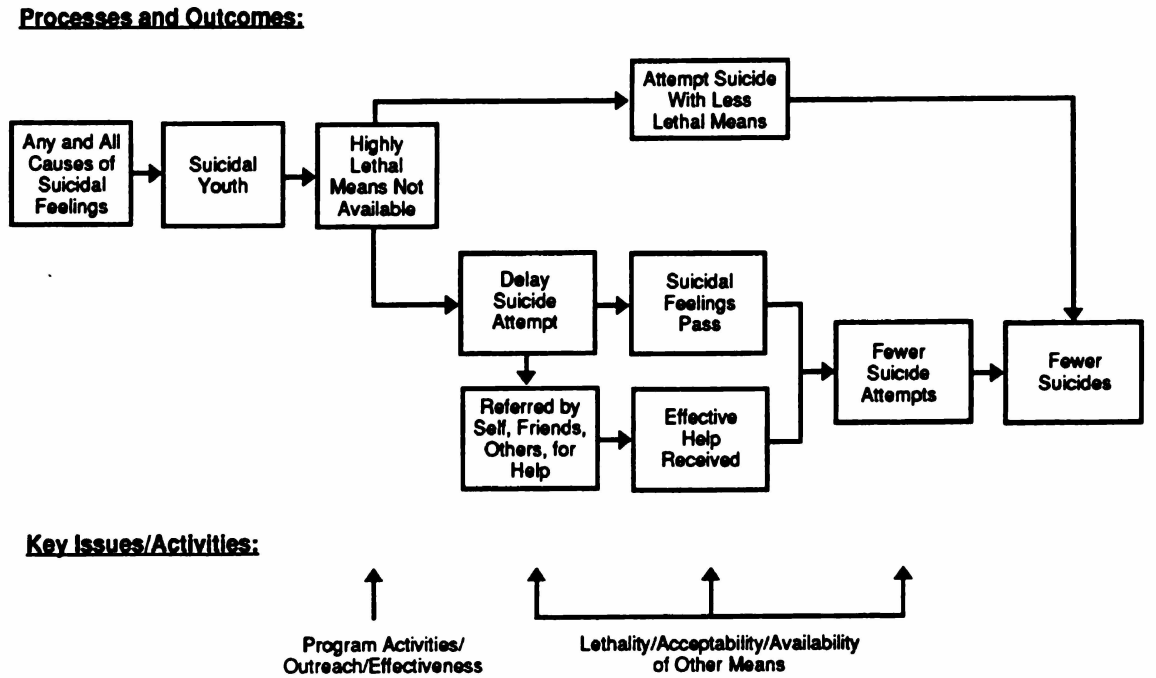
Chapter 8
Means Restriction

Overview and Rationale

Means restriction refers to suicide prevention efforts that reduce access to firearms, drugs, high places, and other common means of committing suicide. The rationale behind this approach is based on several elements. First, impulsiveness appears to play an important role in suicide, especially youth suicide. Unlike adults, most youths who commit suicide do not suffer from concomitant clinical depression at the time of their suicide (Shaffer, et al., 1988). Furthermore, for practically all suicides, ambivalence is a prominent characteristic; i.e., the determination to commit suicide waxes and wanes. For these reasons, many suicide prevention specialists argue that, if lethal means are not readily available when a person decides to attempt suicide, he or she might either (1) delay the attempt, allowing for the possibility of later deciding against suicide, or (2) use a less lethal means, allowing for a greater possibility of medical rescue (see Figure 8). Note that, as illustrated in Figure 8, means restriction has the potential for preventing suicides *even if it does not decrease the incidence of suicide attempts*. This is the only strategy with such potential reviewed in this guide. In addition, at least some portion of impulsive decisions to attempt suicide might never be acted on if substantial efforts were needed to arrange for a method of suicide.

FIGURE 8.
Rationale for Means Restriction Programs to Prevent Youth Suicide



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Ready access to firearms may be a particularly important risk factor for suicide among young people. Among males, 15 to 24 years of age, nearly two-thirds of all suicides are committed with guns (Table 8). Unlike drug ingestions, carbon monoxide poisoning, and many other methods of suicide, a suicide attempt with a firearm is often immediately lethal, leaving little or no opportunity for rescue after the attempt. The accessibility of a firearm may both limit the preattempt opportunity for intervention by others and facilitate impulsive suicidal acts (Boyd, 1983; Kellerman, et al., 1991; Sloan, et al., 1990).

Research Findings

Although more research is needed in this area, many public health practitioners and researchers nevertheless believe that the evidence is sufficiently compelling to strongly advocate that parents prevent their children from having unsupervised access to handguns and other firearms. A comprehensive review of the epidemiologic evidence suggesting the importance of ready access to lethal means in the etiology of suicide is beyond the scope of this discussion.* A few key studies, however, might be mentioned in this context.

Sloan, et al. (1990), compared suicide rates in King County (Seattle), Washington, with that in the Vancouver, British Columbia, metropolitan area, where handgun regulations are considerably more restrictive. The rate of youth suicide from other means (e.g., poisoning and hanging) was similar in both areas, but the rate of suicide by handguns among 15- to 24-year-olds was about 10 times higher in the Seattle area (Table 9). Neither Vancouver nor Seattle, however, substantially restricts access to rifles or shotguns, and in both communities the rates of suicides involving these classes of weapons were similar.

Brent, et al. (1988), compared adolescents who committed suicide with suicidal inpatients who had either seriously considered or actually attempted suicide. Both groups had similarly high rates of affective disorder and family histories of affective disorder, antisocial disorder, and suicide. Availability of firearms in the home, however, was significantly more prevalent

*For a full review of this issue, see: Centers for Disease Control. Prevention of violence and injuries due to violence. In: *Position Papers from the Third National Injury Control Conference: Setting the National Agenda for Injury Control in the 1990s*. Atlanta, Georgia: Centers for Disease Control, 1992:159–254.

TABLE 8.
Methods By Which 15- to 24-Year-Olds In the United States Commit Suicide

	1970		1980		1988	
Method	**Males**	**Females**	**Males**	**Females**	**Males**	**Females**
Firearms and explosives	52.3%	34.2%	64.9%	55.7%	64.2%	45.4%
Hanging, strangulation, and suffocation	21.4%	8.5%	21.8%	11.1%	20.5%	12.3%
Poisoning by solid or liquid substances	10.0%	41.5%	3.9%	17.2%	3.9%	23.7%
Poisoning by gases	9.4%	7.4%	4.9%	7.3%	7.1%	11.5%
Other means	6.9%	8.5%	4.5%	8.6%	4.2%	7.1%

Source: 1970, 1980 percentages: Centers for Disease Control. *Youth Suicide in the United States, 1970–1980*. Atlanta: CDC, 1986.
1988 percentages: Calculated from NCHS Annual Mortality Files (compressed).

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among those who committed suicide, suggesting access to these home firearms may have been an important determinant of completing suicide. More recent research by Brent (1991) provides even stronger evidence that access to guns is a critically important risk factor for adolescent suicide.

Evidence from Great Britain supports the supposition that means restriction can be effective. Before 1957, self-asphyxiation with domestic cooking gas accounted for 40 percent of British suicides (Kreitman, 1976). From 1957 to 1970, the mean carbon monoxide content of domestic gas in Great Britain was reduced from 12 percent to 2 percent. During this time, British suicide rates from carbon monoxide asphyxiation declined sharply until, by 1971, only 10 percent of suicides were committed by this method. Over the same period, all suicides declined 26 percent, suggesting that people did not turn to other, more lethal methods of suicide when the means for gas asphyxiation was restricted. Loftin, et al. (1991), recently published another study showing clear evidence of the effect of reduced access to guns on suicide. In Washington, D.C., a law was passed in 1976 requiring restrictive licensing of handguns in the District. Although many proponents of this law were most interested in its hypothesized effect on homicide, Loftin, et al., showed that rates of both suicide and homicide sharply declined after implementation of this law.

The results of these investigations are compelling. We should note, however, that there are other examples where means restriction was not successful in reducing the overall rate of suicide. In Surinam, for example, a government ban on the sale of undiluted acetic acid (the ingestion of which was a common means of suicide in that country) prevented virtually all suicides by undiluted acetic acid (WHO, 1986). However, the decline in such suicides was almost completely offset by a concomitant increase in suicides by ingestion of paraquat, a potent herbicide widely available in Surinam. Suicides by ingestion of agricultural poisons were already on the rise in Surinam, but the offsetting trends nevertheless raise the question of substitution of one method of suicide for another when the latter is made less accessible.

TABLE 9.
Suicide Rates Among 15- To 24-Year-Olds in King County, Washington, and the Vancouver, British Columbia, Area

Cause of Death	King County	Vancouver Area	Relative Risks
Handgun	4.49	0.47	9.6*
Rifle	1.93	1.25	1.5
Shotgun	0.96	0.63	1.5
Poisoning†	3.85	2.35	1.6
Hanging	2.09	3.76	0.6
Jumping/Drowning	1.28	2.04	0.6
Other	1.12	0.94	1.2
Total	**15.72**	**11.43**	**1.4***

Note: Rates are the number of deaths per 100,000 members of the population. The relative risks shown are for King County relative to the Vancouver metropolitan area. The table is based on 98 youth suicides in King County and 73 youth suicides in the Vancouver area.

*$P<.05$.

†Includes suicides by poisoning, overdose, or carbon monoxide.

Adapted from: Sloan, J.H., Rivara, F.P., Reay, D.T., Ferris, J.A.J, Path, M.R.C., and Kellerman, A.L. Firearms Regulations and Rates of Suicide. *The New England Journal of Medicine* 1990;322:369–373. Reprinted by permission of *The New England Journal of Medicine*.

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Illustrative Programs

Despite increasingly convincing research evidence and broad consensus among suicide prevention specialists that means restriction may be highly effective, none of the programs we encountered in this study had a major component dealing with restricting access to the means of suicide.

Evaluation Needs

The evaluation of a means restriction initiative should be used to establish the chain of events between the initiation of a program and its effects on the availability of means of suicide and on the rate of suicide among young people. The following questions would be important to address:

- What actions were taken to reduce access to means of suicide? Possible actions include education to encourage families to lock up firearms, and passage of state legislation and local ordinances to reduce access to firearms.
- What was the effect of those actions on access to means of suicide? For instance, did changes occur in the levels of handgun purchases or ownership?
- What was the impact on rates of suicide attempts, suicides, and serious injuries?

Finally, because means restriction initiatives are new and barriers to community action exist, it will be important to document how groups successfully dealt with these barriers. This information can then be shared with other communities.

Summary

Means restriction appears to be an important potential strategy in reducing the rate of suicide among young people. The issue of "gun control" is often a contentious one in our society, and including means restriction as part of a broader suicide prevention effort has at least the potential for embroiling the suicide prevention program in controversy. Because of the broad consensus that minors should not be allowed to have unsupervised access to drugs or to lethal weapons such as firearms, however, encouraging parents to secure such items from their teens should not be controversial. Unfortunately, despite the potential of means restriction for reducing the incidence of youth suicide, few of the programs we examined had a major emphasis on means restriction.

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Chapter 9
INTERVENTION AFTER A SUICIDE

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Chapter 9
Intervention After a Suicide

Overview and Rationale

In the event of a youth suicide, one of the aims of crisis intervention involves mobilizing the staff and other resources in order to reduce the risk of a suicide cluster developing. Suicide clusters are groups of suicides occurring closer in space and time than would normally be expected. Such clusters occur predominately among adolescents and young adults. The mechanism generating suicide clusters has not been well established but seems to involve a sort of "contagious" phenomenon, by which exposure to the suicides of friends or others increases one's own risk of suicide. For this reason, schools and other community agencies should be prepared to respond quickly to minimize the likelihood of suicide contagion following one or more teen suicides. In this section, we focus primarily on the potential of crisis response in the prevention of suicide contagion. Crisis response has many other important functions and benefits as well; several are noted in the program descriptions that are listed at the end of this chapter.

The crisis intervention response is guided by a contingency plan developed in advance of the event as a part of suicide prevention efforts. According to the *CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters* (CDC, 1988), the crisis intervention plan should identify a coordinating committee to manage day-to-day response to the situation, and a host agency to "house" the plan, monitor youth suicide, and call the coordinating committee into action. The plan should be activated in the event of a suicide cluster or one or more traumatic deaths that might lead to the development of a suicide cluster, especially if these deaths occur among adolescents or young people.

The CDC goes on to recommend the following in managing a crisis situation:

- The first step taken by the coordinating committee should be to contact and prepare key groups, especially teachers, school counselors, support staff in schools, and others who will deal directly with friends and classmates of the suicide victim. These people should be briefed on the proper means of announcing the death, supporting the reactions of teenagers, and identifying and counseling close friends of the victim and other high-risk persons.
- The crisis response should be conducted in a way that avoids glorifying the victim and sensationalizing the suicide.
- High-risk persons, such as relatives, boyfriends or girlfriends, close friends, and past suicide attempters, should be identified, screened, and, if needed, referred for further counseling.
- Accurate data, in a timely flow, should be provided to the media.
- Elements in the environment that might increase the likelihood of further suicide should be identified and changed. Immediate access to the means of suicide, especially those used by the victim, should be restricted.
- Long-term issues suggested by the suicide cluster should be addressed and used to modify the suicide prevention program in the community.

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Research Findings

In the absence of a crisis, evaluating the adequacy of a crisis intervention plan is difficult. The CDC recommendations include input from local school and government officials who have dealt with actual teenage suicide clusters and reflect what was learned from these situations. Many of the programs included in this report were implemented in response to clusters of teen suicides, and so were born of the need to prevent similar tragedies. Unfortunately, the materials submitted for this resource guide include no evaluations of the effectiveness with which crisis intervention plans have operated.

The advisability of a crisis intervention plan to manage the risk of multiple youth suicides is widely accepted by experts. The CDC recommendations were produced by a workshop with expert participants from education, medicine, local government, and public health and mental health agencies. Also present at the workshop were persons who had played key roles in community responses to nine different teenage suicide clusters.

Illustrative Programs

Virtually all school-based suicide prevention programs and most other suicide prevention programs have some kind of crisis intervention plan. Here are four examples of crisis intervention plans:

Bergen County Task Force on Youth Suicide Prevention
Bergen County, New Jersey

Following the task force recommendation, the county supports a 1-day training seminar in crisis response for municipal crisis response teams identified by community leaders. The task force recommends that teams include an educator, a clergyman, a policeman, a government leader, and a mental health professional from the community.

Department of Crisis Intervention
Dade County Public Schools
Miami, Florida

Every school district in Florida must develop an individual suicide prevention plan as part of a legislatively mandated state plan to prevent youth suicide. As part of its suicide prevention efforts, Dade County (Miami) trains "Crisis Care Core Teams" in every school to counsel staff and the community after a suicide or accidental death of a young person. The department also provides awareness and prevention training to all school employees, whether teachers or support staff.

Project SOAR
Dallas Independent School District
Dallas, Texas

Project SOAR is a school-based program that works with school gatekeepers and provides in-depth training to one staff member from each school to coordinate crisis response and postvention efforts.

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Special Initiatives Team (SIT)
Indian Health Service (IHS)
Albuquerque, New Mexico

As part of its program to provide consultation to violence prevention programs in Native American communities, SIT provides direct technical assistance to communities seeking to develop crisis intervention plans. In 1988, crisis intervention assistance was provided to six Native American communities. The SIT has also developed a document with detailed recommendations for precrisis planning, crisis management, and postcrisis programs for the prevention of suicide cluster episodes. In addition, they will develop and pilot a community-based suicide surveillance system for IHS and tribal mental health programs that will be used to monitor potential crises.

Evaluation Needs

In an evaluation of crisis intervention programs, two factors must be considered: the adequacy of planning for a crisis and the operational effectiveness of the plan in an actual crisis. In the absence of a crisis situation, there is no obvious way to assess the likely effectiveness of a contingency plan. Simulations, or "dry runs," such as those used in emergency response programs, are not ethically acceptable in a situation of teen suicide. The only feasible guide to whether a contingency plan is likely to work is the experience of educators and officials who have managed actual crises. This experience is embodied in the CDC recommendations. The CDC requests further input from people involved with crises for purposes of updating its recommendations.

The outcome variables targeted by crisis intervention programs are suicide attempts and completed suicides. The impact of crisis intervention on these behaviors can be derived only with difficulty in an actual crisis situation, because there is frequently no way to establish a baseline for program effects. The CDC recommends that analysis of the risk factors and characteristics found among the cluster of people committing or attempting suicide be used to identify program elements that need to be developed or strengthened.

As an intermediate step, we need to assess whether persons identified through the crisis intervention were (1) the sort that might not have been identified otherwise, and (2) at high risk of suicide, as determined by screening or interviews with psychiatrists and other mental health professionals.

Process evaluation of the operation of a crisis intervention plan should be part of the program design. Following implementation of the crisis intervention program, participants and key personnel should be asked about their perceptions of the appropriateness of elements of the contingency plan and how well it operated. This input should then be used to revise the plan.

Finally, no matter how well developed a crisis intervention plan might be, it will not work effectively if (1) school personnel are unaware of its content or even its existence, and (2) school staff and community members are not fully supportive of the plan. To ensure a coordinated, cooperative response in the event of a tragedy, school staff and community members should be educated about the content and rationale of a crisis intervention plan.

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Summary

Intervention after one or more youth suicides is designed in part to prevent or minimize the effect of "copycat" suicides. Although few data are available on the effectiveness of these approaches, the advisability of using a crisis intervention plan to manage the risk of multiple youth suicides is widely accepted by suicide prevention experts.

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Intervention After A Suicide: Program Descriptions

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Suicide Postvention Project
Survivors of Suicide Groups

Location: Piscataway, New Jersey
Contact: Karen Dunne-Maxim, R.N., M.S., (908) 463-4109

Suicide Postvention Project

Targets: Survivors of the suicide (close friends, students, teachers, and other school personnel); social service agency staff who work with youth; family members; and media personnel.
Years in operation: 5
Source of funding: New Jersey Department of Education; school systems; per diem from various agencies.
Amount of funding (per year): $35,500 (approximately).

Program description: Postvention program provides crisis intervention to school personnel, students, community residents, social service agency staff, and media personnel in the aftermath of a suicide. Over the last 2 years, such intervention services have expanded beyond youth suicide to include homicides and deaths from unintentional injuries. These services are a series of strategic interventions designed to help the school or worksite administrations help themselves and their students to effectively cope with suicide, homicide, or tragic death. These interventions are also provided to the community at large when appropriate. Human service agency personnel receive consultation on how to work with school staff in identifying suicidal youth and the risk for contagion. Media personnel receive consultation on how to report the suicide story in a responsible fashion, thereby reducing the risk for copycat or cluster suicides.

Exposure: Intensive intervention typically lasts 1 to 2 weeks. The duration of the services varies from 6 to 50 hours, depending on the recipients' needs.

Coverage: The postvention program has been provided to over 2,590 recipients in 82 postvention sessions since 1986.

Content/topics: Coping and grief strategies.

Referral/selection procedures: Appropriate school personnel (guidance staff, child study team members, student assistance counselors) are either referred to the project staff or staff members contact the school or worksite when a suicide, homicide, or unintentional injury death has taken place in the state.

Evaluation: Evaluation studies are being developed. Particular interest lies in conducting impact evaluation on the postvention program. This evaluation would determine the efficacy of the intervention services in decreasing maladaptive coping responses in the aftermath of suicide, homicide, or tragic death.

Data available: None.

Special population outreach: None.

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Survivors of Suicide Groups

Targets: Family members or significant others of someone who has died of suicide.
Years in operation: 9
Source of funding: County Community Mental Health Center.
Amount of funding (per year): None.

Program description: Survivors of Suicide (SOS) group meetings are conducted monthly for family members or significant others of someone who has died of suicide. The groups stress self-help and mutual support and educate the survivors about the emotional issues and strategies involved in surviving the suicide of someone close. The program also trains group members in becoming group leaders should they wish to organize an SOS group in their local community.

Exposure: Group participation varies greatly. Some people are regular participants of the group each month, whereas others attend only a few times or in the months preceding holidays.

Coverage: Participants in the SOS groups in the last 9 years include members of well over 800 families.

Content/topics: The groups educate the survivors about the emotional issues and strategies involved in surviving the suicide of someone close. If requested, group leaders teach participants to organize an SOS group in their local community.

Referral/selection procedures: Referrals are made from a variety of sources, including past participants, clergy, police, funeral directors, self-help clearinghouses, social service and mental health professionals, and schools.

Evaluation: Evaluation studies are being developed. Particular interest lies in conducting an impact evaluation on the SOS groups. This evaluation would determine the efficacy of the SOS intervention in creating positive change in participants' level of perceived support, guilt and other maladaptive coping patterns, suicidal ideation and behavior, depression, and level of knowledge about suicide and the aftermath of suicide.

Data available: None.

Related components:

- Postvention
- Screening
- Survivors' support groups

Address: Suicide Postvention Project
Karen Dunne-Maxim, R.N., M.S.
UMDNJ - CMHC
671 Hoes Lane
Piscataway, NJ 08855-1392

Reports: Not described.

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Crisis Intervention
Dade County Public Schools

Location: Miami, Florida
Contact: Dr. J. L. DeChurch, (305) 995-7315

Targets: All students.
Years in operation: 5
Source of funding: School district and grant.
Amount of funding (per year): $120,000.

Program description: In 1987, Dade County established a Department of Teenage Pregnancy and Suicide Prevention, which, in turn, became the Department of Crisis Intervention, whose purpose is to prepare staff at the district, region, and school levels to identify, assist, and refer students at risk. The department trains "Crisis Care Core Teams" in every school to counsel staff and the community in times of crisis. A hotline is available to assist administrators, counselors, and other support staff. Additionally, the District Crisis Team responds if a "crisis" situation occurs to provide help with coping and grief strategies.

Exposure: The District Crisis Team, which consists of one counselor and one psychologist, trains crisis core teams in the schools. Training consists of a 3-hour program, and so far about 1,000 individuals have been recipients.

Coverage: Crisis teams are present in all schools; this is a county-mandated requirement. School staff includes counselors, teachers, social workers, occupational specialists, college advisors, psychologists, bus drivers, cafeteria workers, students, peer counselors, and parents.

Content/topics: Coping and grief strategies.

Evaluation: Participant written and verbal feedback, which has been positive.

Findings: In 1988, there were 19 suicides, and in 1989, only 7, but program staffers are not sure whether they should take credit for this apparent decline. They found students in middle school to be most at risk and also found a link between suicidal tendencies and sexual abuse.

Data available: Program staffers are building a data base and want to use it for research and evaluation, but it is not yet operational.

Special population outreach: Not described.

Related components:

- General suicide education
- Means restriction
- Parent education
- School gatekeeper training
- Screening

Address: Dr. J. L. DeChurch
Executive Director
Division of Student Services
Dade County Public Schools
1444 Biscayne Boulevard, Suite 202
Miami, FL 33132

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Project SOAR (Suicide: Options, Awareness, Relief)
Dallas Independent School District

Location: Dallas, Texas
Contact: Judie Smith, MA, (214) 565-6700

Targets: Survivors of suicide.
Years in operation: 3
Source of funding: Local school district funds.
Amount of funding (per year): $90,000, which provides the salary for three professionals. Clerical salaries and the cost of office supplies and training materials are absorbed by Psychological/Social Services Department budget.

Program description: Project SOAR is a comprehensive school-based program that covers prevention, intervention, and postvention. Postvention consists of training primary caregivers and following planned procedures (American Association of Suicidology Postvention Guidelines) after the suicide of a student or teacher. The Psychological/Social Services Crisis Team assists the staff and students during the grief process and helps them return the school to its normal level of functioning. All students who are known to be at risk for suicide and to be close friends of the person who committed suicide are screened. Follow-up counseling is provided as needed.

Outreach: During the first follow-up training (see School Gatekeeper Training), SOAR trainers provided all school counselors with 3 hours of training in postvention procedures and grief counseling. The instruction is now incorporated into the SOAR initial training course for all new counselors and staff members of the Psychological/Social Services Department.

Coverage: Each of the district's 194 schools has at least one trained crisis counselor who joins the Psychological/Social Services Crisis Team after a suicide on his or her campus. The district has 60,000 secondary school students and 72,000 elementary school students.

Content/topics:
- Children's understanding of death
- Tasks of mourning
- Grief counseling
- Postvention procedures

Referral/selection procedures: One counselor was selected from each school to receive training in crisis intervention and to become the campus primary caregiver. The training was continued each year for the remaining counselors and new members of the Psychological/Social Services Department staff.

Evaluation: No written evaluations or tests are done at this time.

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Data available: A written summary of each intervention after a suicide is included in the Psychological/Social Services Department year-end report of all major crisis events. The data include the number of students the crisis team saw, the number of hours spent on the campus, the number and kinds of services provided, and the number of students needing follow-up counseling.

Special population outreach: No special effort at this time. The Dallas Independent School District is 49 percent black and 30 percent Hispanic.

Related components:

- General suicide education
- School gatekeeper training
- Peer support

Address: Project SOAR
Judie Smith, MA
Specialist in Psychological Social Services
Dallas Independent School District
1401 South Akard
Dallas, TX 75215

Reports: Yearly summary of crisis events.

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Special Initiatives Team (SIT)

Location: Albuquerque, New Mexico
Contact: Lemyra DeBruyn, Ph.D., (505) 766-2873/6575

Targets: Native Americans.
Years in operation: 4
Source of funding: Indian Health Service (IHS).
Amount of funding (per year): Not provided.

Program description: This program is targeted at Native Americans. The SIT has the capacity to respond to community crises surrounding violent behaviors and is available for consultation with tribes or Indian communities and IHS units on crisis intervention and prevention strategies. Some schools have developed suicide prevention programs and school policies and procedures. Most Native American suicide prevention programs are community specific, not age specific. The team attempts to incorporate cultural, historical, and environmental factors relevant to the Indian communities served. Services offered by the team include assistance, consultation, and referral. The SIT also works with domestic violence, child abuse, child sexual abuse, and other forms of violence that have been found to be connected with suicidal behavior.

Communities have done a variety of things to promote suicide prevention. Some examples include developing crisis response teams, youth activities and programs, and school policies and procedures; removing access to water towers; implementing a suicide surveillance system; developing natural healers or "talking circles"; and implementing suicide awareness education programs.

Evaluation: None.

Data available: Data are being collected with the use of a Suicide Surveillance System developed on the CDC Epi Info Software program. Data have been collected and analyzed for some specific communities. The SIT also collects data on the types of requests it receives, including topic and target groups. These data are collected on an intake form and used in completing an annual report.

Related components: Postvention.

Address: Special Initiatives Team
Lemyra DeBruyn, Ph.D.
Special Initiatives Team - Team Leader
Mental Health Programs Branch
Indian Health Service
2401 12th Street N.W.
Albuquerque, NM 87102

Special population outreach: Native Americans.

Reports: Specific reports include "Development of Community-Based Suicide Surveillance Systems" and "Cluster Suicide Prevention in Native American Communities."

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Appendix A

GEOGRAPHIC LISTING OF SUICIDE PREVENTION PROGRAMS DESCRIBED

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Appendix A
Geographic Listing of Suicide Prevention Programs Described

Program	Components Described	Page
East:		
Massachusetts		
Jail Suicide Prevention Program National Center on Institutions and Alternatives (NCIA) Mansfield, Massachusetts	Community Gatekeeper Training	57
New Jersey		
BRIDGES Piscataway, New Jersey	School Gatekeeper Training	19
Suicide Postvention Project Piscataway, New Jersey	Intervention After a Suicide	161
Adolescent Suicide Awareness Program (ASAP) Lyndhurst, New Jersey	Community Gatekeeper Training General Suicide Education	47 75
New Jersey Adolescent Suicide Prevention Project Trenton, New Jersey	General Suicide Education	79
Pennsylvania		
Pennsylvania Network for Student Assistance Services (PNSAS) Pittsburgh, Pennsylvania	School Gatekeeper Training	21
Services for Teens At Risk (STAR) Pittsburgh, Pennsylvania	School Gatekeeper Training	23
Rhode Island		
The Samaritans of Rhode Island Providence, Rhode Island	General Suicide Education	81
Midwest:		
Ohio		
Suicide Prevention Center Dayton, Ohio	School Gatekeeper Training General Suicide Education Crisis Center and Hotline	25 83 137

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Program	Components Described	Page
Midwest: (continued)		
Minnesota		
Rural Minnesota Program Minneapolis, Minnesota	Screening Program	109
Link-Up St. Paul, Minnesota	Peer Support	121
South:		
Delaware		
Delaware Youth Suicide Prevention Pilot School Program Wilmington, Delaware	General Suicide Education	85
Florida		
Crisis Intervention	School Gatekeeper Training	27
Dade County Public Schools Miami, Florida	Screening Program Intervention After a Suicide	111 163
Louisiana		
Jewish Family Service (JFS) New Orleans, Louisiana	General Suicide Education	87
Maryland		
Youth Crisis Hotline Baltimore, Maryland	Crisis Center and Hotline	138
Texas		
Project SOAR	School Gatekeeper Training	29
Dallas Independent School District Dallas, Texas	General Suicide Education Intervention After a Suicide	89 164
Crisis Center of Collin County Plano, Texas	General Suicide Education Crisis Center and Hotline	91 141
Virginia		
Adolescent Suicide Prevention Program Fairfax, Virginia	School Gatekeeper Training	32
Youth Suicide Prevention Program Manassas, Virginia	Community Gatekeeper Training	49

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Program	Components Described	Page
West:		
Alberta		
LivingWorks Education, Inc. Calgary, Alberta, Canada	Community Gatekeeper Training	51
California		
Suicide Intervention Skills Workshop Department of Mental Health Sacramento, California	Community Gatekeeper Training	53
California School Suicide Prevention Program Los Angeles, California	General Suicide Education	93
Colorado		
Weld County Suicide Prevention Program Johnstown, Colorado	School Gatekeeper Training General Suicide Education	34 95
Nevada		
Suicide Prevention and Crisis Call Center (SPCCC) Reno, Nevada	General Suicide Education Crisis Center and Hotline	97 143
New Mexico		
Center for Indian Youth Program Development Albuquerque, New Mexico	Community Gatekeeper Training	55
Special Initiatives Team (SIT) Albuquerque, New Mexico	Intervention After a Suicide	166
Washington		
Youth Suicide Prevention Project Bothell, Washington	Peer Support	123

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Appendix B

CROSSWALK OF SUICIDE PREVENTION PROGRAMS BY STRATEGY

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Appendix B
Crosswalk of Suicide Prevention Programs by Strategy

Program	School Gatekeeper Training	Community Gatekeeper Training	General Suicide Education	Screening Programs	Peer Support Programs	Crisis Center and Hotline	Means Restriction	Intervention After a Suicide
East								
MA								
Jail Suicide Prevention Program Mansfield, MA		●		○			○	○
NJ								
Adolescent Suicide Awareness Program Lyndhurst, NJ	○	●	●	○				○
BRIDGES Piscataway, NJ	●			○				○
Suicide Postvention Project Piscataway, NJ				○				●
Adolescent Suicide Prevention Project Trenton, NJ	○		●					○
PA								
Pennsylvania Network for Student Assistance Services Pittsburgh, PA	●							○
Services for Teens at Risk (STAR) Pittsburgh, PA	●			○				○
RI								
The Samaritans of Rhode Island Providence, RI	○		●			○		○
Midwest								
OH								
Suicide Prevention Center Dayton, OH	●	○	●			●		○
MN								
Rural Minnesota Program Minneapolis, MN	○		○	●				
Link-Up St. Paul, MN					●			

Key: ○ Program component.
● Description of the program component provided in this resource guide.

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Program	School Gate-keeper Training	Com-munity Gate-keeper Training	General Suicide Education	Screening Programs	Peer Support Programs	Crisis Center and Hotline	Means Restriction	Inter-vention After a Suicide
South								
DE								
Delaware Youth Suicide Prevention Pilot School Program Wilmington, DE	○		●					○
FL								
Crisis Intervention, Dade County Public Schools Miami, FL	●		○	●			○	●
LA								
Jewish Family Service New Orleans, LA	○		●		○			○
MD								
Youth Crisis Hotline Baltimore, MD						●		
TX								
Project SOAR Dallas, TX	●		●		○			●
Crisis Center of Collin County Plano, TX	○	○	●			●		○
VA								
Adolescent Suicide Prevention Program Fairfax, VA	●							○
Youth Suicide Prevention Program Manassas, VA	○	●	○				○	○
West								
ALBERTA								
LivingWorks Education, Inc. Calgary, Alberta	○	●						○
CA								
California School Suicide Prevention Program Los Angeles, CA	○		●					○
Suicide Intervention Skills Workshop Sacramento, CA	○	●						○

Key: ○ Program component.
● Description of the program component provided in this resource guide.

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Program	School Gatekeeper Training	Community Gatekeeper Training	General Suicide Education	Screening Programs	Peer Support Programs	Crisis Center and Hotline	Means Restriction	Intervention After a Suicide
West (continued)								
CO								
Weld County Suicide Prevention Program Johnstown, CO	●	○	●					○
NV								
Suicide Prevention and Crisis Call Center Reno, NV	○		●		○	●		○
NM								
Center for Indian Youth Program Development Albuquerque, NM	○	●			○		○	○
Special Initiatives Team Albuquerque, NM								●
WA								
Youth Suicide Prevention Project Bothell, WA	○	○	○	○	●	○		○

Key: ○ Program component.
● Description of the program component provided in this resource guide.

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Appendix C

NATIONAL SOURCES OF INFORMATION ON SUICIDE

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Appendix C
National Sources of Information on Suicide

American Association of Suicidology
2549 Ash Street
Denver, CO 80222
303-692-0985

American Suicide Foundation
1045 Park Avenue
New York, NY 10028
212-410-1111

Centers for Disease Control
National Center for Injury Prevention
and Control
1600 Clifton Road, N.E.
Atlanta, GA 30333
404-488-4646

National Institute of Mental Health
Public Inquiries Section, Room 15C05
5600 Fishers Lane
Rockville, MD 20857
301-443-4515

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