



Center for School Mental Health Analysis and Action

News You Can Use

Suicide Prevention in the Schools

Because of its drastic consequences, concern over suicide has spurred the creation and implementation of a wide variety of prevention and intervention approaches. In 2001, aiming to move toward a nationwide model, a National Strategy for Suicide Prevention (NSSP; www.mentalhealth.samhsa.gov/suicideprevention) was implemented by the United States Department of Health and Human Services. It was the first national blueprint to address this serious public health problem and was designed to be a comprehensive and far-reaching proactive approach. The NSSP presents a framework to guide nationwide suicide prevention strategies and services and to transform social attitudes toward suicide and policies. This framework includes specific guidelines for how schools should be involved in this national effort. It calls for schools to collaborate with other agencies, to increase implementation of research-supported prevention programs, to train key people in schools to iden-

tify youth at risk, and to devise effective school screening programs.

Preventing suicide is increasingly on the national agenda. The 2003 President's New Freedom Commission on Mental Health final report on mental health care supports the NSSP and calls for schools to have a greater role in identifying and preventing mental health difficulties. This year, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) reported that over \$9.7 million would be available to support first-year grants on youth suicide prevention efforts. These types of programs are now being implemented across the country, but not without strong debate and concerns about how and whether they should be implemented.

Impact of suicide

Suicide rates declined for youth aged 10-19 from 1992 to 2001; however the problem remains very serious. Suicide is the third

leading cause of death for 10-24 year olds with 4,270 deaths recorded for this group in 2002.¹ Focusing on completed deaths from suicide only partly addresses the number of affected youth. In 2003, a survey of a nationally representative sample of over 15,000 high school students indicated that over the past year 16.9% of students had seriously considered a suicide attempt, 16.5% students had made a plan, and 8.5% of students had made one or more suicide attempts.² Among persons aged 15 to 24 years, suicide attempts and suicidal ideation account annually for nearly one-quarter (24%) of hospitalizations due to injury, and nearly two-thirds (64.5%) of hospitalizations due to intentional injuries.³

Schools' roles in suicide prevention

As schools are a major point of contact for children and adolescents, they are natural settings for suicide

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prevention efforts. However, the CDC's 2000 report on School Health Policies and Programs indicated that fewer than half of states mandate suicide prevention in at least one grade.⁴ Prevention efforts undertaken by schools typically fall into one of 3 categories: universal suicide education, gatekeeper training, and mental health screening.

Recommended school responsibilities in suicide prevention:⁵

- Ensure that school staff are knowledgeable of warning signs for suicide and informed about guidelines for reporting concerns about students
- Develop policies for notifying parents of suicidal youth including referrals and recommendations for how they should intervene
- Offer consistent counseling and support by school staff for suicidal students

Suicide Education

Universal suicide education targets all students regardless of risk and is based on research findings that students are more likely to disclose suicidal thoughts to peers than adults.^{6,7} The programs are designed to increase the resources available to students and to promote improved mental health school-wide.

Its goals are generally threefold: educate students about suicide and mental health problems, increase awareness of warning signs, and teach them how to get help for themselves and their peers. Similar to arguments against anti-drug and sexual education, there are some that fear that education about suicide may engender negative effects such as promoting suicidal thinking and introducing suicide as a potential option to students. Research reporting links between media coverage of suicide and subsequent increases in suicide rates⁸ are used to support this view. Others question whether increasing knowledge will necessarily lead to positive behavioral change and express concern about the potential to stigmatize help-seeking. Moreover, noting the considerable financial limitations experienced by schools, some argue that because relatively few students are at risk for suicide, these types of universally delivered programs are not a cost-effective use of resources.⁹

Reviews of school-based preventive approaches indicates mixed results and suggests that all programs are not equal.^{10,11} A few studies have demonstrated improvements in students' knowledge, attitudes, and help-seeking; however, no improvements as well as negative effects have also been documented. Adverse effects have included increased hopelessness, and reduced reports that one would recommend seeking help to a friend. A safeguard against these problems may be ensuring that only well-developed and well-researched programs, implemented by highly trained professionals, are implemented in schools. There is some evidence that more

extensive programs, such as those consisting of at least three sessions or more, may be more likely to have beneficial effects.¹² Focusing instruction on how mental health problems rather than stressful circumstances contribute to suicide may also be more effective.

A potentially less controversial alternative to educating specifically about suicide in schools is to conduct programs to enhance social and emotional learning and other positive coping and cognitive skills that may protect against depression and other risk factors for suicide. Research on the effects of these programs on suicide outcomes is limited, but promising.¹¹

Gatekeeper Training

In contrast to the universal programs, which target increasing student knowledge, "gatekeeper training," involves training school staff such as teachers, counselors, and coaches to identify students who might be at risk and how to refer students for appropriate assessment and treatment. Teachers, it is asserted, are on the front-line and well-positioned to provide immediate intervention to youth in trouble. However, arguments against this strategy include concerns about whether this type of intervention may violate the rights and privacy of youth and families who may not want school staff to probe into mental health issues. Moreover, it may not be appropriate to increase the role of teachers who may already feel overburdened. They also might not have the sensitivity or clinical skill to handle the job of intervening with at-risk youth.

Currently, there is not much research of the effectiveness of gatekeeper training, yet a few studies support use of this strategy. A review of the area indicates that documented improvements have been found in school staff skills, knowledge, attitudes, and referrals.^{11,12}



Mental Health Screening

Another prevention strategy available to schools is mental health screening which involves assessing all students' risk for suicide or other mental health problems, including depression and substance abuse problems. The goal of screening, which is to identify students early so that they can be appropriately treated before difficulties worsen, has garnered national support including an endorsement from the President's New Freedom Commission on Mental Health and federally funded initiatives to support screening in schools. Screening also aims to improve cost-effectiveness based on the expectation that students will require less intensive interventions if identified early.

However, screening has become a highly contested issue. First, it has been argued that it is inappropriate for mental health matters to fall under the purview of schools. Second, screening on a large scale is very expensive, raising serious questions about who should be responsible for funding. Beyond surveying students, additional effort, support mechanisms, and money are required to ensure that there will be services available and that they are utilized effectively. Third, there is concern that screening may violate the rights and privacy of students and families. Also, across different cultures, using

standardized measures may not be appropriate.¹⁰ Fourth, there is the potential for negative effects when students are incorrectly identified. Negative outcomes may include possible stigmatization of identified students or, more seriously, making it more likely for a student to commit suicide because they have been informed that they are at risk. Due to these concerns, high school principals may not allow school-wide screenings of students and be more favorable toward staff education and student educational programs.¹³

Beyond ethical and financial concerns, screening is not a foolproof strategy. A 2000 review of available suicide screening instruments asserts that each measure has strengths and weaknesses and that the necessary research has not been done to systematically evaluate their usefulness.¹⁴ For instance, there is a lack of studies which assess the predictive validity of suicide screening measures (i.e. do they predict future ideation and suicide attempts). Across studies, research has shown that measures are more likely to incorrectly identify students as at risk when they are not, but less likely to miss at risk students.¹¹ High numbers of falsely identified students may overburden already limited treatment resources. A recent study using one screening measure in high schools identified 29% of students as at-risk, prompting the researchers to suggest that the feasibility of using these measures in real settings needs to be tested.¹⁵ Suicide risk is also not constant among teens and thus multiple screenings may be necessary.¹⁶

In contrast, proponents of screening contend that the potential to save lives and prevent suffering outweighs the potential difficulties and that many of the concerns are unfounded. They argue for a change in perspective toward viewing mental health treatment as beneficial. Just as screening for medical problems such as vision and hearing is routine, evaluating children's emotional functioning is equally essential. As recommended by the New Freedom Commission, broad screening is best implemented at sites that are known to have unaddressed behavioral problems. Supporters of screening assert

that valid and reliable measures of identifying youth at risk do exist.^{10,12} Furthermore, parental rights are not violated because schools are required to obtain consent from guardians to administer measures and screening is voluntary for students. Additionally, those in favor of screening suggest that students may not be as vulnerable as critics fear. Research does not support concerns that students may be harmed by screening alone. A recent study indicated no negative effects in terms of contributing to feelings of distress or suicidal ideation immediately following the survey or two days later.¹⁷ In fact, the school environment will be improved if appropriate interventions result in more successful students.

What Strategies Can Schools Apply?

The **SOS Signs of Suicide Program** (mentalhealthscreening.org) is an empirically supported suicide prevention program for students in secondary schools. It has been identified as a SAMHSA model program and utilizes education and screening components. Students are instructed through use of a video, real-life interviews, and a discussion guide about how to identify depression and suicidal signs and how to seek help for themselves and others. Students also complete a brief depression screening measure. The program is completed on average in 2.5 days and costs \$200 to obtain a program kit. Results from a multi-site evaluation indicated a 150% increase in student self-referrals for depression/suicidality and a 70% increase in referrals made on behalf of a friend during the 30 days following the program.¹⁸ At 3 months following the program, referrals for counseling were still significantly higher than pre-program levels. Another SOS study indicated a 40% decrease in suicide attempts for program participants.¹⁹

The goal of **Columbia University's TeenScreen program** (www.teenscreen.org) is to promote voluntary national mental health screening and suicide risk screening programs for youth aged 11-18. The initiative provides free technical assistance and helps



Below are some internet resources that schools and communities may find useful:

Suicide Prevention

Resource Center: This website features news, events, an online library, training tools, and links to many resources.
(<http://www.sprc.org/index.asp>)

Youth Suicide Prevention

School-Based Guide: This comprehensive guide provides checklists for school administrators and staff that can be used to help assess a school's suicide prevention policies and programs and specific strategies and resources that schools can use.
(<http://theguide.fmhi.usf.edu/>)

National Center for Mental Health Promotion and Youth Violence Prevention:

This website includes links to suicide prevention organizations, statistics on suicide, and other resources.
(http://www.promoteprevent.org/resources/resource_pages/issues/suicide_prevention.htm)

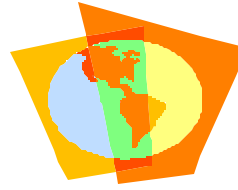
National Institute of Mental Health:

This website answers some frequently asked questions about suicide.
(<http://www.nimh.nih.gov/SuicidePrevention/suicidefaq.cfm>)

SAMHSA's National Mental Health Information Center-

This website contains a comprehensive set of links to suicide prevention resources such as state suicide prevention plans, trainings, resources for professionals, on-line resources, and many others.
(<http://www.mentalhealth.samhsa.gov/links/default2.asp?ID=Suicide&Topic=Suicide>)

communities set up screening programs in local agencies, including schools. Sites participating in the TeenScreen program are provided access to materials and to suicide, depression, and mental health screening questionnaires (available in English and Spanish). Parent permission and student assent are required to complete the questionnaires. Students identified as at-risk on the screening tools are interviewed by a clinician to determine need for further evaluation or services. Consultation is also offered to help determine which tools are suitable for a program. Currently, there are over 400 screening sites in 43 states. An evaluation of the program, which surveyed approximately 2,000 students, found that 74% of students with suicidal ideation and 50% of students who had made a previous suicide attempt, were not identified by school staff as having problems.²⁰



International Guidelines

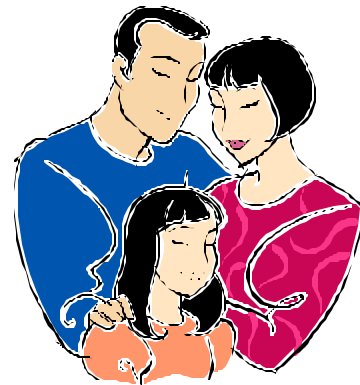
The World Health Organization advocates for strong suicide prevention efforts at the school level, noting that in many countries suicide is the first or second leading cause of death for children aged 15-19. A 2000 report recommended that schools implement the following procedures:²¹

- Improving the mental health of teachers and other school staff
- Providing experiences for students that foster self-esteem and emotional expression
- Ensuring students have information about how to access help
- Preventing bullying and school violence
- Training and guidelines for staff on how to identify problems and intervene
- Developing emergency plans to respond to school suicides if they occur

Information for Parents and Caregivers

You should seek help for your child if you observe any of the following:²²

- Changes in eating and sleeping habits
- Withdrawal from friends, family, and regular activities
- Violent or rebellious behavior
- Running away
- Drug and alcohol use
- Unusual neglect of personal appearance
- Distinct changes in personality
- Difficulty concentrating or decline in school performance
- Frequent complaints about physical symptoms
- Loss of interest in pleasurable activities



A teenager who is planning to commit suicide may also:

- Complain of being a bad person
- Make comments like, "I won't be a problem for you much longer."
- Gives away favorite possessions or throws away important belongings
- Suddenly become cheerful after a period of depression

Some additional resources that can be found on-line include:

Suicide: What should a parent know?:
<http://www.dshs.state.tx.us/mhprograms/78D.pdf>

Family guide: What families should know about adolescent depression and treatment options.
http://www.nami.org/Content/ContentGroups/CAAC/Family_Guide_final.pdf

Preventing Suicide: Information for Families and Caregivers.
http://www.naspcenter.org/resourcekit/suicide2004_rk.html

Endnotes

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The mission of the Center for School Mental Health Analysis and Action (CSMHA) is to strengthen policies and programs in school mental health to improve learning and promote success for America's youth. The CSMHA has four over-arching goals:

1. Further build a community of practice in school mental health (SMH) to facilitate analyses of successful and innovative policies and programs, to enhance collaboration between diverse stakeholders, and to develop strategies to maximize policy and program impact.
2. Enhance understanding of successful and innovative SMH policies and programs across urban, suburban, rural and frontier settings, and across local, state, national, and international levels.
3. Further develop a rapid, innovative and widespread communications framework to disseminate to all interested stakeholders findings and recommendations on successful and innovative policies and programs in SMH.
4. Promote knowledge utilization and application toward the advancement of successful and innovative policies and programs in SMH.

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