Reprinted from

Advancing Suicide Prevention

schools and suicide

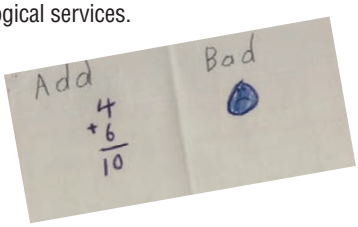
January 2006 Volume II Issue 1

"School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge."

Carnegie Task Force on Education

schools and suicide

As a psychologist in a New York City school district in the early 1990s, Susan Williamson saw far too many youngsters in need of psychological services.



But one story stays with her. It was that of a seven-year-old boy who talked about putting a knife into his heart. Williamson snagged the youngster by his belt as he tried to throw himself down a flight of stairs. Perhaps the event that summed up this child's despair occurred when Williamson was in her office on the phone with social services. The child was with her. "He crawled into my wastepaper basket. The symbolism struck me. He felt totally alone and worthless. Like a throwaway child," Williamson recalls. The unsettling incident happened 15 years ago. Yet it is still very present in her thoughts and work today as a school psychologist in Plymouth, Wisconsin.→

"We're talking about **millions of school-age children who are losing hope** in themselves and their future." This is youth suicide: tragic, shocking, incomprehensible.

—A. KATHRYN POWER, MEd, Director, Center for Mental Health Services, SAMHSA, U.S. Department of Health and Human Services

Jonathan Zablotny awoke at 6:45 a.m. on a Tuesday last February. The high school senior got out of bed, showered, ate breakfast, and departed for his school five blocks from his San Francisco home. He never made it. Instead he jumped from a bridge that day, his backpack, filled with schoolbooks and binders, still strapped to his back.

Jonathan's father Ray Zablotny, a clinical psychiatrist who has practiced for 25 years, served on his hospital's suicide review committee until his son's death.

"I can't do it anymore," says Zablotny of his committee role. "You do all you can to protect them. And then this happens."

Jonathan is one of thousands of children and young adults who die tragically by their own hand each year. A heartbreaking yet often preventable tragedy, suicide is *the third leading cause* of death among 10- to 24-year-olds. Moreover, experts estimate that only 1 out of every 100 to 200 youth suicide attempts result in death.

The upshot? In a typical high school classroom, it's likely that three students have made a suicide attempt in the past year, according to the American Association of Suicidology.

Since the 1950s suicide among youths ages 15–24 has increased by **200%**

The numbers don't improve for post-high school young adults, with suicide rising to be the second leading cause of death for college students. Among them is University of Pennsylvania running back Kyle Ambrogi, a 21-year-old college senior who killed himself on October 11, two days after scoring two touchdowns in what was reported to be one of the best games of his career. Friends and teammates knew Ambrogi suffered from depression, but thought he had been getting better recently, reported *The Daily Pennsylvanian*.

"We're losing 4000 children every year to an outcome that's preventable. The ripple effect of that is huge," says psychiatrist-researcher Morton M. Silverman, MD, an expert on youth suicide and former director of the Student Counseling and Resource Service at the University of Chicago. "Research shows eight or more people are affected quite dramatically by each death. And there's the morbidity associated with suicidal behavior among hundreds of thousands of people. The cost to society is huge. For every youth suicide death, there can be 100 or more attempts; hundreds of thousands of visits to emergency rooms each year for suicidal behaviors. That's a drain on all kinds of economic systems. And a lot of people who attempt, will repeat; they have a higher risk for dying by suicide."

More than one in four Hispanic girls in grades 5–12 report symptoms of depression. And Hispanic adolescent girls have higher rates of reported suicide attempts than Non-Hispanic White and Black adolescent girls or boys. Yet because of language, cultural, economic and other barriers, far too few of these vulnerable youngsters receive the mental health services they desperately need.

These statistics—and the real people behind them—distress A. Kathryn Power, director of the Center for Mental Health Services at SAMHSA, the Substance Abuse and Mental Health Services Administration. Power addressed the topic of youth suicide at the August 2005 national conference of the U.S. Department of Education's Office of Safe and Drug-Free Schools.

"We're talking about millions of school-age children who are losing hope in themselves and their future," she said. "This is youth suicide: tragic, shocking, incomprehensible. Angry, guilty and bewildered, we find ourselves asking, 'Why are these children giving up on themselves? What signs did we miss? What can we do to prevent this tragedy from happening again?'"

Schools—a fitting place for suicide prevention?

Halting youth suicide has become a focus at federal, state, tribal and local levels. And schools are among the key settings where suicide prevention can occur, according to experts in education, pediatrics, child psychiatry and violence prevention.

"Schools have a mandate to educate and protect students. It's in the legislation state by state," says Rutgers University researcher John Kalafat, PhD, an expert in implementing and evaluating school-based suicide prevention programs. "The kids are there already—that's where you're going to find them. So that's where prevention and intervention can occur."

Because they interact with children during so much of the day, staff can pick up on changes in performance that are precursors for troubled behaviors in children. Wisconsin educator Linda Larson knows this all too well. An experienced elementary-level teacher with a master's degree in education and "tons of psychology courses," Larson was still unable to recognize early signs of mental illness in her fifth-grade son Adam, the eldest of her three children.

"I remember the principal in my elementary school had a whole lot of background on troubled adolescents," recalls Linda, with the clarity of hindsight. "He spoke to me about Adam and the signs he saw for potential trouble later. He even put an EAP (employee assistance program) slip in my mailbox at school."

Linda saw her former boss nine years later, after her son had dropped out of high school and endured years of substance abuse. He ended his own life on April 22, 1992, at age 20.

"I told my former principal, 'You saw this coming a long time ago, didn't you?' But as parents, we didn't accept it at the time. He was our first child. We didn't accept the message right away." →

By the numbers

45%
College students who reported they feel so depressed that they can barely function (American College Health Association survey)

900,000
Youths who planned suicide during their worst or most recent episode of major depression, with 712,000 attempting suicide during such episodes (SAMHSA)

124,409
Visits to U.S. emergency departments after attempted suicides or other self-harm incidents among persons ages 10–24 years (CDC)

16.9%
Students in grades 9–12 who have seriously considered attempting suicide during the past 12 months (CDC)

Emotional disturbances in young children can indicate potential for mental illness and thoughts of suicide as they grow older.

Young struggles

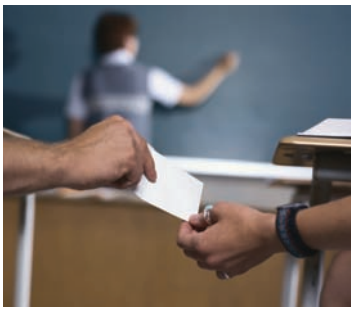
In its National Comorbidity Survey Replication (NCS-R) released in July 2005, the National Institute of Mental Health (NIMH) revealed the incredible prevalence of mental illnesses, the early age of onset and the tragically long delay before most individuals sought treatment.

Often emerging in childhood

The age of onset for most mental disorders is concentrated in a narrow range during the first two decades of life. Surprisingly, half of all lifetime cases of mental illness begin by age 14, and three-quarters of illnesses by age 24.

These are the sorts of red flags that parents or the community may not recognize, but schools—by virtue of their unique roles—can see. These include sexual promiscuity, substance abuse, emotional disorders and propensity for violence, turned both outward and inward.

"All the things society sort of dumps on schools," Kalafat muses. "But I think we as a society all share the failure. For better or worse, schools are the site for a lot of prevention programs."



Youths may confide in friends about feelings and thoughts, including those of suicide. Yet most peers are ill-equipped to deal with these matters of life or death.

Additionally, schools can at times be the source of bullying and other problems that can lead to suicide. Therefore it seems appropriate that schools take steps to minimize factors that lead to student alienation and despair.

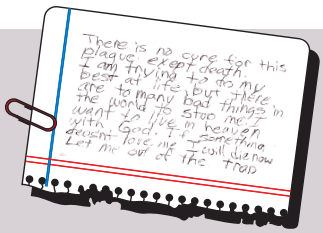
Psychiatrist-researcher Silverman agrees that schools indeed are a fitting place for suicide prevention.

"Schools have a significant role. I have no doubt about that," he says."How does that role mesh with their stated mission and goals?" asks Silverman. "Is suicide prevention an add-on or extension of what they're doing? How is it perceived, adapted, accepted and funded?"

All good questions. And with answers that vary among states and from one district to another, depending on the mind-set and priorities of those who set school policy.

Emphasis on academics

Rosemary Rubin thinks schools should be engaged in prevention so kids don't start down the continuum of self-destructive behaviors that can culminate in suicide. Co-chair of the Los Angeles County Child and Adolescent Suicide Review committee, Rubin works in the LA Unified School District and has spent a decade in its suicide prevention unit. Her experiences with suicidal children as young as 10 years



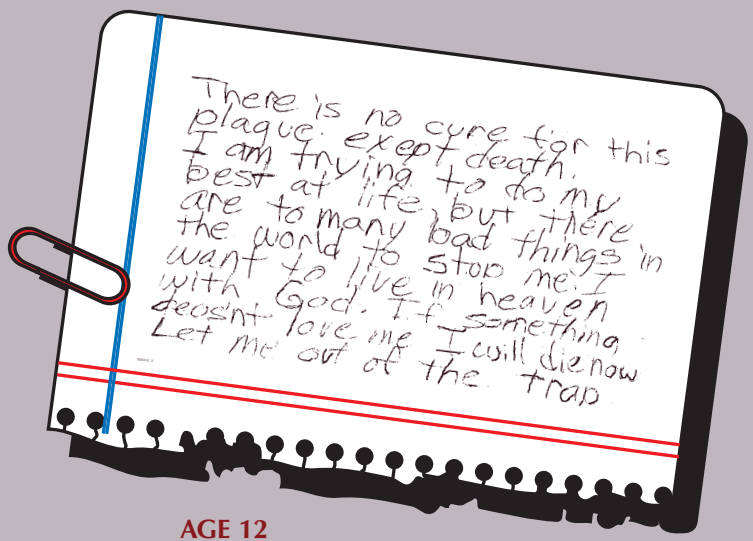
EDITOR'S NOTE: The original notes and artwork presented here were shared by parents of a child who, at age 11, was tested for ADHD when he was in the 4th grade. Instead, the diagnosis was severe clinical depression with suicidal ideation. Seven years later this child took his life. He had just turned 18, was a month into his senior year of high school, and considered studying art and architecture in college.

More common than we think

Mental disorders are highly prevalent with about half of Americans meeting the criteria for a DSM-IV diagnosis over the course of their lifetime, and with first onset usually in childhood or adolescence.

Not recognized or treated quickly enough

Documenting long delays between the onset of a mental disorder and first treatment, the NCS-R suggests that the earlier in life a disorder begins, the slower the individual is to seek therapy—and the more persistent the illness.



AGE 12
Excerpt from letter to psychotherapist

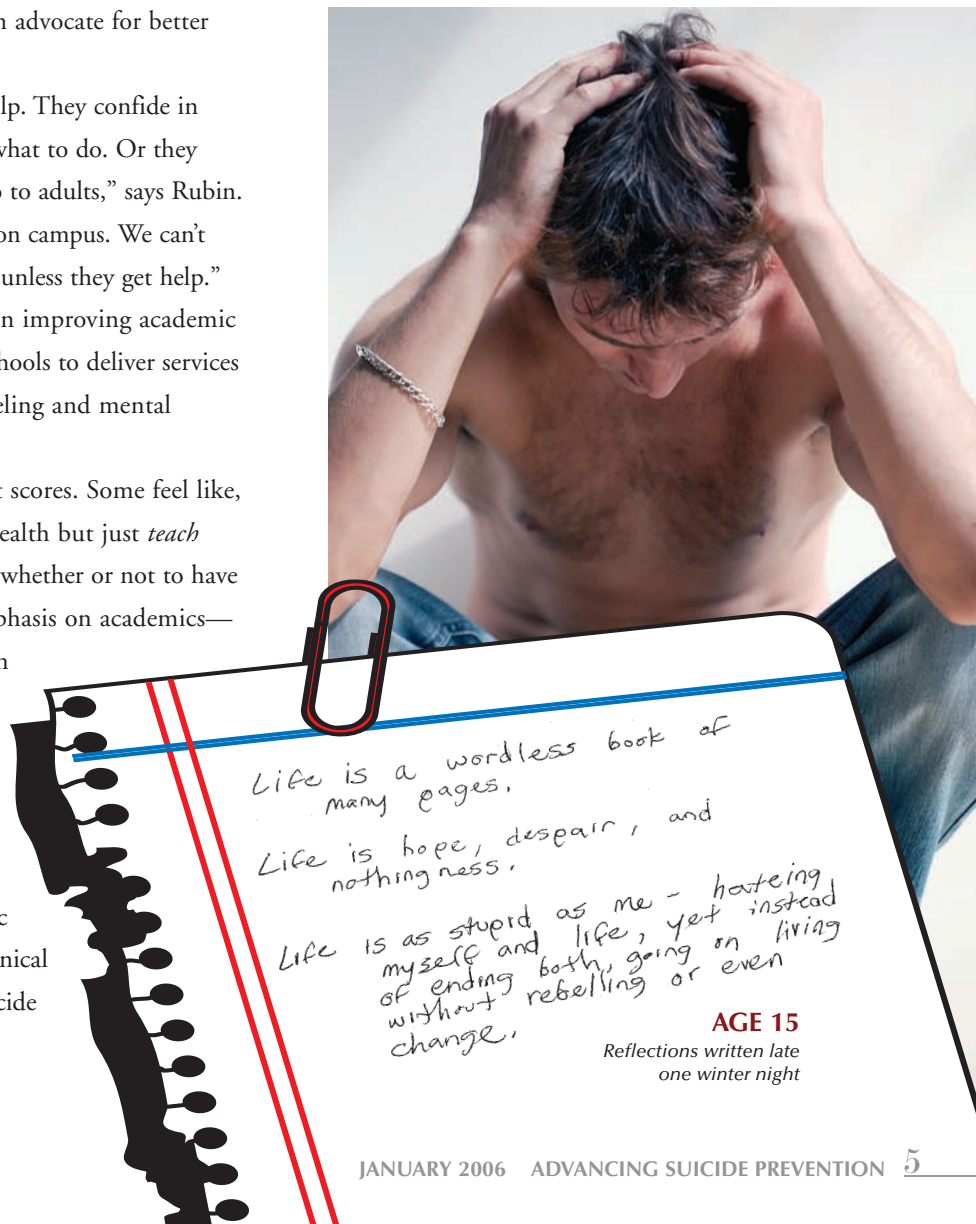
old has left its mark on Rubin and made her an advocate for better suicide prevention in schools.

"So many kids have a hard time getting help. They confide in peers, and peers for the most part don't know what to do. Or they won't break a confidence; they don't want to go to adults," says Rubin. "Administrators need to know suicidal kids are on campus. We can't ignore them. They won't benefit from learning unless they get help."

Rubin believes that the recent emphasis on improving academic performance has compromised the ability of schools to deliver services that address the whole child, including counseling and mental health services.

"Schools are so focused on improving test scores. Some feel like, 'What we need to do is *not* focus on mental health but just *teach better*,'" Rubin notes. "Schools are questioning whether or not to have mental health counselors on campus. The emphasis on academics—especially among low-achieving schools—is an outcome of the *No Child Left Behind* mentality, and it's tied to funding dollars. But these low-performing schools may be the ones who need mental health counselors most."

When a child is suicidal, involving parents can be challenging, especially in ethnic communities. Sherry Davis Molock, PhD, a clinical psychologist and researcher who focuses on suicide among diverse populations, explains why. →



AGE 15
Reflections written late one winter night

Gatekeepers

People who can intervene to help troubled, vulnerable or suicidal youths include:

- Teachers
- Parents
- Siblings
- Relatives
- Peer friends
- Guidance counselors
- School psychologists

- Coaches
- School bus drivers
- Health-care workers
- Police officers
- Librarians

- School administrators
- Substance-use counselors
- Juvenile detention staff

Youngsters from ethnic or impoverished communities face struggles that can place them at increased risk for suicide.

"Participating in a school setting for families in communities of color can be a challenge," notes Molock. "Either they can't get off work, or they need transportation or child care. Some distrust the school system; they've felt the system has been racist or oppressive. They perceive a program as being punitive, and that puts it at a disadvantage. They may see it as a way of labeling their child as being deviant or bad. Parents sometimes feel, 'I won't trust you with my child's education, so why would I trust you with their mental health?'"

Delivering services to children in need is only one aspect of suicide prevention. Another aspect is teaching all children what good mental health is comprised of—and how to recognize signs for suicide in themselves or others.

"Schools can really help by building depression, anxiety, impulsivity into regular biology or health classes," says David Shaffer, MD, professor of psychiatry and pediatrics at Columbia University/New York State Psychiatric Institute. Shaffer is a renowned expert in youth suicide prevention. "The average child doesn't have any conception of what depression is, as an illness. They're aware of medication because a lot are on it. But they don't know what's involved in treatment. They don't know the subtle signs of depression—criticizing of self, feeling unwanted by other people. These cognitive aspects of depression are not known (by children), not talked about. I don't know why they're not being taught. We need a movement behind this, a curriculum behind it."

Shaffer notes that even more treatable than depression is anxiety—performance, separation and social in nature, and all prevalent among school and college youths. Yet if anxiety disorders go untreated, they can make one vulnerable to depression and thoughts of suicide.

"Anxiety is so common, so well understood that I think we should do more," adds Shaffer.

Scared to death

When it comes to suicide and schools, many adults are scared to death to address this, and misperceptions remain.

"Schools are very hesitant. They're afraid to talk about suicide for fear it will give students ideas," says Nora Howley, project director for HIV/School Health with the Council of Chief State School Officers (CCSSO).

Yet research shows that asking teenagers about suicide won't make them more likely to contemplate it, as some parents and school officials fear.

"This is an astounding impediment to these (suicide prevention) programs," says Madelyn Gould, PhD, MPH, a researcher at Columbia University and New York Psychiatric Institute. Gould was the lead author on an important study published last year that demonstrated no untoward effects of suicide screening emerging with two days of screening among students of New York City suburban high schools.

"Asking about suicide clearly didn't induce stress; it clearly relieved somebody in distress," adds Gould. "Kids think they can handle this on their own, yet on the other hand they're waiting for someone to ask them."

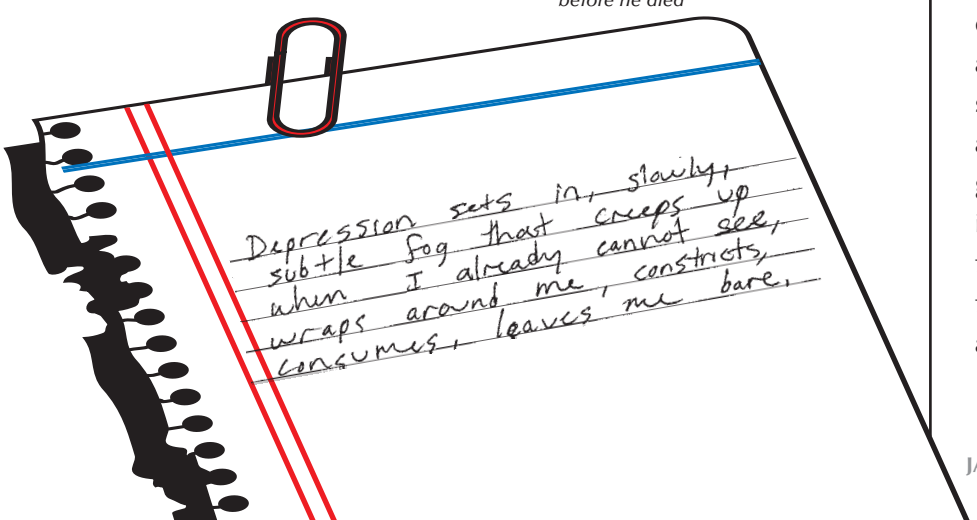
But saying the "s" word in school isn't the only fear schools have.

"And there's the contagion effect and the impact of celebrity suicide," continues CCSSO's Howley. "Quite frankly, schools try to include a lot. Prevention programs are important for schools to have. But how each state or district actualizes that varies. There are demands on school time. There's also liability—what happens if we train for something and then miss something? This is what schools are grappling with."

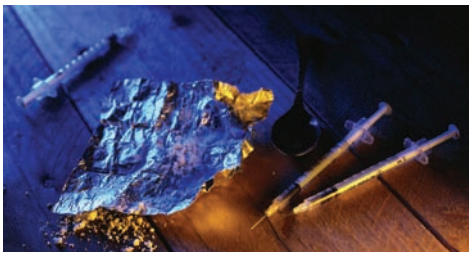
Susan Wooley, executive director of ASHA, the American School Health Association, agrees. →

AGE 18

Journal entry written a month before he died



Suicide:
Not an isolated event



Emotional problems in children and adolescents can be both serious and long-lasting—and may frequently lead to consequences such as:

- ✔ **Poor academic achievement**
- ✔ **Social isolation**
- ✔ **Failure to complete high school**
- ✔ **Self-medication with drugs or alcohol**
- ✔ **Promiscuity**
- ✔ **Involvement in correctional system**
- ✔ **Lack of vocational success**
- ✔ **Inability to live independently**
- ✔ **Health problems**
- ✔ **Suicide**

The settings that affect children's emotional well-being run broad and deep, including their families, schools, communities, employers and our nation at large. So it makes good sense to address mental health issues in children at early stages, and for many reasons including ethical, familial, occupational, financial—and societal.

Girls attempt suicide four times as often as boys, but boys die more frequently by their own hand, in part because they are prone to use more lethal means.

"By the time someone is in the 11th or 12th grade, **it's a little late to start talking suicide prevention.** It's a little late to talk about coping skills, resiliency, competency. You're behind the curve."

—MORTON M. SILVERMAN, MD, University of Chicago

"Suicide prevention is a controversial topic. It's typically covered in school health in places that address it. But a lot of schools don't," says Wooley.

Last year her organization issued a resolution on suicide prevention and intervention in schools. But ultimately schools have autonomy in how—and if—they choose to treat suicide education in the classroom setting.

"There's not one curriculum out there, and not one thing all schools do," Wooley notes. "Schools just don't work that way."

Even for schools willing to address suicide prevention, the challenge is where to fit it into the curriculum. Some dovetail suicide into instruction on recognizing depression and how to get help. But very few elementary schools address mental illness or depression—much less suicide—in classroom instruction, according to Wooley.

"It's more likely when some event happens. It's unfortunate that it occurs after the event rather than before," she notes.

Yet psychiatrist-researcher Silverman sees appropriate elementary-level instruction as pivotal in addressing not only suicide but a host of other related and destructive behaviors.

"By the time someone is in the 11th or 12th grade, it's a little late to start talking suicide prevention," notes Silverman. "It's a little late to talk about coping skills, resiliency, competency. You're behind the curve."

Helping the whole child

Suicide typically doesn't occur in isolation. Other factors are usually present such as access to weapons, engaging in unprotected sex, clinical depression, bullying, tobacco use and drinking alcohol.

"Everybody won't have all of them. But if you have one, you're likely to have more," says David A. Brent, MD, academic chief of child and adolescent psychiatry at the University of Pittsburgh School of Medicine.

So when families, schools or clinicians see risk-taking behaviors in youths, behaviors that could lead to suicide, approaching the whole child is critical.

"That can be potentially life threatening," warns Brent of a singular or silo approach to treating a child with multiple risk factors. "The question is how to help the whole kid without overwhelming the clinician, school or family."

Brent sees school-based health clinics as a step in the right direction. These centers provide physical and mental health services to children in need of care—and at locations accessible to them. Their numbers have grown to nearly 1500 in the 2001/2002 school year, according to 2003 data released by the Robert Wood Johnson Foundation.

"School-based clinics, something between student counseling and intensive clinics, are good. A place where kids get help on campus and wouldn't have to go to another facility," notes Brent.

"They are a lot more beneficial because students can be referred internally, meaning low hassle and earlier intervention. For those at-risk kids who aren't in school but in correctional facilities, it's the same model: it's integrating mental health care in some place where the kids already are." →

Issues that impede treatment of children and teens

Barriers to treating suicidal youths are staggering, formidable and can have dire and deadly consequences. These barriers include:

Youths' reluctance to seek help

Harmful attitudes about help-seeking behaviors among vulnerable adolescents are real and life threatening. Research shows that youths at most serious risk for depression and suicidal ideation are the ones who often reject reaching out for help. Alarmingly, they are much more likely than their stable peers to feel that suicidal thoughts should be handled by oneself, and are unlikely to advise suicidal friends to seek out a mental health professional.

Access to guns

Suicide can be an impulsive act, particularly among youths. When a gun is used, the suicide attempt is likely to be fatal. So giving depressed or suicidal youths access to guns—no matter what the justification—can be deadly. This is supported by research showing that areas with higher household gun ownership rates have higher suicide rates, even when controlling for things also associated with suicide, like divorce rates and unemployment.

Severe shortage of child mental health practitioners

There are only about 7400 child and adolescent psychiatrists in the United States, with most practicing in highly populated areas. Yet, conservatively about 12 percent of U.S. children and adolescents suffer from functionally impairing mental disorders, according to cautious estimates from the Institute of Medicine and National Institute of Mental Health. This dearth of child psychiatrists places a burden on pediatricians, family physicians and others to identify at-risk children—and make referral and treatment decisions for which they may be inadequately trained.

Fragmented services

Identifying youngsters at risk for suicide is only a first step; getting them help is critical to saving lives. That can be a challenge for schools, parents and others who must identify fragmented community services and integrate those services to best serve vulnerable children.

Stigma and parental resistance

Facing the fact that their child could be suicidal is more than many parents can emotionally bear. In defense they may contend their child's problems aren't that serious. Or their parenting skills may be impaired by mental illnesses or addictive disorders of their own. Other reasons for parental resistance in getting help for suicidal children can include societal stigma toward suicide and mental illness, an assumption that the parent is always going to be blamed, insensitivity or lack of understanding about actual risk for suicide in their child, or privacy issues and having family matters opened to public scrutiny.

Financial limits

Over 43 million Americans lack health insurance, and those who have coverage often face discriminatory and strict limits imposed on mental health services. Yet suicidal youths may require intensive treatment that is not covered by health insurance, or can wipe out coverage in a brief period of time.

Antidepressant medication safety warnings

The number of antidepressant prescriptions dispensed to youths 18 and under dropped significantly after the FDA issued a strong warning regarding their safety in 2004. While use of antidepressants in children and adolescents has been controversial, some fear backlash from this warning may put emotionally disturbed youngsters at risk. Those who might benefit from medication may no longer have access to it because of fears of parents or prescribing physicians.

Threat of litigation

Recent lawsuits brought against school districts and universities whose students have completed suicide have made many educators take notice. They've also brought attention to evidence-based school interventions that address youth suicide. Yet some schools remain reticent to implement effective, comprehensive programs and policies, even though *absence* of these may place students, staff and school districts at risk.

"The competent community is where **everybody tries to support and take care of one another**—and where they have the competence to do that." —JOHN KALAFAT, PhD, Rutgers University

The competent community

A key in deterring a child from engaging in risky behaviors—including suicidal thoughts and acts—is how engaged the youngster feels to both family and school. This is according to research, including findings from the 1997 National Longitudinal Study on Adolescent Health. In fact, a feeling of connectedness was the number-one protective factor for students against suicidal behavior according to the study, which surveyed more than 90,000 students in grades 7–12.

"Drifting, not being engaged in family or school has a very strong association with suicide in young men," the University of Pittsburgh's Brent adds. "So increasing the connection to school, family and others is good."

A caring, competent and connected community is critical to suicide prevention, say experts. This "competent community" offers a climate where students feel respected, supported and comfortable with approaching an adult when facing problems. It's where prevention programs are not short-term or delivered in isolation, but well-integrated. And it has strong community links with parents, health providers, social services, juvenile justice, treatment facilities and other institutions.

Being engaged in family, school and community is a key to preventing suicide. It's important for youths to feel comfortable, connected, respected and supported by peers and adults.

"The Air Force took up this theme. That's the model: Leaders dedicated to protecting members of the community," says school suicide prevention expert Kalafat. He is referring to the U.S. Air Force suicide prevention initiative which uses a system-wide community approach and has been shown to markedly reduce rates of suicide among enlisted personnel.

Yet building a competent community that can address youth suicide is challenging. Priorities vary for school administrators, parents, staff, children and community agencies. And critical issues may be neglected because different community stakeholders have limited time, scopes of responsibility and views regarding suicide.

"The stigma associated with suicide is huge," notes the University of Chicago's Silverman. "So it's not simple to convince principals and school administrators that this is a needed, important, valuable part of their curriculum."

Kalafat agrees and notes that inundated school administrators think twice about adding another element to their curricula or campus services, especially when it has to do with suicide.

"Schools are dealing with so many things. And they think, 'How often does suicide occur, and how often on school grounds?'" Kalafat notes. "An administrator will tell me, 'Look, I'm having to deal with violence, drugs, pregnant teens, an increasingly heterogeneous student population—some of which are totally unprepared to learn. Tell me why I have to deal with this.'"

But that's exactly the point. Sound suicide prevention programs can have many spin-off benefits, according to research, sort of a "halo effect" in curbing other youth risk behaviors.

"We have to convince school administrators that a competent community is what they'd support. That it dovetails with a good school climate where we support and respect each other," adds Kalafat. And that means not just focusing on suicide prevention, but on reduction of substance abuse, violence, bullying and other benefits that can accompany it. It's about building help-seeking behaviors in general among youngsters—and having people trained to respond appropriately to these children when they reach out."

SUICIDE PREVENTION PROGRAMS FOR SCHOOL SETTINGS

School-based suicide prevention programs can include suicide-awareness curricula, screening, gatekeeper training, peer helper programs, postvention/crisis intervention or skills training. Care should be taken when selecting a program because some have not been shown effective. Below are programs worthy of consideration from SPRC, the Suicide Prevention Resource Center (sprc.org). Also see The Youth Suicide Prevention School-Based Guide, a valuable and comprehensive tool for schools at theguide.fmhi.usf.edu/.

EFFECTIVE

C-Care/CAST
(Coping and Support Training)
Combines one-on-one counseling with small-group training sessions
Target ages: 14–18
Info: elainet@u.washington.edu

PROMISING

Lifelines
Curriculum on warning signs of suicide, how to respond to a suicidal peer, help-seeking and school resources
Target ages: 12–17
Info: kalafat@rci.rutgers.edu

Reconnecting Youth
Semester-long class for youths with at-risk behaviors; teacher and peer group support is core hypothesis
Target ages: 14–18
Info: beth.mcnamara@comcast.net

Zuni Life Skills Development
Culturally tailored intervention to improve communication, increase goal setting, manage anger and depression, respond appropriately to a suicidal peer
Target ages: 14–18
Info: lafrom@stanford.edu

Columbia TeenScreen®
Screens teens (with parental permission) to identify those at greatest risk so that appropriate intervention can occur
Target ages: 11–18
Info: teenscreen@childpsych.columbia.edu

SOS Signs of Suicide®
Combines two prominent strategies into single program: curriculum and screening
Target ages: 14–18
Info: highschool@mentalhealthscreening.org

UNRATED

ASIST
Knowledge of warning signs, how to help
Info: info@livingworks.net

Yellow Ribbon®
Promotes help-seeking behavior
Info: Ask4help@yellowribbon.org

EFFECTIVE: Utilized superior evaluation methods. PROMISING: Evaluated with less rigorous methods or showed moderate causal link between program and outcomes. UNRATED: Theoretically sound but not sufficiently evaluated to place them in other categories.

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