

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.

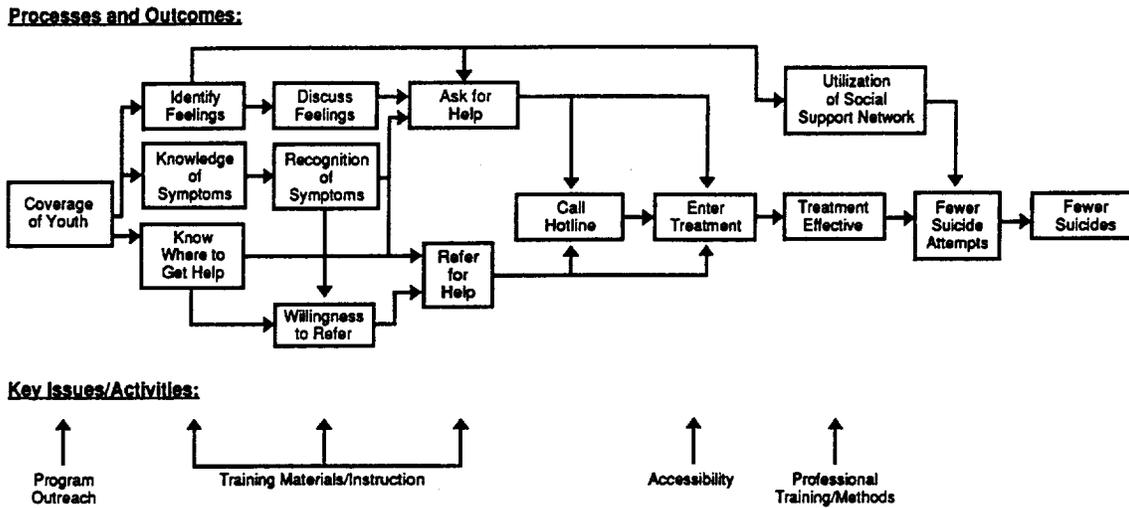
General suicide education programs are designed to achieve some or all of the following goals:

- **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.

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.

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.

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)	Comparison (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

Issue	Demonstration		Comparison	
	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.

- 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

Issue	Demonstration		Comparison	
	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.

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."

- **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, 489 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.

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.

<u>Program</u>	<u>Rationale for Inclusion</u>
East:	
Adolescent Suicide Awareness Program (ASAP) Self Esteem For Life Fitness (SELF) "Getting to Know Me" Lyndhurst, New Jersey	<ul style="list-style-type: none"> ● Nine years in operation ● Strong ties to community program
New Jersey Adolescent Suicide Prevention Project Trenton, New Jersey	<ul style="list-style-type: none"> ● Multischool program ● Evaluation study
Samaritans of Rhode Island Providence, Rhode Island	<ul style="list-style-type: none"> ● Statewide program ● Evaluation data
Midwest:	
Suicide Prevention Center Program Dayton, Ohio	<ul style="list-style-type: none"> ● Ten years in operation ● Comprehensive program
South:	
Delaware Youth Suicide Prevention Wilmington, Delaware	<ul style="list-style-type: none"> ● Eight-day lesson program ● Multischool program
Jewish Family Service New Orleans, Louisiana	<ul style="list-style-type: none"> ● Four-day program by nonschool group ● Large minority population
Project SOAR Dallas, Texas	<ul style="list-style-type: none"> ● Comprehensive program ● Large minority population
Crisis Center of Collin County Plano, Texas	<ul style="list-style-type: none"> ● Eight years in operation ● Strong link with hotline
West:	
California School Suicide Prevention Los Angeles, California	<ul style="list-style-type: none"> ● Large school program ● Minority population
Weld County Suicide Prevention Johnstown, Colorado	<ul style="list-style-type: none"> ● Comprehensive program ● Rural youth
Suicide Prevention and Crisis Call Center Reno, Nevada	<ul style="list-style-type: none"> ● Comprehensive program ● High suicide-risk area

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

Dunne-Maxim, K. Can a suicide prevention curriculum harm students' health? *The School Administrator* 1991;48(5):25.

Nelson, F.L. Evaluation of a youth suicide prevention program. *Adolescence* 1987;20:813-825.

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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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

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

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.

**General Suicide Education:
Program Descriptions**

**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).

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.

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.

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.

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.

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

Youth Suicide Prevention Programs: A Resource Guide

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

**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.

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.

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

Youth Suicide Prevention Programs: A Resource Guide

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.

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.

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.

Youth Suicide Prevention Programs: A Resource Guide

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.