Suicide Prevention Resource Packet

Center for School Mental Health Assistance
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OVERVIEW

The suicide rate among youth ages 10 to 19 has increased dramatically in the last few decades and is currently the third leading cause of death among youth ages 15-24 (National Center for Injury Prevention and Control, 2002). From 1980-1997, the rate of suicide among youth ages 15-19 years old increased by 11% and increased 109% among youth aged 10-14. The rates of suicide increased among African-American youth, age 15-19, 105% from 1980-1996 (Centers for Disease Control, 2000). More youth die from suicide each year than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease ***combined*** (U.S. Public Health Service, 1999). According to a survey conducted by the Centers for Disease Control (1995) of 10,000 high school students, 24.1% had serious thoughts about suicide, 17.7% made a plan to attempt suicide, and 8.7% had made a suicide attempt during that past 12 months.

Gender differences in suicide rates are prevalent. Four to seven times the number of men than women die by suicide each year (National Institute of Mental Health, 1999). However, women report attempting suicide 2 to 3 times more often than men and women report higher rates of depression. The discrepancy is likely due to differences in suicide methods. Men are more likely to use firearms, which are fatal 78% to 90% of the time, while women are more likely to ingest poisons. Additionally, lesbian and gay youth are two to six times more likely to attempt suicide than other youth and account for 30% of all completed teen suicides, though it is difficult to ascertain these numbers as many youth hide their sexual identities (U.S. Department of Health and Human Services, 1997).

Suicide rates vary widely among different ethnic groups in the United States as well. While the majority of people who commit suicide are Caucasian, Native American and Alaskan Natives are 70% more likely to commit suicide than Caucasians (Hyman, 2000). In contrast, suicide rates are lower among African-Americans than Caucasians. Unfortunately, there is a paucity of information on suicide rates for Latino Americans (Canino & Roberts, 2001). Studies have shown that Latino Americans often have limited access to mental health services potentially compounding the problem when a crisis arises. The risk for suicide is greatest among young White males, but is increasing rapidly among Black males.

According to a 1999 Surgeon General's report, suicide risk and protective factors form the empirical basis for suicide prevention. The vast majority (90%) of those who attempt suicide have a diagnosable mental health disorder such as depression or substance abuse (National Institute of Mental Health, 2001). Clinical risk profiles vary by age and gender and can include biological, psychological, cognitive, and/or environmental risks. Some events that make one more susceptible to suicide include experiencing adverse life events, previously attempting suicide, witnessing or experiencing family violence or abuse, access to firearms, incarceration,

mental illness, family discord, and exposure to other's suicidal behavior, including family, peers or reports of suicide in the media. Additional risk factors, particularly for youth, include a predisposition for depression or impulsivity, low self-esteem, helplessness, or hopelessness, rigid thinking patterns, the breakup of a significant relationship, and the use of drugs or alcohol.

Risk Factors for Suicidal Behavior

• Adverse life events (Legal/Disciplinary issues)	• Previous suicide attempt	• Witness/experience family violence or abuse
• Access to firearms	• Incarceration	• Exposure to other's suicide behaviors
• Depression	• Helplessness	• Hopelessness
• Impulsivity	• Poor self-esteem	• Rigid cognitive patterns of thinking
• Social isolation	• Drug or alcohol abuse	• Pregnancy

There are multiple warning signs that can suggest a child is distressed. During early childhood (age 5 to 14), children exhibit signs of distress vis-à-vis truancy, physical complaints, poor school performance, anxiety, sleep disturbance, aggression, low frustration tolerance, and impulsivity. Younger children, due to their concrete thought processes, may express immature views of death such as the belief that death is not final should they make an attempt on their life (American Academy of Child & Adolescent Psychiatry, 1998).

During adolescence, some of the above symptoms may prevail, as well as additional warning signs such as change in daily habits or regular activities, self-mutilation, withdrawal from family and friends, change in personality or mood swings, isolation, drastic change in friendships, behaviors, or appearance, use of drugs or alcohol, violent/rebellious actions or running away, persistent boredom, and an inability to tolerate praise or rewards (Patros & Shamoo, 1989; American Academy of Child & Adolescent Psychiatry, 1998). Children and adolescents may also display a lack of patience with self or others, poor attention or concentration, verbal or physical abuse of self or others, theft, and a lack of respect for self or property. They may complain of physical problems and ask to see the nurse or complain often of feeling tired or

bored. Threats or illusions to suicide may be expressed either out loud or in student's writing assignments. Students may also make overt preparations for death such as giving away their possessions or making comments such as "I won't be a problem for you anymore," or "I'll be going away" (American Academy of Child & Adolescent Psychiatry, 1998).

Simply because a student exhibits one or more of these behaviors does not mean the student is suicidal (Patros & Shamoo, 1989). There are multiple reasons for students' behaviors and if a teacher is concerned, a referral should be made to the school's mental health professional. The American Academy of Child and Adolescent Psychiatry (1998) notes that by simply asking a student about his/her thoughts of suicide, you will not put the idea in his/her head. Instead, it might be the opportunity to tell the student you care.

Signs/Symptoms of Disturbance

• Verbal threats of suicide	• Change in classroom behavior	• Gives away belongings
• Truancy or repeated absences	• Aggression	• Somatic complaints
• Poor/decreased school performance	• Low frustration tolerance/ Irritability	• Change in habits, dress, peer group
• Macabre/overt allusions to suicide/death in assignments	• Poor attention/ concentration	• Impulsivity
• Self-mutilation	• Excessive tobacco, drinking, drug use	• Violent behavior towards other students

SUICIDE PREVENTION

The effectiveness of school-based suicide awareness programs is questionable (see National Institute of Mental Health, 2002; Shaffer, et al., 1990; Kalafat & Elias, 1994; Vieland, Whittle, Garland, Hicks, & Shaffer, 1991). In a review of the literature, Gould and Kramer (2001) suggest that there are several reasons why such large-scale prevention programs may not be appropriate. These reasons include: 1) only a minority of students require such intervention and education; 2) changes in attitudes or knowledge may not correlate with behavior change; 3) some

programs might unwittingly stimulate imitation; and 4) the peer networks of suicidal youth may not be as strong or supportive as those of nonsuicidal youth. Thus, programs that encourage youth to look for signs of suicide and depression in their friends might be overlooking those people who have limited friendship networks to begin with.

The NIMH (2002) endorses the reduction of suicide tendencies through the promotion of school-based activities that attempt to lessen stigma associated with mental health problems and promote wellness and healthy living. Successful school-based approaches to preventing and addressing mental health issues will incorporate classroom activities and discussions, beginning in the elementary school and continuing through high school. School-age youth should be taught coping skills, problem-solving skills, interpersonal communication, and conflict resolution skills throughout their academic lives, not just in the face of a crisis. Prevention programs for older youth should focus on reducing early risk factors for depression, substance abuse, aggressive behaviors, and family and peer conflict. Activities should include comprehensive school-based programs with a deep focus on overall positive health with classes on topics such as self-esteem, anger management, bullying, and coping skills. Additionally, a healthy school environment should foster positive self-esteem via conveying high academic expectations and offering opportunities for students to feel connected to the school and its staff.

Additionally, the World Health Organization (2000) encourages the promotion of children's self-esteem through assisting youth in developing positive identities, confidence in self, and the knowledge that they are loved. The WHO suggests that in order for youth to achieve positive self-esteem they need to establish independence from their family and peers, be able to relate to the opposite sex, have significant career aspirations, and develop a meaningful personal philosophy for life. Both parents and educators play significant roles in the development of these traits in youth and incorporation of these values into classrooms, conversations with parents, and one-one interactions with youth is imperative. Parents, as well as teachers and school administration, may need to be educated about what is developmentally appropriate for children and become aware that some outwardly poor displays of behavior warrant medical or psychological attention rather than punishment. Finally, parents and school staff need to be educated about the importance of restricting access to the means of committing suicide (e.g., firearms, pills) which may be critically important in reducing risk.

Therefore, the focus of suicide prevention efforts can target students, teachers, primary care or school health clinics, parents, and community leaders. These are all gatekeepers who come into contact with youth and who have the ability to impact them on their decisions. All of these individuals should be considered partners in the creation and dissemination of a larger suicide awareness campaign.

Suicide prevention efforts should target all gatekeepers who come into contact with youth and who have the ability to impact them on their decisions including: Students, Teachers, School Health Clinics, Community Leaders, and Parents.

Students

Although the results of providing a comprehensive school-based suicide program have been found to be questionable, most researchers suggest that some education and awareness raising about suicide and depression may be appropriate. According to Kalafat and Elias (1992), many teenagers know suicidal peers but do not know how to respond to their suicidality. Some education might be feasible in the form of workshops, classroom discussions or assemblies that increase awareness about mental health problems overall and suicidal behavior, in particular, that educates teens in how to identify at-risk peers as well as how to take action to assist them. Additionally, professionals must convince adolescents of the need to seek help for friends and must encourage students to confide in and trust others, especially adults. Misconceptions about mental health should be addressed and allayed, including providing definitions of mental illness, describing the treatment process, confidentiality, hospitalization, and offering expectations for recovery.

Teachers

According to Gould and Kramer (2001), school personnel, rather than students, should be trained in identifying youth who are at risk for suicidal behavior or other mental health issues. Teachers should receive adequate training in mental health issues as they have the most contact with students and thus may be better positioned to observe significant and worrisome changes or behaviors in youth. On the prevention end, teachers and staff play an important role in making youth feel welcome and supported in the school. Multiple strategies can be used to help students to feel connected to one another as well as to the school, which can not only decrease their likelihood of suicide, but also of drug use, school dropout, pregnancy, and violence (Isakson & Jarvis, 1999; Goodenow, 1993). Teachers should promote high standards for youth and encourage them to set high academic and personal goals. Strategies include cooperative learning, peer tutoring, mentoring advocacy, peer counseling and mediation, human relations, and conflict resolution.

In addition to recognizing specific students who may be at-risk, teachers can also attempt to create classrooms that reduce student stress overall. Teachers can assist students to be better prepared for tests or classroom assignments by helping them to focus on the specific topics that they will be tested on. Other suggestions include grading based on multiple sources rather than on any one activity such as tests alone and monitoring children who are at risk for failure early on and referring them appropriately. Teachers may need to be flexible with creating assignments sensitive to the varying levels of different student’s abilities. Teachers should be encouraged to identify strengths and weaknesses in all children and to model acceptance of all students (Patros & Shamoo, 1989).

Finally, the World Health Organization (2000) suggests that teachers need to attend to their own mental health needs and wellness. Teaching is a stressful occupation and asking teachers to recognize and manage suicidal crises in students, when they are not trained or prepared for such episodes, can create conflict and stress within the teachers and other staff. In order to reduce

burnout and to make teachers more accessible for students, the school should provide teachers with a supportive working environment.

Primary care/School health clinics

One way to identify at-risk youth is through direct case-finding. A study of pediatricians and family physicians found that only 23% frequently or always screen adolescents for suicide risk factors (Frankenfield, Keyl, Gielen, Wissow, Werthamer, & Baker, 2000). Therefore, suicidal youth are often overlooked, and schools are in a good position to identify them. The American Academy of Child and Adolescent Psychiatry (2000) suggests that 15 to 19 year olds could be systematically screened, through a school-based health clinic or school-wide screening day for previous suicide attempts, suicidal ideation, depression, or alcohol/substance abuse, with referrals made where appropriate.

The American Medical Association (1997) developed Guidelines for Adolescent Prevention Services (GAPS) which can be used by a school-based health clinic to determine a student's need for mental health care. The GAPS serves as a screening tool for a wide range of physical and emotional issues including eating habits and weight concerns, relationships with friends and family, exposure to violence, and questions about emotional issues. If a student endorses any items of concern, appropriate referrals to a mental health counselor can be made. Similar to teachers, nurses should take all disclosures of thoughts of suicide seriously, even if they don't believe the student is at imminent risk of danger. Researchers point out, however, that there are shortcomings with regard to screenings of students. In particular, suicide risk is not constant among teens and thus multiple screenings may be necessary (Berman & Jobes, 1995). Additionally, high school principals may not allow school-wide screenings, whereas they might allow curriculum-based programs or staff education (Miller & Hemenway, 1999).

Community Gatekeepers

Specific personnel in the community who have access to youth such as scouting leaders, coaches, boys' and girls' club counselors, or clergy should also be trained to recognize signs and symptoms of depression and suicide and know how and where to make referrals. Lists of community agencies capable of treating youngsters at risk of harm should be developed so that when training for staff or students is needed or in the event of a crisis, relationships will already have been fostered.

SUICIDE INTERVENTION

All threats of suicide should be taken seriously. In the event that a student does share thoughts of suicide, a risk assessment should be conducted by a trained mental health professional. This should include an assessment of the lethality of the plan. Certain means are more lethal (gunshot, hanging, carbon monoxide) than others. It is also important to note whether or not the student has access to the means. The time frame should be established, e.g., whether the student is saying, "someday I might…" versus "when I get home today I will…". Finally, students who have made previous suicide attempts are at greater risk for making another attempt. The mental

health professional will then have the job of deciding whether hospitalization is necessary or not, based on the above information. Hospitalization, although often feared by students and parents, can be useful and can allow the student to be seen immediately and to receive more intensive services. Although at times it is more difficult in the schools, as compared to a more traditional outpatient practice, it is helpful to consult with other mental health professionals regarding the necessity for hospitalization or the creation of a treatment plan.

Confidentiality is secondary to saving the child's life and staff should be strongly encouraged to share concerns they have about any student. Students should be warned about the limits of confidentiality at the start of psychological services (i.e., duty to report harm to self, others, or abuse/neglect). Parents or guardians of youth must be notified in the event that the child expresses thoughts of suicide. The student should be included in the process of telling the parents. A student can be released to parents' care when it is believed that parents are equipped to provide help. The Los Angeles Unified School District Suicide Prevention Program (1998) suggests that parents may need time to digest the urgency of the need for inpatient treatment for their child. The clinician may have to provide the parent with considerable education and support before the parent will feel capable of moving forward. However, in the event that the parents are unresponsive regarding their child's need for immediate medical care, it may be necessary to file a neglect/endangerment report. If a child is hospitalized, it is helpful for the school health clinic, counselor, and teachers to be notified when they will return so that they can assist the student as they reenter school and check in regularly. The Los Angeles Unified School District Suicide Prevention Program (1998) recommends that, following hospitalization, before students can be readmitted to school, they must have written confirmation from their physician approving the child's return indicating that the child is no longer a danger to him/herself or others. Additionally, they suggest that the student should be cleared through the school nurse or school physician as well. All steps should be carefully documented.

All schools should have a crisis plan for how they plan to deal with suicidal students during the school day including who will complete the assessment, where a student should be hospitalized, how transportation will be provided, who will contact the family, and who will accompany the student to the hospital in the event the parent cannot come. The team should include administrators, counselor, psychologist, social worker, and health clinic personnel. Some municipalities operate psychiatric mobile response teams that could be used to transport the child to the emergency room.

In the event that the clinician does not feel that immediate hospitalization is necessary, the use of a No-Suicide contract can be employed, though these are controversial. This is a written contract that asks students to write out an agreement that they will not attempt suicide and asks that they document alternative coping strategies as well as places they can call or people they can contact in the event of a resurgence of the suicide thoughts. Although this may allay the anxiety of the clinician and certainly allows for a discussion of more adaptive responses, some clinicians do not feel that No-Suicide contracts are useful. Importantly, No-Suicide contracts are not legally

binding, however, any discussions with students about their suicidality and what treatment steps were implemented should be documented.

Intervention Checklist

- → **Have crisis team and plan established before crisis occurs**
- → **Take all threats seriously**
- → **Assess lethality**
- → **Determine need for hospitalization**
- → **Notify parents in all cases**

SUICIDE POSTVENTION

In the event that a student does commit suicide either at home or in school, the school will need to respond swiftly and acknowledge the death. Similar to other recent violent events in schools, the use of crisis counselors is crucial to helping students and staff to recover from the trauma. Students should be given as much information as possible about the event, though the family's privacy should be considered. It may be necessary to hold parent/community meetings or send newsletters home updating parents on the school's response to the suicide. Additionally, procedures for contacting and updating the media will need to be established. After the initial shock has dissipated, part of the counseling process may need to include revisiting aspects of the school's prevention program such as education about causes of suicide, signs to look for, and where to go for help. Many students and staff may require short-term individual treatment to allow them to share their personal experiences and behaviors towards the person who died. Staff and students should be provided with opportunities to discuss feelings of guilt, responsibility, and grief in classrooms. Students who were particularly close to the student should be monitored and should be approached by staff and offered additional support (Los Angeles Unified School District, 1998).

The media should be encouraged to downplay the suicide in any articles regarding the event. Mental health professionals have worked with the media around portraying suicide more accurately so that teens who see others commit suicide on television will not believe that it means they become martyred by the school or their family. While the school should recognize the loss of the student, there should not be memorials or dedications to the deceased student. The Los Angeles Unified School District recommends instead that donations be made to the family, charity, suicide prevention programs, or for the establishment of support programs at school.

Conclusions

In conclusion, research on best practices to address suicide in youth is still in its infancy. Although it is clear that there is a need to better understand and tackle this issue, there is, as of yet, little empirical basis for the recommendation of one specific suicide prevention program. A review of the literature finds that current suicide prevention strategies focus on two main areas: direct case finding (e.g., school-wide screening programs) and training and education of school and community gatekeepers in how to identify youth in need of mental health services. The effectiveness of school-based suicide prevention programs is controversial. Instead, several recommendations have been suggested for schools and communities to address risk and protective factors for suicide or other mental health problems among adolescents. These interventions include the promotion of positive self-esteem, and the development of positive coping skills, anger and stress management, and overall life skills. Also, schools should provide some education to students about symptoms of depression, suicidality and other mental health issues, as well as where to seek treatment for themselves or others. While not normalizing these experiences, it is important for youth to be aware that these issues are treatable and where to go to for help.

Once schools have identified at-risk youth, they will need to have mechanisms in place for the provision of treatment by adequately trained in-house counselors or have relationships with outside providers to whom to refer students. Additionally, schools should have a plan in place as to how to respond to a student who becomes suicidal while in school, specifically regarding notification of parents and transportation to a hospital. Finally, a school should have a plan in the event that a student does commit suicide including how to notify the student-body and parents, how to provide opportunities for surviving students and staff to grieve, and who will respond to media inquiries.

Suicide Prevention Programs

Several school-specific suicide prevention programs have been developed and will be presented here for the reader's review, though these are offered with caution as most have not been researched.

"Personal Growth Class". For schools that do allow for identification of students who are at-risk for suicide, either through screenings, or through teacher, counselor, parent, or self-referrals, there is some evidence that small group, school-based prevention programs specifically geared for those students, can be successful (Eggert, Thmopson, Herting, & Nicholas, 1995). This school-based prevention program teaches students to respond to real-life problems as well as offers group support, via a one- or two-semester long 55 minute class period called a "Personal Growth Class". This class is conducted by trained school personnel (teacher, counselor, nurse) who function as the group leader and provide leader-to-student support as well as facilitate peer-to-peer support. Students are taught life skills such as self-esteem enhancement, decision making, self control (e.g., anger and stress management, coping with depression), and interpersonal communication. Additionally, skills training focuses on activities such as developing and maintaining motivation and suicide-specific behaviors and beliefs are addressed

such as how to engage external support networks.

Signs of Suicide (SOS). This is sponsored by Ronald McDonald House Charities and is advertised through Screening for Mental Health, Inc. The SOS High School Suicide Prevention Program educates teens about the signs of suicide and details steps to dealing with suicidality. This is a primary prevention program and centers around the acronym, ACT, which stands for Acknowledge, Care, Tell. These steps teach teens to first acknowledge when a friend is exhibiting signs of suicidality and take it seriously, then letting him or her know you care, and finally, telling a responsible adult. The goals of the program are to teach teens about depression, become aware that depression and suicide are treatable, train students to identify serious depression or potential suicidality in their friends, and impress to students that they are in the best position to prevent a friend's death by telling an adult. The educational materials include a video and discussion guide. Screening for Mental Health SOS/HS, One Washington Street, Suite 304, Wellesley Hills, MA 02481-1706, (781) 239-0071, (http://www.mentalhealthscreening.org/sos_highschool/index.htm).

Brief Cognitive-Behavioral Family Therapy for Suicidal Adolescents. This program is based on the Successful Negotiation/Acting Positively (SNAP) therapy process, a six-session, highly-structured family-oriented treatment program for adolescent suicide attempters. (J.C. Piacentini, M.J., Rotheram-Borus, & C. Cantwell. (1995). Brief Cognitive-Behavioral Family Therapy for Suicidal Adolescents (Innovations in Clinical Practice: A Source Book, v. 14). Professional Resource Press/Professional Resource Exchange, Inc.: Sarasota, FL.

Study on Suicide (SOS). This program provides a training manual with step-by-step instructions addressing general information about adolescent suicide as well as identifying youth who are at risk. (J. Coombs. (1990). Study on Suicide: Training Manual. Mental Health Materials Center. P.O. Box 304, Bronxville, NY 10708, (914) 337-6595.

Programs to contact for more information

Los Angeles Unified School District
644 W. 17th Street
Los Angeles, CA 90015
Tel: 213/763-8306
Fax: 213/763-8322
http://www.lausd.k12.ca.us/lausd/offices/student_health/suicide_prevention.htm

Youth Suicide Prevention Program
Prince William County Community Services Board
Prevention Branch
8033 Ashton Avenue
Manassas, VA 22110
(703) 792-7730

BRIDGES (Building Skills to Reach Suicidal Youth)
UMDNJ-CMHC
671 Hoes Lane
Piscataway, NJ 08855-1392
(908) 463-4109

STAR – Services for Teens at Risk
Western Psychiatric Institute and Clinic
Pittsburgh, PA 15213
(412) 624-5211

Suicide Prevention Center Programs
P.O. Box 1393
Dayton, OH 45401
(513) 297-9096

Crisis Intervention
Division of Student Services
Dade County Public Schools
1444 Biscayne Boulevard, Suite 202
Miami, FL 33132
(305) 995-7315

Project SOAR (Suicide: Options, Awareness, Relief)
Dallas Independent School District
1401 South Akard
Dallas, TX 75215
(214) 565-6700

Adolescent Suicide Prevention Program
Special Education Department
Fairfax Public Schools
10310 Layton Hall Drive
Fairfax, VA 22030
(703) 246-7745

Weld County Suicide Prevention Program
5290 Mesquite Court
Johnstown, CO 80534
(303) 587-2336

Organizations Involved in Suicide Prevention

American Association of Suicidology
4201 Connecticut Avenue, NW
Suite 408
Washington, DC 20008
(202)237-2280
www.suicidology.org
Provides information on current research, prevention, ways to help a suicidal person, and surviving suicide. A list of crisis centers can be provided as well.

American Foundation for Suicide Prevention
120 Wall Street, 22nd Floor
New York, NY 10005
(212)363-3500
(888)333-AFSP (2377)
www.afsp.org
Provides research, education, and current statistics regarding suicide; links to other suicide and mental health sites are offered.

American Psychological Association
(800)964-2000
www.apa.org
Provides information about who is at risk, suicide warning signs, and steps toward suicide prevention.

Boys Town
(800)448-3000 (crisis hotline)
(800)545-5771
www.boystown.org
Boys Town is an organization that cares for troubled children—both boys and girls—and for families in crisis. Their hotline staff is trained to handle calls and questions about violence and suicide.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention/Suicide Prevention Research Center
(770)488-4362
www.cdc.gov/ncipc/dvp
Provides links to suicide statistics, the SafeUSA web site, and safety information.

The Center for Mental Health Services
www.mentalhealth.org/highlights/suicide

Provides information on general mental health issues. This is a program of the Department of Health and Human Services.

The Jason Foundation
116 Maple Row Boulevard, Suite C
Henderson, TN 37075
(615)264-2323
www.jasonfoundation.com
Provides information about people with brain injuries. Assists families in accessing medical and rehabilitative support and insurance.

Lifekeeper Foundation
www.lifekeeper.org
Raises suicide awareness by creating a quilt for almost every state with pictures of individuals who have died by suicide. Also sell jewelry, artwork, and poetry at suicide conferences.

The Link's National Resource Center for Suicide Prevention and Aftercare
348 Mt. Vernon Highway NE
Atlanta, GA 30328
(404)256-9797
www.thelink.org
Offers therapy, support groups, and educational programs. Provides resources to those affected by suicide.

National Alliance for the Mentally Ill (NAMI)
(800)950-NAMI (6264)
www.nami.org
Provides information about family support and self-help groups. Their web site includes links to information about teen suicide, child suicide, brain biology and suicide, as well as general suicide information links.

National Depressive and Manic-Depressive Association (NDMDA)
(800)82-NDMDA (63632)
www.ndmda.org
Information on local patient and support groups. Their web site provides information about biological causes for suicidal feelings, what to do if you or someone you know is suicidal, and possible suicide therapies.

National Hopeline Network
609 East Main Street, #112
Purcellville, VA 20132
(800)442-HOPE
(540)338-5756

www.hopeline.com
www.livewithdepression.org
National 24 hour, 7 day a week toll-free suicide hotline: 1-800-SUICIDE

The National Mental Illness Screening Project Suicide Division
(800)573-4433
www.nmisp.org
Hotline can help you locate a free, confidential screening.

National Organization for People of Color Against Suicide (NOPCAS)
P.O. Box 125
San Marcos, TX 78667
(830)625-3576
www.nopcas.com
Provides education on suicide intervention, prevention, and postvention and conduct research.

Organizations for Attempters and Survivors of Suicide and Interfaith Services (OASSIS)
4541 Burlington Place, NW
Washington, DC 20016
(202)363-4224
www.oassis.org
Works with people who have been affected by suicide to increase suicide awareness and to remove the stigma on attempters and survivors. Offers education, training to caregivers, and consultative services.

The Samaritans
PO Box 5228
Albany, NY 12205
(518)689-0080
Affiliated with 1-800-SUICIDE, a toll-free crisis line.

Suicide Awareness\Voices of Education (SA\VE)
7317 Cahill Road, Suite 207
Minneapolis, MN 55439
(952)946-7998
www.save.org
Provides suicide education, facts, and statistics on suicide and depression. It links to information on warning signs of suicide and the role a friend or family member can play in helping a suicidal person.

Suicide Information & Education Centre (SIEC)
201-1615-10th Avenue, SW
Calgary, Alberta, Canada T3C 0J7

(403) 245-3900
www.siec.ca
SIEC is a special library and resource center providing information on suicide and suicidal behavior.

Suicide Prevention Advocacy Network (SPAN)
5034 Odin's Way
Marietta, GA 30068
(888)649-1366
www.spanusa.org
SPAN is a nonprofit organization dedicated to creating an effective national suicide prevention strategy. SPAN links the energy of those bereaved by suicide with the expertise of leaders in science, business, government, and public service to achieve the goal of significantly reducing the national suicide rate by the year 2010.

Suicide Prevention Research Center
www.suicideprc.com
Affiliated with the University of Nevada, Trauma Institute. Keeps suicide statistics and completes research on suicide for the state of Nevada. Developing methologically sound procedures for the study of suicide.

Yellow Ribbon Foundation
Light for life Foundation International
P.O. Box 644
Westminster, CO 80036-0644
(303) 429-3530
www.yellowribbon.org
Geared towards youth and schools, offers training and workshops. Disseminates yellow ribbons to commemorate death of loved ones to suicide.

Bibliography

Addressing Barriers to Learning (Summer, 1999). Youth Suicide/Depression/Violence. Center for Mental Health in Schools. Volume 4 (3). School Mental Health Project, UCLA.

American Academy of Child and Adolescent Psychiatry (1998). Teen suicide. Facts for Families, 10. Washington, DC: Author.

Berman, L. & Jobes, D. (1995). A population perspective: suicide prevention in adolescents (age 12-18). Suicide and Life Threatening Behavior, 25, 143-154.

Centers for Disease Control (1995). Youth Risk Behavior Surveillance System.

Centers for Disease Control (2002). Suicide in the United States: The problem. National Center for Injury Prevention and Control: Atlanta, GA. Retrieved on October 31, 2002 from http://www.cdc.gov/ncipc/factsheets/suifacts.htm.

Cliffone, J. (1993). A classroom presentation to adolescents. Social Work, 38, 197-203.

Eggert, L. L., Thompson, E. A., Herting, J. R., & Nicholas, L., J. (1995). Reducing suicide potential among high-risk youth: tests of a school-based prevention program. *Suicide and Life Threatening Behavior, 25 (2)*, 276-296.

Frankenfield, D.L., Keyl, P.M., Gielen, A., Wissow, L.S., Werthamer, L., Baker, S.P. (2000). Adolescent patients – healthy and hurting? Missed opportunities to screen for suicide risk in the primary care setting. Archives of Pediatrics & Adolescent Medicine, 154(2), 162-168.

Goodenow, C. (1993). The psychological sense of school membership among adolescents: Scale development and educational correlates. Psychology in the Schools, 30, 79-90.

Gould, M. & Kramer, R. (2001). Youth suicide prevention. Suicide and Life Threatening Behavior, 31 (Suppl), 6-31.

Isakson, K. & Jarvis, P. (1999). The adjustment of adolescents during the transition into high-school: A short-term longitudinal study. Journal of Youth and Adolescence, 28, 1-26.

Kalafat, J. & Elias, M. (1992). Adolescents' experience with and response to suicidal peers. Suicide and Life-Threatening Behavior, 24, 315-321.

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

Los Angeles Unified School District website. Retrieved February 26, 2003 from http://www.ac.wwu.edu/~hayden/spsp/los_angeles_Bulletin.htm Youth Suicide Prevention Program Bulletin No. Z-36, March 31, 1998.

Miller, M. & Hemenway, D. (1999). The relationship between firearms and suicide: a review of the literature. Aggression and Violent Behavior, 4, 59-75.

National Institute of Mental Health (1999). Frequently asked questions about suicide. Bethesda, MD: Department of Health and Human Services. Retrieved on October 31, 2002 from http://www.nimh.nih.gov/research/suicidefaq.cfm.

Overholser, J. C., Hemstreet, A., Spirito, A., & Vyse, S. (1989). Suicide awareness programs in the schools: effect of gender and personal experience. Journal of the American Academy of Child and Adolescent Psychiatry, 28, 925-930.

Patros, P.G. & Shamoo, T.K. (1989). Depression and suicide in children and adolescents: prevention, intervention, and postvention. Boston, MA: Allyn and Bacon, Inc.

Shaffer, D., Pfeffer, C. R., Bernet, W., Arnold, V., Beitchman, J., Benson, R. S., Bukstein, O., Kinlan, J., McClellan, J., Rue, D., & Shaw, J. (2000). Practice parameters for the assessment and treatment of children and adolescents with suicidal behavior. Washington, DC: American Academy of Child and Adolescent Psychiatry.

Shaffer, D., Vieland, V., Garland, A., Rojas, M., Underwood, M., & Busner, C. (1990). Adolescent suicide attempters: response to suicide-prevention programs. Journal of the American Medical Association 264(24), 3151-3155.

Suicide Information and Education Centre (2002). SIEC Alert #41. Retrieved August 21, 2002 from www.siec.ca/library/alert/alert41.pdf.

U.S. Public Health Service, *The Surgeon General's Call To Action To Prevent Suicide*. Washington, DC: 1999.

Vieland, V. Whittle, B. Garland, A. Hicks, R., & Shaffer, D. (1991). The impact of curriculum-based suicide prevention programs for teenagers: an 18-month follow-up. Journal of the American Academy of Child and Adolescent Psychiatry, 30, 811-815.

Weist, M. (1999). Challenges and opportunities in expanded school mental health. *Clinical Psychology Review, 19*, 131-135.

World Health Organization (2000). Preventing suicide: A resource for teachers and other school staff. Mental and Behavioural Disorders, Department of Mental Health. Geneva: Author.