NEW JERSEY DEPARTMENT OF HUMAN SERVICES
Division of Mental Health and Hospitals

Governor's Advisory Council on Youth Suicide Prevention

FINAL PROJECT REPORT

March 1988

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April, 1988

The Honorable Thomas H. Kean
Governor, State of New Jersey
The State House
Trenton, NJ 08625

Dear Governor Kean:

On behalf of the Governor's Advisory Council on Youth Suicide Prevention, I am pleased to forward to you a copy of our final project report.

This report is the culmination of many hours of work by the dedicated members on the Advisory Council and an outstanding staff. I'm sure you will be pleased to learn that the Council's efforts have been greatly facilitated by the excellent cooperation we received from Commissioner Drew Altman's staff at the Division of Mental Health and Hospitals, and by Commissioner Saul Cooperman's staff in the Division of General Academic Education. This unique partnership has greatly enhanced the work of the Council and contributed to making us unique in the nation. It is only with the collaboration of both the educational system and the human services system that these difficult issues can be challenged.

We believe this report clearly depicts the leadership position the State of New Jersey is in with regard to the prevention of and intervention in youth suicides. Under your direction and guidance, New Jersey stands alone among the states in having the only program which has been subject to an impartial evaluation which has determined its effectiveness.

We hope you will join with us in continuing the work of this Council so we can more adequately address all of the unmet needs of youth who are at-risk of suicide.

Sincerely,

Gary W. Lamson

Gary W. Lamson, Chairman

COUNCIL MEMBERS

Joel Bloom
Patricia Fredericks
Dennis Lafer
Joyce Meyers
Michael Redpath
Michael Ryan
Peter Scerbo
Mike Tolino
Judith Wilcox

DEPARTMENT OF HUMAN SERVICES

Division of Mental Health and Hospitals

GOVERNOR'S ADVISORY COUNCIL ON YOUTH SUICIDE PREVENTION

Final Project Report

March 1988

ACKNOWLEDGEMENTS

For their interest, continuing support, and life-affirming commitment to the youth of New Jersey, the Governor's Advisory Council on Youth Suicide Prevention would like to gratefully acknowledge:

The Honorable Thomas H. Kean, Governor of New Jersey

Senator Richard J. Codey; D; District 27

Assemblyman George J. Otlowski; D; District 19

Assemblyman Frank J. Gargiulo; R; District 32

Assemblyman Charles J. Catrillo; R; District 32

Assemblyman Jose O. Arango; R; District 13

Assemblyman Ronalda Dario; R; District 33

Drew Altman, Commissioner, Department of Human Services

Saul Cooperman, Commissioner, Department of Education

The Council would like to especially acknowledge the following schools whose support, cooperation, and patience were integral to the Project's success:

Academic High School, Jersey City, NJ
Science High School, Newark, NJ
Ferris High School, Jersey City, NJ
Barringer High School, Newark, NJ
New Brunswick High School, New Brunswick, NJ
Monroe Township High School, Jamesburg, NJ
Hopatcong High School, Hopatcong, NJ
Delsea High School, Franklinville, NJ
Egg Harbor Township High School, Egg Harbor Township, NJ
Gateway Regional High School, Woodbury Heights, NJ
Point Pleasant High School, Point Pleasant, NJ

Executive Summary

Suicide is a serious public health problem. While suicide is a concern at every age, its rank as a leading cause of death is highest among New Jerseyans aged 15-24, where it is tied with homicide as the second leading cause of death.

As part of New Jersey's response to this tragic phenomenon, Senate Bill 2005, sponsored by Senator Richard J. Codey, and signed into law by Governor Thomas H. Kean in June 1985, created the Adolescent Suicide Prevention Project. This report, a summary of the Project's activities over the last 2 years, is presented by the Governor's Advisory Council on Adolescent Suicide Prevention. The Advisory Council was established by the legislation and appointed by the Governor to oversee the Project and make recommendations for statewide replication at the Project's completion.

One of the Project's primary tasks has been the development of school-based adolescent suicide prevention programs, complete with an evaluation of effectiveness provided by an independent investigator with an international reputation in the field of adolescent suicide. This evaluation is the first in the nation and provides base-line data on adolescent suicide prevention for schools throughout the country.

From its inception in 1986 through the spring of 1987, the Adolescent Suicide Prevention Project delivered quality suicide prevention programs to large numbers of students, educators and parents statewide. In the schools where pilot programs were conducted, over **1,140** students, **485** faculty, and **300** parents received the message that adolescent suicide is preventable. The Project's central theme, prevention through identification and education, was reiterated through programs that provided information about suicide's warning signs and stressed the importance of identifying at-risk teens and referring them for help. The Project also alerted audiences to referral resources both within the school and local community.

Findings from the evaluation of these pilot programs provided important data to indicate that teens who are thinking about suicide will self-identify. Screening for students currently thinking about suicide uncovered **72** students who self-identified as feeling suicidal and were then referred for help as a result of the programs. In addition, over **11%** of the students admitted to having made previous suicide attempts, which also placed them in the high-risk category. Another critical finding was that there was no evidence to support the concern some mental health professionals and educators have expressed that school-based programs of the type evaluated increase suicidal preoccupations or behaviors in vulnerable students. Fewer than **10%** of the students were either

personally distressed by the programs or knew of another student who had been distressed by them. Among students who identified reasons for this distress, a predominant response was remorse or regret over missed opportunities to help another student who had been suicidal. The evaluation also demonstrated that the majority of students were somewhat knowledgeable and held relatively sensible attitudes about suicide. Eighty-nine percent (**89%**) of the participating students reported they would encourage participation by other students in similar programs. There was no consistent change in the small minority of students who were distrustful of help and would keep suicidal preoccupations to themselves. Obviously, this is a group upon which to focus future program efforts. There was a statistically significant increase in educator knowledge about suicide warning signs, community resources, and school policies for identifying and referring at-risk students. Educators also evidenced overwhelming support for providing suicide awareness programs to students.

In addition, the Project provided technical assistance, program information, and consultation to over **250** mental health agencies and educator groups both in New Jersey and across the nation. Regional conferences were also held to bring information about school-based suicide awareness programs to over **600** New Jersey mental health professionals and educators.

One of the Project's most visible additional accomplishments was its assistance to the Borough of Bergenfield in the aftermath of the multiple suicides that occured in March, 1987 (ie, "postvention"). In keeping with the Project goal of developing a coordinated and practical system for making mental health resources available to school districts, a team of mental health professionals and educators from the Departments of Human Services and Education worked closely with Bergenfield High School staff to provide consultation and intervention to school administrators and faculty for several weeks following the crisis. Technical assistance was also provided to the team of community leaders coordinating Bergenfield's short- and long-term strategy. Project staff also spent many hours responding to the hundreds of media requests for information about adolescent suicide and encouraging responsible journalistic reporting of the events.

Because the Project's response to the Bergenfield tragedy was so effective, the National Center for Disease Control requested that staff from the New Jersey Project host a workshop considering recommendations for the prevention and containment of suicide clusters. Several New Jersey mental health professionals and community leaders spoke at the workshop about the strategy developed in response to the Bergenfield suicide cluster. Materials were drafted that will be disseminated nationally by CDC. The participation of the Project with CDC

was a recognition of the leadership role developed in New Jersey in the field of adolescent suicide prevention. The Project provided significant information which will be used to aid other communities that experience suicide clusters.

The experience of the New Jersey Project during its initial phase underscores the importance of further study and assessment of suicidal adolescents in school settings. It establishes the critical need for continuing school-based programs and for developing and delivering training in crisis intervention and treatment to educators and human service providers on a local level. Finally, postvention, which is a coordinated and planned response in the aftermath of a suicide, must be available and accessible statewide.

Specific recommendations for Project continuation, which are based on project activities and evaluation results,include:

1. Establish a grant program to continue development and evaluation of school-based prevention programs focusing on at-risk students. These would be coordinated by staff at the state level.

2. Continue the Governor's Advisory Council on Adolescent Suicide Prevention to provide support and leadership in this important area.

3. Continue funding for staff at the state level to coordinate programming, research and training activities on a state-wide basis at school-based clinics, where programs will be established for training mental health providers and educators in assessment, treatment, and postvention. This will provide a continuing, local mechanism for training in the area of adolescent suicide.

4. Continue regional conferences, coordinated at a state level, as a mechanism for dissemination of current research and information about intervention strategies about at-risk teens.

5. Provide funding for the provision of postvention to school systems statewide.

PROGRAM COMPONENT	FUNDING REQUIREMENT
1. Grant Programs for Adolescents At-Risk for Suicide Current Project experience supports the fact that a significant percentage of these teens can be easily identified or will self identify. A state-wide program to develop and evaluate creative school-based interventions to address their potential self-destructiveness is clearly an appropriate focus of suicide prevention.	$1,000,000.00
2. Training for Crisis Intervention For At-Risk Teens Funds to be distributed on a county level for training in Crisis Intervention, assessment, and treatment of at-risk teens, as well as for provision of postvention in the aftermath of completed suicides.	$ 250,000.00
3. Statewide Administration, Training and Consultation To continue to provide consultation and training from the Division of Mental Health and Hospitals and the Department of Education for coordination of activities designed to build county and local resources for adolescent suicide prevention.	$ 100,000.00
TOTAL:	$1,350,000.00

In summary, the year of pilot implementation with school-based programs and state-wide postvention efforts documented the pervasive need for continuing program development in adolescent suicide prevention.

NEW JERSEY ADOLESCENT SUICIDE PREVENTION PROJECT

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Project Description

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I. PROJECT DESCRIPTION

A. Background

The New Jersey Adolescent Suicide Prevention Project was conceived in 1984, when State Senator Richard J. Codey introduced legislation for funding a pilot project to create a comprehensive and coordinated statewide approach to the problem of teen suicide. Senate Bill 2005, signed by Governor Thomas H. Kean in June 1985, provided $300,000 to the State Department of Human Services, Division of Mental Health and Hospitals, to fund three one-year pilot projects in adolescent suicide prevention. This legislation, which was the most comprehensive of its kind in the country, directed that participating mental health centers and school districts work collaboratively in the design, implementation and evaluation of school-based suicide awareness programs. [See Appendix A]

The legislation also created an Advisory Council appointed by the Governor to oversee the Project and make recommendations for statewide replication at the Project's completion. The Council provided the Project with a broad base of community participation that demonstrated shared responsibility for problem-solving in regard to adolescent suicide. Adolescent suicide must be viewed as a community concern if realistic, community-based solutions are to be developed.

The school is the center of the adolescent's community, and a partnership between mental health and education is a critical element in overall project design. While a large percentage of currently existing suicide awareness or prevention programs bring mental health practitioners into the school, the important partnership between these two systems has often been lacking. At the state level, the Project's official recognition of the mental health-education partnership was the assignment of staff from both the Department of Human Services (Division of Mental Health and Hospitals) and the Department of Education to coordinate project activities.

The overall objectives of the Project were as follows:

1. To increase awareness of the problem of suicide in educators, students, and

parents.

2. To impart skills in identification and referral of high risk teens by these same groups.

3. To insure a coordinated, practical system for providing mental health services to the school system.

The Project clearly recognized that school faculty are not trained to provide therapy to suicidal youth, but agreed with the position taken by most educators that school personnel do have responsibilities in the following areas:

1. To identify students who are at-risk.

2. To link these students and their family members to appropriate treatment agencies.

3. To work cooperatively with mental health agencies to assist with students who are in treatment.

4. To help others in the school community deal with the intense emotional reactions evident after an attempted or completed suicide, i.e., postvention.

B. Implementation

Through a competitive grant program, one mental health agency was selected in each of three regions of the State to work collaboratively with 2 school districts to accomplish the above-stated Project objectives. Agency selection was based on a pre-existing relationship with local school districts and experience with program development in adolescent suicide. An emphasis was placed on program development in rural and urban areas, since most previous efforts in this field have been with suburban populations. The following is a list of funded programs:

1) **Northern Region**

Agency: South Bergen Community Mental Health Center, Inc.
Lyndhurst, NJ
Program Title: "Adolescent Suicide Awareness Program" (ASAP)
Location of Schools: Implemented in Jersey City Schools in conjunction with Christ Hospital CMHC; Academic and Ferris Public High Schools

2) **Central Region**

Agency: University of Medicine and Dentistry of New Jersey - Community Mental Health Center at Piscataway
Program Title: "It's Okay To Ask For Help"
Location of Schools: Implemented in the New Brunswick and Monroe Township Public Schools

3) **Southern Region**

Agency: Community Mental Health Center for Gloucester County
Gloucester, NJ
Program Title: "Lifelines"
Location of Schools: Implemented at Delsea Regional High School and Gateway Regional High School

While implementation strategies differed among sites, program components remained constant; intervention efforts were directed at students, teachers, parents, and school administrators. This was to insure that everyone in the school community received the same information and was aware of school and local resources for helping at-risk teens. [For more complete program descriptions, see Appendix B.]

Interventions in the six Project schools for faculty, parents and students took place from April through December, 1986. A total of **1140** students were exposed to the programs. The mean age of the students was **14.7** years; **45%** were white, **27%** were black, and **22%** were Hispanic. Four hundred eighty five **(485)** educators and **280** parents also participated in Project activities.

C. Evaluation Design

Incorporation of process and outcome evaluation criteria was a critical element of program design. The evaluation was consistent across program sites and coordinated by a team of researchers from Columbia University, College of Physicians and Surgeons, who are doing other seminal work in the field of adolescent suicide. Despite the fact that the number of school-based youth suicide prevention programs is increasing, there is a dearth of research evaluating their impact. There are a wide variety of programs which have been implemented in schools, but there is no general agreement on whether one is more effective than another. New Jersey's Project was the first to evaluate whether programs were effective and if so, which methods were most effective.

Another reason to investigate the impact of school-based suicide prevention programs is the concern over the role of imitation as a risk factor for youth suicide. Recent research by Gould and Shaffer (1986), and Phillips, (1986), supports the assertion that youth suicide rates seem to be influenced by dramatic or factual reports of suicide in the media. One of the goals of prevention programs is to increase student awareness and willingness to discuss suicide in order to promote disclosure and subsequent identification of the high risk student. It is critical to evaluate whether or not this has the opposite efffect and in fact, increases the risk in vulnerable students.

The evaluation had 2 goals:

(1) to measure outcome variables such as change in participant knowledge, attitudes, behavior, and information about adolescent suicide after program exposure, and

(2) to examine and document the actual process of program implementation to facilitate replication of successful methods.

The evaluation design included pre-and post-program self-report instruments to assess outcome variables. Questions were designed to evaluate knowledge and attitudes about suicide and the student's willingness to seek help for mental health problems. Students were also asked whether they had ever made a suicide attempt, whether they were currently suicidal, and whether they wanted help for emotional problems. The protocol called for the pre-program instruments to be completed immediately preceeding the initial presentation of the program, and post-program instruments to be completed one month after the final program presentation.

Similar data were collected from **1093 "control"** students who attended 5 comparison high schools that did not receive a suicide prevention program. The comparison schools were chosen to resemble the demonstration Project schools in terms of location, size of the student body, ethnic distribution, special education features (i.e., high academic achievement), and grade level of participating students. The control schools selected included: Barringer High School (Newark); Egg Harbor High School; Point Pleasant High School; Hopatcong High School and Science High School (Newark). [See Appendix C]

In the analyses, comparisons were drawn between the prevalence of responses given during the first and second surveys and between the response rate for each group (Control vs. Demonstration). Differences between the

groups were assessed for statistical significance. Subsidiary analyses were undertaken to determine whether responses differed by sex of respondent, by the program they had been given or the school they had attended. A set of additional analyses was undertaken on **11.4%** of the students who reported that they had previously made a suicide attempt.

II. SUMMARY OF FINDINGS

Analysis of evaluation data demonstrated the following important program outcomes: [Appendix D contains more detailed description of evaluation results).

- A majority of students found the programs interesting and helpful. Students who had participated in a program could identify more behaviors as warning signs than controls and were more knowledgeable about how to contact a mental health professional through a hotline than either controls or they themselves had been before the program.

- 89% of students felt that other high school students should participate in similar programs. Students from urban schools were the most positive in their reception of the programs.

- There was no evidence from this limited study that the programs increased suicidal preoccupations or behavior in participating students.

- Screening for currently suicidal students, which was permitted in 7 of the 11 participating schools and included approximately **1,300** students, identified **72** students who self-identified as feeling suicidal and were then referred for help.

- Response to evaluation questions also disclosed that **11.4%** of the students in 7 of the 11 schools admitted to having made previous suicide attempts.

- The majority of high-risk students (which included students in the 2 above-named categories) responded favorably to the programs; **68%** said that the programs made it easier to deal with their friends' problems and approximately one-half complained that the programs had been too short.

- The Northern Regional Program (ASAP) was rated favorably by a higher percentage of both students and educators than the other programs, although the program seemed no more effective than the others in

increasing student knowledge or changing attitudes.

- In the general school population, girls were consistently found to receive the programs more favorably than boys and to be better inclined towards disclosing suicidal thoughts and seeking help.

- Approximately **40%** of the students knew a place other than school where they could discuss their problems or the problems of their friends with a mental health professional. Before the program, **24%** said they would do so by using a hotline. This was increased to **34%** by exposure to a program. There was a similar small but significant increase in the proportion of students who would advise a suicidal friend to use a hotline to obtain help. There were no changes among control students. Only **13%** said if they had problems, they would want to talk to a mental health professional; approximately half might want to do so and **30%** said they would not. These proportions were unchanged by exposure to a program. The reluctance to seek help from mental health professionals was present even though most students thought that mental health professionals could be effective and trusted.

- Fewer than one-fifth of the students believed that teens who talk about suicide do not mean it. Approximately **5%** felt that suicide was a good or only solution for people with many problems, and about **15%** said they would keep suicidal thoughts to themselves. The proportion who voiced these views was unchanged by exposure to a program.

- In support of the underlying philosophy of school-based adolescent suicide programs which provide peers with information for helping friends, two-thirds of the students said their preference was to discuss problems with a friend; a third with their parents.

- Educators responded positively to the programs. A majority indicated that although they knew that school policies for the management of students at-risk for suicide existed, they were generally ignorant about how these were implemented. Their knowledge about this increased dramatically as a result of exposure to the programs. Knowledge about treatment resources and suicide warning signs also increased after exposure to the programs. The majority of educators were also extremely favorable about having their own

children participate in similar programs.

PROCESS EVALUATION looked specifically at the interface and collaboration between the mental health and educational systems in order to provide information for replication of similar programs at other sites. The theme underlying all process observations was the importance of education and awareness by both systems of the needs, responsibilities, and limitations of the other. It was clear that the most effective mental health programming occurred when the working partnership with the school system included a mutual assessment of respective roles and a joint investment in program design and delivery.

III. RECOMMENDATIONS

The original mandate of the New Jersey Adolescent Suicide Prevention Project reflected both the foresight of Governor Kean and the legislature as well as their concern for the well-being of the youth of New Jersey. In the spirit of the legislation, the Project's activities have continued to position New Jersey as a national leader in formulating programs for the prevention of adolescent suicide.

As of June 30, 1987, all legislative appropriations for the Project have been exhausted. Although New Jersey is a forerunner in addressing the problem of adolescent suicide, there is still work to be done.

Future Project direction is guided by the findings of the pilot study, the experience in Bergenfield, and the needs that have been articulated by mental health agencies and school systems that have been part of the Project's broader scope of activities. The following areas are identified as specific targets for Project involvement during 1988 and 1989:

(1) Development of programs for adolescents who are identified as at-risk for suicide. Current Project experience supports the fact that a significant percentage of these teens can be easily identified or will self-identify. Creative programs to address their potential self-destructiveness is clearly an appropriate focus of suicide prevention;

(2) Implementation of school-based programs that incorporate the modifications suggested by the pilot study to school systems statewide. Particular attention should be paid to implementing programs in urban areas where deficits in knowledge are greatest and where pilot programs were best received. Resistant attitudes toward help-seeking must also be studied more closely and addressed. Educator

programs should also be implemented more broadly to increase awareness of school policies on identifying and referring suicidal teenagers;

(3) Provision of training in the identification, referral, and treatment of at-risk or suicidal teens to educators in both public and non-public school systems and mental health providers;

(4) Continuation of the executive and supportive functions of the Governor's Advisory Council on Adolescent Suicide Prevention. The Council serves as an official demonstration of the concern and support of the citizens of New Jersey for the development of services for suicidal teens, their schools, families and communities.

(5) Creation of regional teams of mental health providers and educators specially trained to provide "postvention" services to schools that experience a suicide;

(6) Implementation of training programs in crisis intervention techniques and referral procedures for school "special services staff" (guidance staff, nurses, administrators) who are responsible for assessing and referring troubled students;

(7) Development of a statewide network of resources for adolescent suicide education and prevention activities centrally coordinated by the Project;

Since its beginning in February, 1986, the New Jersey Adolescent Suicide Prevention Project has established a national reputation for school-based programs in adolescent suicide awareness. Through innovative Project design and evaluation, the Project has begun to address some of the issues and concerns that have frequently surrounded programs in this difficult and sensitive area. But there is still a need to do more. Adolescent suicide is a unique phenomenon with causes and solutions that are only beginning to be understood. New Jersey has begun the effort to study the problem in depth. More time, energy, and financial resources need to be committed to study the problem so that statistically significant cognitive, attitudinal and behavioral changes occur among students at risk. With continued legislative support, New Jersey can continue to maintain its position of leadership and can actualize its commitment to helping the children of the state grow into responsible and productive citizens.

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SENATE, No. 2005

STATE OF NEW JERSEY

INTRODUCED JUNE 28, 1984

By Senator CODEY

Referred to Committee on Institutions, Health and Welfare

AN ACT establishing a youth suicide prevention *[demonstration]* program and making an appropriation therefor.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. The Legislature finds and declares that the incidence of suicide among adolescents has increased alarmingly and suicide presently ranks as the second leading cause of death for adolescents between the ages of 15 and 24 years; that the increase in the rate of adolescent suicide is often associated with the significant changes in lifestyles, values and family relationships that are occurring in our society; that the occurrence of adolescent suicide is found among youth of all racial, social and economic backgrounds and even though suicide is underreported as a cause of death for adolescents, in 1982 114 youth suicides were reported in New Jersey; that mental health professionals believe that many suicides can be prevented through suicide awareness education programs in the schools and crisis intervention programs for adolescents and their families in the community; and that in order to ensure that the most effective prevention and crisis intervention programs are available and *[ultimately]* developed Statewide, it is necessary to establish a youth suicide prevention *[demonstration]* program in the State Department of *[Education]* **Human Services* which will be administered by *[local boards of education in cooperation with]* community mental health services providers **in cooperation with local boards of education*.

2. The Commissioner of the Department of *[Education]* **Human Services* shall establish a program of youth suicide pre-

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter printed in italics *thus* is new matter.

Matter enclosed in asterisks or stars has been adopted as follows:

*—Senate committee amendments adopted October 18, 1984.

**—Senate committee amendments adopted December 6, 1984.

community mental health services providers in consultation with local boards of education. The objectives of the program shall include but are not limited to the following:

a. Classroom instruction *or materials* designed to achieve the following objectives: to teach students facts about adolescent suicide and how to recognize signs of suicidal tendencies; to inform students of available community services aimed at prevention of suicide; and to increase students' awareness of the relationship between adolescent suicide and drug and alcohol use.

b. Training programs for classroom teachers and other teaching staff members in suicide prevention.

[b.] c. Nonclassroom school or community based programs such as a 24-hour "hotline" telephone service staffed by trained professional counselors, crisis intervention and postintervention services [and] , parent education programs *and programs for the families of suicide victims*.

[c. Training programs for classroom teachers and guidance counselors in suicide prevention.]

3. [a.] The Commissioner of [Education] *Human Services in consultation with the Commissioner of Education* shall prepare guidelines for the youth suicide prevention [demonstration] program. In addition to emphasizing the objectives provided in section 2 of this act, the guidelines shall foster cooperation between local boards of education and community mental health services providers.

[b.] *4. a.* The commissioner shall solicit proposals for [demonstration] *suicide prevention* projects from [local boards of education] *community mental health services providers* interested in participating in the program.

[c.] The commissioner shall review the project proposals and approve and fund within the limits of monies appropriated for this purpose, [at least two] *three* proposals which best meet the objectives of the [demonstration] program.

b. In addition to meeting the program objectives provided in section 2 of this act, a proposal shall include procedures for evaluating the project.

c. The commissioner shall fund one proposal from the northern, central and southern regions of the State in order to ensure that program services are available Statewide.

[4. The Commissioner of Education shall report to the Governor and Legislature no later than three months before the expiration date of this act concerning:

a. The effects of the demonstration program on adolescents in the schools;

b. An assessment of the most efficient and effective methods for establishing youth suicide prevention programs in the schools and in conjunction with community services agencies;

c. The projected costs for establishing prevention programs throughout the State; and

d. Recommendations for establishing a Statewide youth suicide prevention program.]*

*5. *The community mental health services provider shall prepare its funding proposal in cooperation with two or more local boards of education which are interested in participating in the suicide prevention program. The provider also shall agree to provide information and training within the limits of available funds, to other local boards of educaton that are interested in providing for suicide prevention programs, upon their request.*

6. a. There is established in the Department of Human Services a Youth Suicide Prevention Advisory Council. The council shall consist of 10 members as follows: the Commissioner of Human Services and the Commissioner of Education, or their designees, who shall serve as ex officio members, the project director of each of the three suicide prevention projects funded pursuant to this act, and five public members appointed by the Governor who are residents of this State, two of whom are generally knowledgeable about issues concerning youth suicide, one of whom is a member of a local school board, one of whom is a school administrator and one of whom is a secondary school classroom teacher. The members shall serve for a term of two years. Vacancies in the membership of the council shall be filled in the same manner as the original appointment. A member of the council is eligible for reappointment. The members of the council shall serve without compensation, but the council shall reimburse its members for the reasonable expenses incurred in the performance of their duties.

The members of the council shall elect from among them a chairman who shall be the chief executive officer of the council, and the members shall elect a secretary who need not be a member of the council.

The council may call to its assistance and avail itself of the services and assistance of any officials and employees of the State and its political subdivisions and their departments, boards, bureaus, commissions and agencies as it may require and as may be available to it for this purpose and may expend any funds as

may be appropriated or otherwise made available to it pursuant to this act.

The Governor shall appoint the public members of the council within 90 days after the effective date of this act and the council shall organize as soon as may be practicable after the prevention projects have been approved and funded and the project directors selected.

b. The council shall: compile information on youth suicide prevention programs that are presently carried out in the State; disseminate this information and relevant information about the projects funded pursuant to this act to local school districts, community mental health services providers and the public; assess the most efficient and effective methods for establishing youth suicide prevention programs in other school districts and by other community mental health services providers; assess the cost for providing youth suicide prevention programs Statewide; and advise and provide technical information to the Commissioners of Human Services and Education on matters pertaining to youth suicide, upon their request.

c. The council shall report to the Governor and the Legislature 18 months from the effective date of this act on the activities of the council, the effects of the three suicide prevention projects funded pursuant to this act, and the council's assessment of the most efficient and effective methods for establishing a Statewide program and the projected cost for doing so. The council shall include in its report recommendations for legislative or administrative action that may be necessary to ensure that youth suicide prevention services are available Statewide.

[5.] *7.* There is appropriated *[$75,000.00]* **[*$150,000.00*]** ***$300,000.00*** from the General Fund to the Department of *[Education]* *Human Services* to carry out the purposes of this act. *The commissioner shall expend at least **85%** of the monies appropriated in this act for the purpose of funding the three suicide prevention projects pursuant to this act.*

[6.] *8.* This act shall take effect immediately *[and shall expire on September 30 following the third anniversary of the effective date]*.

PROGRAM DESCRIPTIONS

Northern Region

Agency: South Bergen Community Mental Health Center, Inc.
Lyndhurst, NJ
Program Title: "Adolescent Suicide Awareness Program" (ASAP)
Location of Schools: Implemented in Jersey City Schools in conjunction with Christ Hospital CMHC; Academic and Ferris Public High Schools

In the **Northern Region**, the Adolescent Suicide Awareness Program (ASAP) was a joint project between South Bergen Community Mental Health Center in Lyndhurst, and Christ Hospital Community Mental Health Center in Jersey City. This program consists of a 2-hour educator's seminar with the following goals: to disseminate critical information about adolescent depression and suicidal behavior , and to build or improve understanding and collaboration between the school system and the community mental health provider. The parent program was sponsored by the Parent-Teachers' Association in each school. The student component of the Adolescent Suicide Awareness Program was presented as a special program in Jersey City's Ferris and Academic High Schools. Jersey City is large urban school district which serves 20,000 children. The program was focused on 10th graders. The format was structured around two 2-hour sessions which included large group lectures and films, followed by small group discussions. Groups were co-facilitated by specially trained mental health professionals and selected school staff.

Central Region

Agency: University of Medicine and Dentistry of New Jersey - Community Mental Health Center at Piscataway
Program Title: "It's Okay To Ask For Help"
Location of Schools: Implemented in the New Brunswick and Monroe Township Public Schools

The **Central Region** project site was the Univeristy of Medicine and Dentistry of New Jersey CMHC's Suicide Prevention Project, a comprehensive program of training and consultation. This Project offers an integrated approach to suicide prevention by providing a wide range of inter-related services. Since the primary program goal was to help schools develop internal

resources, staff training and system analysis preceded the introduction of student curriculum. The program, presented in Monroe Township High School and New Brunswick High School, included the following components: Crisis Intervention training for special service staff, Faculty Awareness Program,, Parent Awareness Program, and student curriculum, directed at all 9th grade students. (The Crisis Intervention Training, a 16-hour instructional course which is designed to help special service staff improve their skills in assessing and intervening with at-risk students, is a special feature of the UMDNJ SPP and was not offered at the Northern or Southern Regional sites.)

The UMDNJ student curricula, entitled "It's OK to Ask for Help," consisted of three, 45-minutes classes placed within the family life curricula. Selected family life teachers received ten hours of training in preparation for their delivery of the curriculum, which emphasized problem solving, stress management, helping suicidal friends, and identifying resources for help. Classroom discussion focused around a videotape which was produced with students from a teen theater group in Trenton and students from East Brunswick who were surviving the suicide of a classmate. These teenagers performed in a series of role-playing vignettes that demonstrated the dilemmas teens face when confronted with a suicidal peer.

Southern Region

Agency: Community Mental Health Center of Gloucester County
Gloucester, NJ
Program Title: "Lifelines"
Location of Schools: Implemented at Delsea Regional High School and Gateway Regional High School

The **Southern Regional** site, the Community Mental Health Center of Gloucester County, established the Adolescent Suicide Crisis Intervention Network (ASCIN) in the Southern region to facilitate unified delivery of services by organizations serving adolescents and their families. Under this title, their specific adolescent suicide prevention program was delivered to all 9th grade students at Gateway and Delsea Regional High Schools. Parents and faculty participated in awareness workshops while students received program curricula called "LIFELINES", in two sequential 45-minute minute health class periods. Classes were conducted by health education teachers who had received 6 hours of training prior to curricula presentation. Specific content of the sessions included information about suicidal warning signs, exploration of the issues involved in helping a suicidal friend, and identification of in school and community resources.

Target and Control Schools

Target School - Academic High School
407 Students; 9-12
SES = A, 12% homes less than $10,696 income
Ethnicity: B-28%, W-25%, H-26%

Control - Science High School
Newark City, Essex County
521 Students
SES = A
Ethnicity: B-66%, W-9%, H-25%

Target School - Ferris High School
1627 Students
SES = A, 67% homes less than $10,696 income
Ethnicity: B-35%, W-7%, H-56%

Control - Barringer High School
Newark City, Essex County
1768 Students
SES = A, 56% homes less than $10,696 income
Ethnicity: B-47%, W-2%, H-51%

Target School - New Brunswick High School
752 Students
SES = B, 31% homes less than $10,696 income
Ethnicity: B-68%, W-3%, H-27%

Target School - Monroe Township
884 Students
SES = G, 2% less than $10,696 income
Ethnicity: B-5%, W-92%, H-1%

Control - Hopatcong High School
Hopatcong, Sussex County
763 Students
SES = G, 2% less than $10,696 income
Ethnicity: B-1.2%, W-96%, H-1.7%

Target School - Delsea High School
1433 Students
SES = B, 12% less than $10,696
Ethnicity: B-16%, W-82%, H-2.3%

Control - Egg Harbor Township High School
Egg Harbor Township, Atlantic County
1403 Students
SES = B, 5% less than $10,696 income
Ethnicity: B-15%, W-81%, H-2.3%

Target School - Gateway Regional High School
1175 Students
SES = D, 9% less than $10,696 income
Ethnicity: B-.3%, W-99.7%, H-0%

Control - Point Pleasant High School
Pt. Pleasant Boro, Ocean County
975 Students
SES = D, .3% less than $10,696 income
Ethnicity: B-.3%, W-98.5%, H-.9%

AN EVALUATION OF YOUTH SUICIDE PREVENTION PROGRAMS

EXECUTIVE SUMMARY

David Shaffer, M.D
Ann Garland, M.A.
Barry Whittle, B.A.

DESCRIPTION OF THE STUDY

This is a report on the impact on students, educators and parents of three educational programs designed to reduce the frequency of suicide attempts and suicides in teenagers.

All of the programs were delivered to students and educators in high schools during regular school hours; evening programs were held for parents. Each of the three programs was delivered in two different high schools that had elected to participate in this demonstration project. One of the programs was delivered only to urban, predominantly minority students, one was delivered only to suburban/rural students, and one was delivered to both. The programs varied in length from 1 1/2 hours to 4 hours. Two of the programs were delivered to 9th Grade students, and the other to students in the 10th Grade. One of the programs was delivered primarily by experienced mental health professionals. The other two were delivered by regular teachers who had been especially trained for this purpose.

Although they varied somewhat in their methods they shared the following goals: 1) to alert students to the risk of suicide in their age group; 2) to inform students and educators about the availability of helping resources within the school and the community; and 3) to educate friends and educators about their role in identifying and helping the suicidal youngster.

A total of 1140 students were exposed to the programs.The mean age of the students was 14.7 years, 45% were White, 27% were Black and 22% were Hispanic.

Assessments were carried out one or two days prior to exposure to the program for the first time and repeated again approximately one month later. Assessments were carried out using precoded self-report forms. Questions were designed to evaluate knowledge and attitudes about suicide and seeking help for mental health problems and suicidal preoccupations and disclosures. Students in 7 of the schools were also asked whether they had ever made a suicide attempt, whether they were currently suicidal and whether they wanted help for emotional problems.

Similar data were collected from 1093 "control" students who attended 5 comparison high schools that did not receive a suicide prevention program. The comparison schools were chosen to resemble the demonstration project schools in terms of location, size of the student body, ethnic distribution and special educational features (i.e., high academic achievement). There were no statistically significant differences in age, sex or ethnic features between the target and comparison groups, and before the programs they were strikingly similar in their responses to a large number of questions designed to assess their attitudes toward suicide, help seeking and knowledge about treatment resources.

In the analyses, comparisons were drawn between the prevalence of responses given during the first and second surveys and between the response rate for each group (Control vs. Demonstration). Differences between the groups were assessed for statistical significance. Subsidiary analyses were undertaken to determine whether responses differed by sex of respondent,

by the program they had been given or the school they had attended. A set of additional analyses was undertaken on 11.4% of the students who reported that they had previously made a suicide attempt.

The main limitation of the study is that the assessment addresses short term changes in attitudes and knowledge but not behavior. It is possible that change (or stability) of attitudes or knowledge will not be translated into a change of behavior. For this reason it will be important to follow up the present study with an examination of behavior changes.

SUMMARY OF FINDINGS

1. General interest of the programs: Approximately 40% of the students rated the programs as interesting or too short, approximately 20% as boring or too long. Most of the students thought that the programs were presented clearly. About half of the students felt they had learned something new, a fifth that they had learned nothing new.

2. Programs as a source of comfort, distress and ability to help others: Approximately three quarters of the students felt comforted by the programs and felt that the programs would make it easier to cope with their own or their friends' problems. 90% felt that the programs should be delivered in other schools.

Fewer than 10% of the students were either personally distressed by the programs or knew of another student who had been distressed by them. Among students who identified the reasons for this distress, a predominant response was remorse or regret over missed opportunities with a student who had been suicidal. Questions about suicide attempts were not asked of students in three of the schools, including both schools served by one of the programs. However in the remainder *there was no evidence that the programs had induced suicidal behavior* in any of the students although behavioral assessments are necessary to more accurately assess the programs' impact on suicidal behavior.

3. Natural support systems: Approximately 20% of the students said they would not want to talk a problem over with anyone else and just under that number felt that it was best to keep feelings of depression to oneself. Two thirds of the students said their preference was to discuss problems with a friend, a third with their parents. *These proportions were unchanged by exposure to a program.*

4. Changes in attitudes towards seeking help from within the school: Only about 5% of the students said they usually talk about a personal problem with either a teacher or a counselor although when asked who they would talk to in the school a quarter said they would talk to a teacher or counselor if they were having an emotional problem. 40% said they would not choose to discuss a problem with any adult in a school. *These proportions were unchanged by exposure to a program.*

5. Changes in attitudes to seeking help for themselves from mental health professionals: Approximately 40% of students knew of a place other than school where they could discuss their problems or the problems of their friends with a mental health professional. Before the program 24% said they would do so by using a hotline. *This was increased to 34% by exposure to a program.* There was a similar small but significant increase in the proportion of students who would advise a suicidal friend to use a hotline to obtain help. There were no changes among control students.

Only 13% said that if they had problems they would want to talk to a mental health professional; approximately a half said they might want to do so and 30% said they would not.*These*

proportions were unchanged by exposure to a program. The reluctance to seek help from mental health professionals was present even though most students thought that mental health professionals could be effective and could be trusted.

6. Attitudes about management of a suicidal problem in themselves or a friend: Two thirds of the students said they would discuss a suicidal disclosure from another student with an adult; around 10% said they would not take a suicidal threat seriously, a similar proportion said they would keep it secret and about a third said they would discuss it with a friend but would not get anyone else's help.*These proportions were unchanged by exposure to a program.* This pattern of responses whereby a majority of students would behave responsibly and a minority unfavorably, with neither group being influenced by the programs, recurred in several areas.

***7. Knowledge of warning signs*:** Approximately 80% of the control students knew that suicide threats and attempts and the use of drugs and alcohol were warning signs of suicide risk. The level of knowledge about these "warning signs" was not greater in those who had been exposed to a program. However, knowledge levels of other signs (e.g., hopelessness and social withdrawal) *was increased by exposure to a program* as shown by higher levels of recognition in the demonstration group.

*8. **Miscellaneous beliefs about suicide and depression:*** Fewer than a fifth of the students believed that students who talked about suicide did not mean it. Approximately 5% felt that suicide was a good or the only solution for people with many problems and about 15% said they would keep suicidal thoughts to themselves. Approximately 10% of the students believed that suicide was a feature of mental illness. The proportion who voiced these views *was unchanged by exposure to a program.*

Before attending a program about 8% felt that drugs and alcohol were a good way to help someone stop feeling depressed. This proportion *was increased after exposure to a program* to 15%, there was no similar change in the control group. The reason for this change is unclear and will be explored in further studies.

9. Suicidal behavior in the students**: Approximately 11% of the students in 7 of the 11 schools admitted to having made previous suicide attempts. Females and Hispanics were disproportionately over-represented in this group which was also somewhat older than the mean for the total student population.

10. Overall responses of suicidal students**: The majority of suicidal students responded favorably to the programs; 68% said that the programs made it easier to deal with their friends' problems and approximately a half complained that the programs had been too short. However, the minority who responded negatively was greater among previous suicide attempters; thus 38% said the programs were boring compared with 23% of the non-attempters, 39% said they had learned little new from the programs, compared with 21% of the non-attempters. Twice as many (12%) of the previously suicidal students said they had been distressed by the programs and three times as many (9%) said that the programs had increased their difficulties in dealing with their problems.

11. Attitudes to disclosure and help seeking among suicidal students**: Previously suicidal students were more likely than non attempters to *know* how to access a mental health professional, but they were more likely to hold negative views about help.They were more likely to keep suicidal disclosures from others or their own suicidal intentions a secret, and less likely to believe that it was helpful to share depressed feelings. They were less likely to tell a suicidal friend to call a hotline. They were more than three times as likely to believe that suicide was a good or only solution to certain problems.

The programs brought about inconsistent changes in these views. On the positive side, they increased the proportion who would advise friends to use a hotline, they slightly increased the proportion who would seek help from a professional and they decreased the proportion who would keep suicidal feelings to themselves. However they did not change the proportion who thought that suicide was a good or only solution to certain problems, and they appear to have decreased the number who felt it was a good idea to share depressed feelings or who felt that mental health professionals were good at helping others.

12. Program Differences: The ASAP program was consistently better received than the other two programs although it did no better in changing attitudes or knowledge than the other programs. The better reception is likely to be due to the fact that the presenters' were mental health professionals and to the small group format that is used. The fact that it was presented solely to urban youth who generally responded more positively to the programs may also be a factor.

13. Screening for currently suicidal students *: Screening for currently suicidal students was permitted in 7 of the 11 schools. A total of approximately 1,300 students were screened twice yielding a total of 72 students (approximately 5%) who were then referred for help.

14. Sex differences in help seeking : Girls were consistently found to receive the programs more favorably and to be better inclined towards disclosing suicidal thoughts and seeking help.

15. Response of educators. Educators responded in a generally favorable fashion to the programs. A majority indicated that, although they knew that school policies for the management of emotional disturbances in students existed, they were generally ignorant about how these were implemented. Knowledge about this increased dramatically as a result of exposure to the programs. Knowledge about treatment resources and suicide warning signs also increased after exposure to the programs.

**= Students in the ASAP program and their matched controls were not asked questions on suicidal ideation or attempts or offered the screening items because school administration prohibited the inclusion of these items on the assessment.*

RECOMMENDATIONS

1. Implementation of Programs

a) On balance we believe that suicide prevention programs of the sort we have evaluated are beneficial. They were generally well received and considered helpful by most students including those who admitted to current distress and suicidal feelings.

However, we caution that the ability of the programs to effectively reduce future suicidal behavior (attempts and completions) has not been demonstrated. To do that would require a different type of evaluation. The programs had relatively little effect on a hard core of teenagers who held views such as that suicide is a good or only solution to many problems, that it is best not to disclose suicidal feelings or disclosures and that recourse to mental health professionals would not be sought. We feel strongly that further development work is required to arrive at more effective intervention programs and we detail this in our suggestions for further research listed below.

b) Particular attention should be paid to implementing programs in urban areas where deficits in knowledge are greatest and where the programs were best received.

c) This study has shown that a simple survey asking students whether they are currently preoccupied with suicidal thoughts can be undertaken effectively. Such surveys should be implemented more broadly in collaboration with community mental health experts who would then be expected to follow up to perform a diagnostic evaluation with identified students.

d) Consideration should be given to the implementation of hotline services specifically for teenagers. The increase in the number of teenagers, both suicidal and non-suicidal, who were influenced by the programs to consider this form of help was more marked than for any other form of accessing help. It would be desirable if hotlines could be advertised in such a way as to be more attractive to male students.

e) Educator programs should be implemented more broadly to increase awareness of school policies on dealing with suicidal teenagers and referral practices.

f) Training programs in crisis intervention techniques and referral procedures should be directed to school "special services staff" (guidance staff, nurses, administrators) who are responsible for assessing and referring troubled students.

2. Research

We recommend:

a) That further appropriate research be undertaken to explore some of the mechanisms behind negative attitudes that are unfavorable to suicide prevention and that were unchanged by attendance at the present programs.

Specifically, these are the beliefs that suicide is a good or only solution to problems; that it is best to keep suicidal thoughts to oneself; that it is best not to disclose suicidal disclosures from others; that it is undesirable to seek help from a mental health professional.

b) That further research be undertaken to identify the elements in the best received program (ASAP) that contribute to its success.

c) That further appropriate research be undertaken to determine whether there is a decrease or increase in the morbidity of suicidal behavior during or after exposure to programs.

d) That further research be undertaken to determine how referral patterns to mental health resources within and outside the school may be influenced by exposure to programs.

e) That further research be undertaken to identify the reasons why distress is caused to some students who experience the program and whether this is different in previously suicidal students (more of whom experience such distress).

f) That the impact of other models of intervention be assessed: e.g. coping skills training programs; courses on the self-identification of symptoms that would justify referral to a mental health professional for full evaluation, and small groups run on clinical lines for self-identified troubled youngsters.

AN EVALUATION OF THREE
YOUTH SUICIDE PREVENTION PROGRAMS IN NEW JERSEY

October 30, 1987

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SECTION I.

INTRODUCTION

This report outlines findings of an evaluation of three suicide prevention programs undertaken among six schools in the State of New Jersey from April, 1986 through December, 1986. The purpose of the evaluation was to assess the impact of these programs on high school faculty, parents, and students. We wanted to know whether the participants found the programs interesting or dull, comforting or distressing, whether they changed their understanding or attitudes about suicide, and whether they improved their knowledge about how to obtain help for emotional problems (for themselves or others).We also wanted to know whether the programs would have any unintended positive or negative effects. Although school based suicide prevention programs are being employed increasingly often, to our knowledge this is the first documented evaluation of such a program.

SECTION II.

STUDENT EVALUATIONS

A. METHODS USED

1. Study Design and Procedures:

Three prevention programs were evaluated, in a total of six schools, each program being given in two schools.

The schools that participated in the demonstration programs were self nominated and selected by the New Jersey Department of Health and Human Services because of their willingness to participate. A special effort was made to recruit urban schools and as a result, the student sample is not representative of all students in New Jersey (see description of sample page 5). The evaluators were not involved in the selection of demonstration schools.

To ensure that any changes observed were attributable to the prevention programs we also studied six control schools (see selection criteria in 3. below). Pupils at the control schools answered similar questionnaires on two different occasions at approximately the same interval as had the youngsters in the program schools. For a change to be attributable to the program it would have to be significantly different to any change that had been observed in the control schools.

All children attending selected grades in the various schools were instructed to attend the programs. Our survey was carried out immediately before the first program was given and again about one month after the program's completion. The same questions about attitudes and opinions about suicide, seeking help for emotional or personal problems, and knowledge about helping resources and the "warning signs" of suicide were administered on both occasions. Items were added to the forms for the students who had participated in the programs to determine their response to these programs. All forms had been developed on teenagers of similar age and background as those in the study to ensure that the wording of the items was generally understandable.

An identification procedure was used to enable matching of individual student's pre and post program questionnaires. Before the students completed the questionnaires a standard protocol was read to them (Protocols are included in Appendix 1). Along with a general introduction to the questionnaire the protocol stated, "You are being asked to write your name on the tear-off cover sheet so that we can assign an identification number to your questionnaire. Your name will not be on the questionnaire. Someone in your school may contact you only if we feel you could benefit from speaking to someone about any problems you might have." Cover sheets were collected and held separately from the questionnaire. Master identification lists were compiled and were held in a secure file available only to the principal of the school and to the research team.These lists were used to match the pre and post program questionnaires.

2. The Prevention Programs and the Schools :

The three suicide prevention programs that participated were:

1. *Adolescent Suicide Awareness Program (ASAP)* (Program A). A program developed by the South Bergen Regional Counseling Center and implemented for this project in collaboration with the Community Mental Health Center of Christ Hospital.

2. *It's O.K. to Ask For Help (Program OK)*. A program developed and implemented by the University of Medicine and Dentistry of New Jersey (U.M.D.N.J.) Community Mental Health Center at Piscataway.

3. *Lifelines (Program L).* This program was developed at St. Clares Hospital and was implemented for this project by the Community Mental Health Center for Gloucester Co.

All three programs shared certain *goals:*

1. *To raise participants' awareness of the problem of youth suicide;*
2. *To enhance participants' ability to identify students at risk for suicidal behavior;*
3. *To educate participants about mental health resources within and outside the school;*
4. *To encourage help-seeking.*

The unique formats and emphases of each of the programs and of the different schools are outlined in Tables 1 & 2.

Table 1

PROGRAM FEATURES

Program	Presenters	Training	Grades	Length	Setting	Materials
ASAP	Mental health professionals Educators	Several Years 6 yrs.	10	4 hrs.	Large assemb./ Sml. Grps.	Film
OK	Educators	10 hrs.	9	3 hrs.	Classroom	Video
L	Educators	6 hrs.	9	1 1/2 hrs.	Classroom	Audio & Film

3. Methods Used to Select Control Schools:

Each project school was matched with a control school (that had never received a suicide prevention program) on the following variables:

1. Ethnic distribution;
2. Socio-economic status of school district based on 1980 census data, including analysis of the percentage of households falling below poverty level;
3. Size of enrollment;
4. Type of community (i.e.., urban/rural);
5. Grade level (i.e., control students for A program were in the 10th grade, while others were in 9th grade).

18 potentially eligible schools were approached from which matches for 5 Demonstration schools were made. A match for the 6th school could not be finalized . Because the average number of students in the Demonstration schools was somewhat higher than in the control schools the numbers in the Demonstration and control groups are similar.

Table 2

School Features

The Project Schools

School	Total Enroll.	Urban/Rural	Special Features
A1	400	Urban	Academically gifted
A2	1600	Urban	
OK1	750	Urban	
OK2	890	Suburban	
L1	1450	Rural/Suburban	
L2	1180	Suburban/Rural	

The Control Schools

School	Total Enroll.	Urban/Rural	Special Features
C1	520	Urban	Academically gifted
C2	1770	Urban	
C3	760	Suburban/Rural	
C4	1400	Suburban/Rural	
C5	980	Suburban	

4. Analysis:

All items were compared by Demonstration vs control group, by program and by school. All items were also analyzed by sex. For the purposes of this report, analyses by sex and suicide attempt status are confined to the total control and Demonstration groups, with no separate analyses by program or school.

Statistics: Where indicated, t-tests, chi-square tests and McNemar tests were done to test for significant differences between Control time 2 and Demonstration time 2 frequency distributions.

5. Description of Student Sample:

Table 3

Student Characteristics

	Controls n=1484	Demonstration n=1322
Sex		
Males	47%	48%
Females	53%	52%
Ethnicity		
White	42%	45%
Black	30%	27%
Hispanic	25%	22%
Other	3%	6%
Average Age	14.9	14.7
Age Range	12-20	12-18

Table 4

Compliance Rates

Intervention Schools

	PRE		POST	
	# of initial forms completed	*% students to complete form*	*# of final forms completed*	*% of Pre*
A1	96	100	95	99
A2	275	90	144	53
OK1	228	99	188	69
OK2	206	100	193	89
L1	198	100	159	79
L2	137	100	161	100
TOTAL	1140	98	940	82
Control Schools				
C1	111	100	110	100
C2	385	95	371	98
C3	159	100	152	96
C4	250	100	262	100
C5	188	100	177	93
TOTAL	1093	99	1072	98
TOTAL ALL SCHOOLS	2233	98	2012	90

Comment:

Overall compliance in returning questionnaires was excellent (90%). There were two exceptions to this that affected the returns on the post questionnaires.In school A2 several educators declined to administer the post questionnaires in their classes because of other curriculum pressures. At school OK1 the post program form was administered the day before the holiday vacation in December, normally a day with a high absentee rate .

The number of forms completed on the first occasion does not reflect the exact number of students attending the program because they were administered to classroom groups from 1 to 3 days before the suicide prevention programs were implemented. Attendance at the programs was mandatory, but absentees on either the form filling or the program implementation day were not recorded.

The selection of control schools was apparently appropriate. Not only were the control students demographically similar, abut so were initial levels of knowledge about resources and attitudes toward seeking help.

B. STUDENT SURVEY RESULTS

1. How Were the Programs Received?

It is likely that a successful program will interest and involve students. Participating students were asked to rate their responses on a 5-point scale and we present the percent of students who replied on either the favorable or unfavorable poles of these scales. The identification numbers refer to the items on the original questionnaire (See Appendix 2). The number of responses was 940 for all items unless otherwise noted.

Table 5

Interest in the Programs

1. Was the suicide awareness program interesting?

	Interesting	Boring
% Total Students	41%	21%

3. Was the information presented clearly?

	Clear	Unclear
% Total Students	78%	4%

6.Was the program upsetting/comforting?

	Comforting	Upsetting
% Total Students	69%	7%

*note: This question was administered to only 4 of the 6 schools N=586

7.Was the program too long/too short?

	Too Short	Just Right	Too Long
% Total Students	36%	44%	20%

* note: This question was administered to only 4 of the 6 schools N=586

11. Did you ask any questions or make comments during the suicide aw program?

	Yes	No
% Total Students	51%	49%

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Intervention Schools

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A1	96	100	95	99
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11. Did you ask any questions or make comments during the suicide awareness program?

	Yes	No
% Total Students	51%	49%

Comment:

Most students received the programs well , although a fifth of them found them boring, and a similar proportion thought that they went on for too long.

There were consistent *sex differences* with more of the girls rating the programs as interesting (girls 46%; boys 35%) and comforting (girls 73%; boys 64%). Girls were also somewhat less likely than boys to find the programs "too long" (girls 17%; boys 24%).

There were also consistent *differences between programs*. The A program was rated as more interesting and more clear on most indices.There were also program related differences on perceived length of the programs (that were unrelated to actual length). Program L which was rated by 36% as being *too long* in fact only lasted approximately 1 1/2 hours. Conversely, Program A and OK, lasting 4 hours and 3 hours respectively, were rated by 40% and by 48% as being *too short*.

These differences need to be interpreted in the light of the very low (53%) post-survey return from school A2. Even though one cannot rule out the selective non-participation of educators whose classes were not favorable to the program , we believe for several reasons that this is unlikely and that there are real differences in the acceptability between the programs. These reasons are:

a) The A program was better received in both the high and the low compliance schools;

b)There is consistency in these ratings. Educators as well as students rated the program most positively.

c)The cause of the low follow-up rate at school A2 was at the educator level rather than at the student level and was therefore likely to affect individual students randomly, rather than by selectively attracting students who liked the program.

Possible reasons for the better acceptability of the A program are provided in the summary and conclusion.

Within program *School Differences* were marked for the OK program schools. Factors that may have contributed to this included employing local personnel with varying educating ability or popularity and student differences between the two OK program schools. Urban schools were generally more positive about the presentations and the better rated OK school was the one in an uban area.

Based on comments made by the educators in school OK2 (see page 27) another factor that may have been important in the poor ratings given by OK2 students was that they may have found the program repetitive due to prior informal instuction in this area following a student suicide within in the last few years.

2. Were the Programs Seen as Helpful?

Did the students feel that the that the programs had helped them learn how to deal with problems? Again, students were asked to rate their responses on a 5-point scale and the table below presents the percent of students who replied on either the favorable or unfavorable poles of these scales. Data were missing on two of the suburban schools on three of the five measures. These items were added after the questionnaires were administered in these schools. Unless otherwise noted, *N=940*.

Table 6

Learning from the Programs

2. Did you learn anything new?

	Learned a Lot	Learned Nothing
% Total Students	49%	21%

4. How do you think the program will help you deal with your friends' problems?

	Make it Easier	Make it more difficult
% Total Students	81%	1%

* note: Only 4 schools received this item. N=586

5. How do you think the program will help you deal with your own problems?

	Make it Easier	Make it more difficult
% Total Students	71%	4%

* note: Only 4 schools received this item. N=586

10. Do you think other high school students in your area should participate in the same program?

	Yes	No
% Total Students	89%	11%

Comment:

The programs were generally perceived as being helpful and informative.

Again, there were *sex differences* with a higher proportion of girls indicating that the program would help them deal with their friends' (girls 86%, boys 74%) and their own problems (girls 78%, boys 64%) and recommending the program for other students (girls 93%; boys 85%).

Small *program differences:* were again apparent with the ASAP program being recommended by more students (96%) than the other programs (87%) and being rated more positively on all the above items. There were also consistent *school differences* with one of the OK school programs being rated as well as the A schools.

3. Knowledge Acquisition:

Did the programs increase the students' knowledge about treatment resources, strategies for helping friends and purported warning signs for suicide ?

3a. Knowledge about Suicide - Where to get help

Table 7

Knowledge of

Treatment Resources

22. *Do you know of any place other than school where you could talk to a mental health professional about personal problems that were troubling you?* (%= yes responders)

	Pre	Post
Control	38%	41%
Demonstration	38%	38%

23. *If you needed to contact a mental health professional outside of school, how would you find out where to go or who to call?*

	Demonstration		Controls	
	Pre	Post	Pre	Post
Ask your parent	32	32	33	31
Ask a teacher, counselor or other adult at school	22	23	20	20
Call a hotline or emergency number	24	34**	20	26

** Difference between demonstration and control groups significant at .01 level

Comment

Basic knowledge levels were surprisingly low. Fewer than half of the students knew any resource other than school where they could receive professional help for an emotional problem.

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. However, when specific response choices were offered (probably a more sensitive way of determining knowledge) there was an increase in the number of students who would call a hotline or

emergency number following the program. Experience in the programs did not change the proportion who thought they had knowledge of resources, although when the question was posed with multiple choices, the proportion of students who said they would use a hotline or mental health center increased significantly among those exposed to a program (More so in girls -15% net change - than among boys - 6%).

3b. Knowledge about Suicide - Helping Friends

Table 8

New Knowledge -

how to help friends

25. *What should you do if a friend tells you he/she is thinking about killing himself/herself?*

	Demonstration		Controls	
	Pre	Post	Pre	Post
"Tell my friend to call a hotline or mental health center"	40	44**	36	36
"Talk to an adult about my friend"	65	65	63	61
"Talk to my friend without getting anyone's help"	33	29	34	33
"I wouldn't take it seriously"	10	12	10	12
I would keep it a secret"	9	7	9	7

** Difference between demonstration and control groups significant at .01 level

Comments:

At time 2, most teenagers, whether or not they had attended a program would tell an adult if a friend of theirs admitted to suicidal intentions. However, there is a small but significant proportion of teenagers (approximately 10% in all of the schools studied) who either would not take such a threat seriously or would keep it a secret and the proportion who felt this way was unaffected by attendance at a program.

An analysis of matched pairs indicated that the programs induced significantly more change in whether or not the pupils took disclosures seriously, but similar proportions of students changed their views in a positive direction (would take disclosure seriously) to those who changed their views in a negative direction (would not take disclosure seriously). Therefore the overall proportion remained stable.

An even greater number of students - nearly a third - would talk to their friend about their suicidal ideas without getting anyone else's help and exposure to a program similarly brought about only a very small reduction in this attitude.

Significantly more students in the demostration group would recommend to a friend that they call a hotline or mental health center if they were thinking about killing themselves.

There were no significant *sex, program or school differences* in these approaches or in the impact of the programs upon them.

3c. Knowledge about Suicide "Warning Signs"

First assessment in the program and control schools:

Students were asked the open-ended question indicated in Table 9 .Space was provided to enter in up to eight different signs.Open ended questions such as this are an unreliable way to determine the extent of knowledge. However, we chose this format because we did not want to "prime" students in any way. The format for the time 2 questionnaire was different. A range of 26 choices reflecting information presented in the programs and warning signs listed by students in the time 1 questionnaire was presented and students were invited to check all or any. Changes in prevalence are presented below for the signs which were checked off most frequently.

Table 9

"Warning Signs"

First Assessment

14. *How would you be able to tell if a person was thinking about killing himself/herself? (Please list as many warning signs as you can think of)*

	Total	Cont	Demo.
Average number of signs listed	3.14	2.99	3.29

The most frequently listed responses were:

1) Depression (53%);
2) Making a suicide threat or warning (29%);
3) Social withdrawal or isolation (27%);
4) Drug and alcohol abuse (19%).

Comment:

There were significant differences between schools in the number of responses listed and the pattern of differences suggests that experience and ability will influence the number of responses given in this open ended mode. Thus, the average number of

responses for the two high ability schools was 4.19 , with only 4% of the students leaving the question blank .The average for the remaining schools was only 2.9 with an average of 27% of the students *not writing in any warning signs.*

Table 10

New Knowledge -"warning signs"

Assessment after Programs

Which of the following do you think may be warning signs for suicide? (You may check more than one answer)

	% Respond		
	Control	Demo.	Significant
1) Saying he wants to kill himself	82	85	n.s.
2) Has tried to kill himself before	82	82	n.s.
3) Using drugs a lot	75	74	n.s.
4) Very bad family problems	66	71	.03
5) Sad or depressed	68	80	.0001
6) Not caring about the future	51	74	.0001
7) Joking a lot about killing self	57	72	.0001
8) Drinking too much	58	64	.0004
9) Keeping too himself	35	57	.0001
10) Not enjoying anything	40	56	.0001

Comment:

Students exposed to a prevention program were more likely to rate 20 of the 26 items. There was least difference in those signs in which the endorsement rate was high in both control and Demonstration schools,suggesting a *"ceiling effect"*. This provides further evidence that information contained in the programs can be transmitted effectively.

3d. Miscellaneous Knowledge about Suicide and Depression

Table 11

New Knowledge

Miscellaneous facts and views about suicide & depression

	Demonstration		Controls	
	Pre	Post	Pre	Post
33. People who talk about suicide do not commit suicide.	18	16	19	19
36 *Almost all kids who kill themselves are mentally ill.*	11	12	13	12
37. Drugs and alcohol are a good way to help someone stop feeling depressed.	8	15**	11	11

** significant at .01 level

Comments:

Relatively few students believe that people who talk about suicide do not commit suicide. However it is interesting that among the small proportion (about 18%) who do hold this view, few had their minds changed by these suicide prevention program. This is in line with the general finding that most students hold sensible and safe views on suicide but those who do not are not changed in their views by attendance at one of the Demonstration programs .

None of the programs unambiguously subscribed to the view that suicide is a feature of mental illness and none featured this point in their programs. Very few students held this belief before the programs - although it was more common among boys (17%) than girls (8%) - and given the lack of programmatic emphasis it was not surprising that this proportion was not increased by exposure to a program. The implications of this are discussed in our conclusions.

There were no significant differences between *programs* or *schools* on these measures.

It is interesting to note that after participating in a program the number of students who believed that drugs and alcohol were a good way to cope with depression increased. More *boys* responded in this way and there were no *program* or *school* effects. We show elsewhere in this report the view was even more likely to be endorsed by students who had made a previous attempt. The idea that drugs and alcohol are sometimes taken as an attempt to self medicate for depression is widely held (although it remains scientifically unsubstantiated) and this was indicated by some of the program teachers.

4. Attitude Changes:

4a. Help Seeking

A number of items measured the students willingness to seek help for emotional or personal problems.

Table 12

New Attitudes to"help seeking"

14. If you have a bad emotional or personal problem, do you talk it over with a ...?

	Demonstration		Controls	
	Pre	Post	Pre	Post
Teacher	6	5	3	4
Counselor	5	10	6	7
Friends	62	66	59	61
Parent	36	35	38	32
Other adult	9	13	8	9
No one	22	21	20	21

21. Who would you talk to in your school if you were having emotional problems?

	Demonstration		Controls	
	Pre	Post	Pre	Post
Teacher	24	25	24	24
Counselor	26	23	28	25
Nurse	10	8	7	6
No-one	42	43	42	46

40. If you are depressed, it is a good idea to keep these feelings to yourself.

	% True	
	Pre	Post
Controls	15	14
Demonstration	12	13

19. I would be willing to go to a mental health professional if I were having personal problems.

	Yes		Maybe		No	
	Pre	Post	Pre	Post	Pre	Post
Controls	13	13	56	53	31	33
Demonstration	14	13	56	56	30	30

15. Mental health professionals (psychologist, counselor, social worker, psychiatrist) are good at helping people cope with personal problems.

	% True	
	Pre	Post
Controls	78	80
Demonstration	81	83

18. Mental health professionals only break a secret when they feel it is a matter of life or death.

	% True	
	Pre	Post
Controls	69	72
Demonstration	70	76

17. Mental health professionals can "read your mind" and find out all your secrets.

	% True	
	Pre	Post
Controls	7	7
Demonstration	7	9

4b. Attitude Changes about Suicide

Table 13

New Attitudes about suicide

43. For people who have a lot of problems in their lives, I think suicide is...

	Never a solution		Possible solution		Good solution		Only solution	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Control	86	84	9	11	2	2	3	3
Demonstration	85	80	10	12	2	4	2	3

44. If I felt like I wanted to kill myself, I would...

	Tell someone		Maybe tell		Not Tell	
	Pre	Post	Pre	Post	Pre	Post
Control	56	50	28	32	15	17
Demonstration	54	53	30	32	16	15

Comments:

The proportion of students (about 20%) who said that they would talk to no one if they were having a bad emotional or personal problem was unchanged by the program.

Most students said they would go to a friend or parent if they were experiencing emotional problems. Fewer than 10% would turn to a teacher or a counselor. After attending a program there was a small increase in the number who said they would go to a counselor (5% to 10%) or to a non-family adult (9% to 13%) . When the question format was changed and the students were asked to choose between different individuals (adults) at school just under half said they would not seek help from anyone in that setting.

Similarly, very few students said they would definitely consult a mental health professional if they had problems and a full 30% said they definitely would not do so. These views were not changed by attending a program . The survey does not reveal why the students hold these views. It does not seem likely to be because they view mental health professionals as incompetent or untrustworthy.Most students felt that mental health professionals were effective in helping people and could be trusted to maintain a confidence although the minority of students who felt that mental health professionals were ineffective (19%) or could not be trusted to maintain confidences (30%) was not altered by the program .

In general, students hold sensible views about suicide. Most students believe that suicide is unjustifiable under most or any circumstances and that if they were feeling suicidal they would seek help. However, those who differ and feel that suicide may be warranted and those who would not be willing to seek help from a mental health

professional did not have their views on these questions changed by participation in the programs (#19).

Girls were more likely than boys to say they would talk about their problems and more likely to see a mental health professional and would be more likely to tell someone if they were suicidal. Boys views on these matters were unaffected by attending a program.

There were no significant or consistent differences on any of these measures of help seeking or on attitudes towards suicide between *schools or programs* . This occurred despite the fact that some programs were administered by educators (non-mental health professionals), others by mental health professionals.

5. Are There Any Adverse Effects on Students?

One of the concerns voiced about suicide prevention programs is that in working to increase teenagers awareness of the features of suicide (to make them more effective "case finders") or in pointing out how some teenagers respond to stress by making suicide attempts (to point out that there are less destructive and damaging ways of dealing with problems) programs may inadvertently introduce the idea of suicide to teenagers who would not otherwise have thought of it.

The most sensitive way of looking at this issue would be to examine the incidence of suicide attempts or completions before, during and after a high school population is exposed to a prevention program. That was beyond the scope of this project. We did, however, ask students whether they were distressed by the program, and if so why ,and we determined the prevalence of suicide attempts made by the students before and after exposure to the program.

7% of those who attended the programs found them "upsetting," and a further 4% reported that they knew friends who had been upset by the program.We asked the students what about the programs had upset their friends .The most common response was that it had brought back upsetting memories. Others answered that it made them upset to think about their own problems. Others simply said it was too long and boring.

To examine whether there was any increase in suicidal behavior or thoughts brought about by exposure to the program we asked students in 7 of the 11 schools (4 Demonstration, 3 control) whether they had ever made a previous suicide attempt (See Table 14 above) or whether they had repeatedly entertained suicidal ideas. This question was not asked of students in the two A program schools (and their matching controls) because the school administration took the view that to pose those questions might lead to difficulties. For the purposes of this analysis, responses were pair matched (that is only students who responded at time one and time two were entered into the analysis). Responses from 563 students in demonstration schools and 584 controls who were present on both occasions are given in Table 14 (below).

Table 14

Self-reported prevalence of suicide attempts and frequent suicidal preoccupations

Demonstration: **Controls:**

47. Have you ever tried to kill yourself?

		After program			*2nd assessment*		
		No	**Yes**			**No**	**Yes**
Before program	**No**	492	16	*1st assessment*	**No**	422	16
	Yes	20	35		**Yes**	15	31

46. Have you thought about killing yourself frequently or all the time.

Before program	**No**	522	18	*1st assessment*	**No**	440	16
	Yes	26	9		**Yes**	14	13

Comments:

On the face of it, Table 14 indicates that 16 teenagers who had not made a suicide attempt prior to attending the program did so afterwards. However, an examination of replies by controls shows an almost precisely similar response. Furthermore, there were just as many pupils who admitted to making an attempt when first questioned who then denied doing so when requestioned . These inconsistent responders (i.e. those who said they had made an attempt at either time one or time two, but not on both occasions) equal the number of consistent responders.

This type of unreliability is not uncommon in survey data of this sort. Inconsistent replies could arise for several valid reasons that are discussed in the concluding remarks to this report (Section VI). It is also possible that they represent invalid random and meaningless responses. In order to examine this possibility, we examined the demographic characteristics of inconsistent responders to see whether they resembled those of the consistent responders. Inconsistent and consistent responders were more or less proportionately distributed among the different schools.Age, sex and ethnic characteristics are provided in Table 15 below.

Table 15

Consistent & Inconsistent responders to questions about suicide attempts - Demographic characteristics

	TOTAL	NON-ATTEMPTERS	ATTEMPTERS CONSISTENT	ATTEMPTERS INCONSISTENT
%FEMALE	50.9	49.5	67.2	53.2
Mean Age	14.8	14.5	15.1	15.5
%WHITE	77.1	78.0	78.1	65.8
%BLACK	15.0	15.1	7.8	9.7
%HISPANIC	5.4	4.5	12.5	10.5
%OTHER	2.4	2.4	1.6	3.9

Table 15 shows the following :

Sex: Consistent responders were much more likely to be female. Inconsistent responders were only slightly more likely to be female.

Age: Both consistent and inconsistent responders are on average older than non attempters with inconsistent responders being older than consistent responders.

Ethnicity: Both consistent and inconsistent responders are disproportionately Hispanic. Both inconsistent and consistent responders are less likely to be black. Whites are proportionately represented in the consistent attempter group but disproportionately underrepresented in the inconsistent responders group.

We conclude from this analysis that consistent and inconsistent responders are similar in their differences to non attempters and that a true suicide attempt rate is probably the sum of both the consistent and inconsistent groups.

With respect to this study, these data provide no evidence for an increase in suicidal behavior or ideation following the suicide prevention programs.

6. Program Effects on Previously Suicidal Students:

One of the objections to school based programs is that they follow a low risk strategy. That is, they apply resources to many students who may not be at risk . It is therefore of interest to know how a high risk group would respond to such a program. The question is also of interest because of the possibility that talking about suicide or describing teenagers who have felt suicidal might have a stimulating effect (i.e.that it may induce some youngsters to contemplate or attempt or complete suicide) . If present, this effect is likely to be most marked in those who are at high risk.

There is general agreement that the group of individuals at highest risk for suicide are those who have already made a suicide attempt (See Shaffer et al., 1987) . We therefore examined separately the replies of students from both control and Demonstration schools who identified themselves as having previously made a suicide attempt. For the reasons given in Section 5 above previous attempters are taken to be students who indicated a suicidal attempt on either or both forms. 11.4 % of students in the combined sample fulfilled these criteria. The cumulative prevalence rates were similar in both the control and Demonstration groups.

6a. Attempters' Global Evaluation of Programs

Suicide attempters were more likely than non attempters to find programs boring (38% v 23%) , to complain that the programs were presented unclearly (13% v 4%), to indicate that the program had taught them nothing new (39% v 21%), and to express the view that the programs should not be shown to other schools (27% v 12%). In spite of their discontent with the programs they were more likely to complain that the programs were too short (50% v 30%).

As with the rest of the student body relatively few of the attempter pils were distressed by the programs but distress was slightly more common than among the non-attempters. 12% of the attempters said they had been upset by the program , (c.f.6% of non attempters), and although 68% of the attempters said that the program would make it easier to deal with their own problems (c.f. 72% of non attempters) 9% said that it would make it more difficult (3% of non attempters).

6b. Attempters' Knowledge about Resources

It is especially important that this group be well equipped with knowledge about where to obtain help, not only because they have already manifested severe emotional difficulties but because they are less likely, as a group, to rely on home support (24% in the Demonstration group attempters would turn to their parents for advice about obtaining help compared with 31% of the non attempters from the same schools).

Before the intervention, slightly (not significantly) more of the attempters (22%) than non attempters (19%) indicated that they would ask a counselor or teacher for advice, and they were significantly more likely to indicate that they would call a hotline or mental health center (36%) than would non attempters (22%). However, barely half knew where to obtain help and that proportion was not increased by exposure to a prevention program. (See Table 16 below).

Table 16

Attempters knowledge of resources

22. Do you know of any place other than school where you could talk to a mental health professional about personal problems that were troubling you?

	NON-ATTEMPTERS PRE	NON-ATTEMPTERS POST	ATTEMPTERS PRE	ATTEMPTERS POST
DEMONSTRATION	37	41	47	49
CONTROL	37	37	33	51

What strategies would the prior attempters use to help friends? This is a question of special interest because attempters have been in such a situation and their attitudes are likely to reflect their own experience, which may, of course, have been either good or bad.

Attempters were less likely to recommend to their friends that they should talk to an adult (50% attempters vs. 68% non-attempters) and were somewhat more likely to recommend talking to a friend *without* getting additional help (46 % attempters vs. 28% non-attempters). Neither of these attitudes changed as a result of participating in the program.

Although before participating in a program they were less likely than the naive non attempters to advise friends to contact a hotline or mental health center, their attitude towards this appears to have been changed by the programs . It can be seen from Table 17 below that in the "post" survey the proportion of attempters who would recommend contact with a professional was almost twice as great among those who had been in a program as among attempters who did not participate in a program. With respect to other attitudes, attempters were not more likely to take a suicide threat lightly, but more attempters would keep such a confidence secret and this was not affected by the program .

Table 17

Advice given by attempters to suicidal friends

25. What should you do if a friend tells you he/she is thinking about killing himself/herself?

	NON-ATTEMPTERS		ATTEMPTERS	
	PRE	POST	PRE	POST
TELL FRIEND TO CALL HOTLINE OR MHC				
DEMONSTRATION	39	43	29	37
CONTROL	35	37	27	20
WOULD KEEP IT A SECRET				
DEMONSTRATION	8	6	17	15
CONTROL	8	6	18	20

6c. Attitudes to Professionals and to Confiding among Attempters

In Table 18 below it can be seen that suicide attempters were *less* likely to believe that mental health professionals were good at helping people cope with personal problems, or that it was a good idea to go to a mental health professional with personal problems. These views were not significantly changed by attendance at a program but, if anything, there was a paradoxical change that was unfavorable to prevention.

On the other hand, the programs did seem to affect attitudes towards disclosing suicidal or depressed thoughts in a favorable way. Before attending the programs (See Table 18), attempters were less likely to feel that it was a good idea to share depressed feelings or to confide in someone else if suicidal .However, attempters attending programs were more inclined to share suicidal intentions whereas there was no such change in the control groups, thus fulfilling a goal of the programs (See Table 18, #44).

Table 18

Attempters attitudes to professional help and to confiding

	NON-ATTEMPTERS		ATTEMPTERS	
	PRE	POST	PRE	POST
15.Mental health professionals are good at helping people cope with personal problems.				
DEMONSTRATION	78	83	75	65
CONTROL	81	83	61	65
19.I would not be willing to go to a mental health professional if I were having personal problems.				
DEMONSTRATION	32	32	43	47
CONTROL	32	33	47	35
40.If you are depressed, it is a good idea to keep these feelings to yourself.				
DEMONSTRATION	9	11	17	23
CONTROL	10	12	29	22
44. If I felt like I wanted to kill myself, I would...				
			Not Tell Anyone	
DEMONSTRATION	15	15	30	20
CONTROL	15	16	29	41

6d. Attitudes Towards the Act of Suicide

Attempters and non-attempters held similar beliefs about whether suicide was a symptom of mental illness (9.5% attempters responded positively vs. 10.5% non-attempters). Attempters and non-attempters did differ in their attitudes toward suicide as a solution to problems with Attempters being less likely to view suicide as unacceptable and more likely to view it as a good or possible solution. However these attitudes changed in a positive direction after attendance at a program (See Table 19).

Table 19
Attempters opinions on
Suicide as a reasonable behavior

43.For people who have a lot of problems in their lives, I think suicide is....

	Never a solution.		Possible solution		Good solution		Only solution	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
NONATTEMPTERS								
Demonstration	89	85	8	10	2	4	2	2
Controls	91	86	8	11	1	1	1	1
ATTEMPTERS								
Demonstration	66	72	25	17	5	5	4	5
Controls	63	60	26	26	2	7	10	7

SECTION III

EDUCATOR SURVEY RESULTS

A. PROCEDURES

As part of the evaluation exercise, teachers, counselors and administrators at schools that participated in the project were surveyed for their views of how the programs had been implemented and for their evaluation of the content and efficacy of the programs. The group that was surveyed (See Table 20) was comprised predominantly of teachers (81%).

Table 20

Educator Sample

	Pre	Post
Teachers	327	264
Guidance Counselors	17	7
Administrators	15	11
Other School Staff	27	9
Nurses	5	1
Psychologists	2	1
PTA Representatives	3	3
Other	25	11
TOTAL*	**426**	**307**

* excluding 19 subjects in OK2 Crisis Intervention Training - These surveys are being analyzed separately.

1. Educator Programs:

All educators were required to attend the suicide awareness programs in each of the six schools. Each of the programs was presented by a mental health professional from the community mental health center implementing the program. Features of each educator program are presented in Table 21

Table 21

The Educator Programs

Program	Duration	Format	A-V material	Special Features
A Program	2 hours	Large assembly & Small groups	Film- "Suicide-The Warning Signs"	
OK Program	2 hours	Large assembly & Small groups	Film-"Suicide- The Warning Signs"	8 week Crisis Intervention Training for special services staff (Counselors, Admin., etc.)
L Program	1 1/2 hours	Large assembly	None	

Questionnaires designed to measure the knowledge and attitude variables that were to be addressed in the programs were administered to the educators just before they participated in the programs and approximately one month after (see Appendix 2 for instrument). The post-program instruments were distributed through the schools' internal mail and collected at a central location.

Table 22 below shows the educator compliance rates for each school.

Table 22

Educators - Compliance Rates

	PRE		POST	
	# Attending Program	# of Forms Completed	# of Forms Completed	Compliance Rate
A1	48	43 (90%)	41	95%
A2	147	137 (93%)	90	65%
OK1	93	59 (63%)	71	100%
OK2	65	64 (98%)	56	88%
L1	64	62 (97%)	33	53%
L2	68	61 (90%)	16	26%
TOTAL	485	426 (88%)	307	72%

Note: In both L program schools and in school A2, the return rate of post questionnaires was low. Results pertaining to L program and A program may therefore be unrepresentative. Between program comparisons must be viewed with this in mind.

All programs were observed by the researchers and, where appropriate, anecdotal remarks about the presentations will be included.

B. RESULTS

1. How Were the Programs Received?

The educators were asked to rate their overall attitude toward the suicide program both before and after they had participated. The percentage of favorable responses to a global question about the quality of the program is presented in Table 23.

Table 23

Educators favorable attitude/response to the programs

Schools	Pre	Post
A1	95%	90%
A2	86	86
OK1	81	93
OK2	86	60
L1	73	39
L2	79	73
Total	83%	79%

Comments:

Expectations about the programs were generally positive, although educators in the ASAP program schools were the most positively predisposed towards the program and educators in the Lifelines program were least favorably predisposed.

One OK program well exceeded its educators' initial expectations and the experience of OK2 and Lifeline 1 were well below anticipated expectations .

1b. Quality of Presentation

The educators were asked whether the information was presented clearly (72% said it was; 8% said it was unclear), whether the purpose of the programs was clear(74% said it was; 14% said it was not) and whether or not there were sufficient opportunities for asking questions or making comments (68% said there were). There were significant school differences in replies to these questions. Almost all educators in schools A1 (98%) and OK1 (90%) rated the programs as clearly presented. However, only 23% of the educators in school L1 reported the presentation as clear; 63% of the educators in school OK2 reported the presentation as clear. Similarly, almost all educators in schools A1 (96%) and OK1 (93%) rated the purpose and goals of the program as clear while only 21% of the educators in school L1 did so.

As with the student programs, the opportunity for questions and comments seemed important. In the poorly performing L1 school only 9% of the educators indicated that they

had an opportunity to pose questions or make comments. 40% of the educators in school L2 and 78% of the educators in school OK2 indicated that they participated in this way.

Further understanding about these results is gained by reviewing the comments that educators wrote on the questionnaires and from our own observations. These comments are included in Appendix 4.

It is important to understand why some programs were better received than others. Some of the factors that influenced the programs' reception were presentation style, prior formal and/or informal instruction in this area, or administrative concerns. For example, L1 educators responded negatively to the fact that the presenter simply read to the group from a paper. This failure of the presenter to communicate adequately must also reflect poorly upon the program organizers who had either failed to adequately train the presenter or to adequately rehearse him. At the time, teachers at this school were being required to teach more hours than usual and tensions between school administrators and educators seemed high. The presentation style, which consisted of reading a prepared manuscript, only served to increase the educators' resentment.

The relatively poor results for school OK2 were unlikely, in our view, to be based on either the program (which was the same as was presented to school OK1 where it was very well received) or on the the presentation. We observed this to be well organized with several different speakers presenting effectively. The audience appeared to be interested and knowledgeable. However, on the post program form the educators remarked that the information was redundant for they had participated in similar programs on several occasions. This may have been because a student suicide had occurred in this school approximately one year before and/or because many teachers had participated in similar programs.

The good reception given to the 2 ASAP programs probably reflects programmatic features or the excellent organization and/or the input of experienced presenters because the schools were very different. School A1 is a small special school for academically gifted students, educators seem to be particularly involved in school affairs, and were very supportive and interested in the program.By contrast ,School A2 is a large urban school where although many educators were interested and supportive of the program, there were others who felt that there were different, more important, problems facing their school. The educators were not as involved as in school A1, perhaps because of the much larger size of the audience.

2. Were the Programs Seen as Helpful?

Regardless of how well presented the programs were, were they seen as helpful? The overall answer to this is not so clear. The number of educators who responded that they "learned nothing" (31%) was very close to the number that responded that they "learned a lot" (36%). 56% said that they found the programs useful while 15% indicated that they thought the programs were not useful. 81% of the educators stated that they would recommend that other schools receive the same program (item#3 on educator questionnaire) and 85% said that they would want their own child to attend such a program (Item# 23).

These moderate responses reflect quite marked school differences. On all items, schools A1, A2 and OK1 are rated most positively and schools L1 and L2 are rated most negatively. In school L1 only 9% of the educators said that they had "learned a lot."

Almost all of the educators from schools OK1 and school A1 recommended the program whereas fewer than half of the educators at school L1 did so.

3. Knowledge Acquisition:

3a. Treatment Resources and Referral Procedures/Policies

Before the program only 45% of the educators said that they knew where to refer a troubled student. This increased to 68% after the program. Only 29% knew anything of their schools policy towards student suicide threats or attempts before attending the program. This increased significantly to 66% after the program.

There were quite marked changes in educators' knowledge at all schools,the largest increases being among educators at schools OK1 , OK2 and L2 .

3b. Clinical Features of the At-Risk Child (Warning Signs)

Educators were asked to present a list of what they felt were the warning signs of suicide before and after they had been through the program. The average number presented before the program was 3.63. This increased to 6.10 after exposure to a program.

Changes in the signs listed are noted in Table 24. The behaviors that showed the most striking increases in recognition were suicide threats and warnings, making final arrangements, changes in eating behavior and risk taking behaviors. Depression, the sign that was listed most often before exposure to a program, was listed less often, falling to fourth place in order of frequency.

Table 24

Warning Signs recognized by Educators

	Pre	Post
1) *Depression*	57%	49%
2) *Social withdrawal*	46	35
3) *Non-specific change*	34	50
4) *Specific suicidal threat/warning*	27	50
5) *Making final arrangements*	24	53
7) *Apathy/indifference*	22	22
8) *Decreased educational performance*	20	29
9) *Eating habits/weight gain, loss*	11	31
10) *Risky behavior*	2	29

4. Attitudes toward Suicide Prevention:

We were interested to see what responsibilities educators felt were appropriate for themselves and to what extent they felt they could break confidences and how these attitudes were influenced by the program.Replies to questions concerning these issues are provided in Tables 25 & 26 (below). It can be seen that the most marked change was that after a program more educators felt that it would be appropriate for them to make a referral to a mental health professional outside the school. There were no significant changes in attitudes towards maintaining confidences after exposure to the programs. It is interesting

to note that fewer than a half of the educators felt that it would be appropriate for an educator to inform a parent that their child was showing behaviors indicating risk for suicide.

Table 25

How to handle at-risk students

Do you feel that any of the following are appropriate responsibilities for you?

	PRE	POST
Identifying students at-risk for suicidal behavior and recommending to them that they seek special help	78	79
Telling a counselor or child study team member about a student who may be at risk for suicidal behavior	98	97
Talking to students directly about their suicidal thoughts or intentions	58	61
Contacting a mental health professional (outside school) about a student who may be at risk for suicidal behavior	46	62
Contacting the parents of a potentially suicidal student	47	47

Table 26

Respecting confidences

If a student confided in you that he/she was thinking about suicide, but asked you not to tell anyone, what would you do?

	PRE	POST
Break the confidence immediately	62	71
Respect the confidence for at least a few days	25	23
Respect the confidence for as long as the student asks	1	1*

*= Responses do not total 100% because several teachers wrote in an "other" response.

5. Educators Views about Peer and Professional Support / Consultation :

Although intermittent educational programs of the sort that we were monitoring may provide some knowledge and direction they are likely to have greater value with adequate back up from school administration and peers. We asked the educators whether they were satisfied with the administrative and peer support they could call on within their school for

consultation and/or supervision on difficult student problems*(Item #21)* . Overall only 45% of the educators reported being satisfied with this level of support. Attendance at the programs decreased the feeling of satisfaction so that only 40% reported being satisfied at that point. The decrease was attributable to increased dissatisfaction expressed in three schools (A2, OK2, & L2).

Dissatisfaction does not seem to be a function of specialist staff deficiencies because 91% of the educators indicated that staff were available within their school for consultation.This increased to 96% after the programs *(# 18)*.

The programs increased knowledge about the availability of outside consultation.Before the programs only 53% of the educators reported that they knew of outside professionals who could be consulted, this increased to 66% after the programs*(#19)*. However they expressed a clear preference for making consultations within school (89% compared with 10% who would prefer to obtain outside consultation) and these proportions were unaffected by attendance at a program*(#20)*.

As might be expected, school differences in staff satisfaction were considerable. School L1, in which the program was consistently rated most negatively, had the lowest percentage of satisfied educators (35%- with no change pre to post). Schools OK2 and L2 had the highest percentage of satisfied educators (63% pre, 52% post) .

6. Practical Impact of the Programs:

At the time of the second evaluation ,which was approximately 4 weeks after the first, we asked the teachers and other staff whether they had identified or referred any pupils since they had attended the program. 12% of the educators said they had identified adolescents who were showing what they felt was at-risk behavior(#15) and 13% said they had referred a teenager to the counselling office (#16) . 5% had referred students to some other form of mental health professional(#17).

SECTION IV.

PARENTS

A.METHODS

Each of the programs includes a parent component for which participation was voluntary. The proportion of parents who attended (and who completed the questionnaires as they entered the meetings) varied from school to school and was likely unrepresentative of the entire parent population.

Except in one school (A2) where the principal felt it inadvisable to circulate the pre-program form, all pre-program questionnaires were distributed with a self addressed envelope that we used to send on the post program questionnaire one month later. However, the return rate for the post forms that was to be mailed back to us (37% of Pre) was low, so the results could not be interpreted as representative of the parents that attended the program . Furthermore, because of small numbers, between-program comparisons would not be meaningful . We therefore present the pre-program results only as an indication of prevailing attitudes in the parent group.

Table 27

Return rate of parent forms

	PRE		POST	
School	# Attending Program	% Completed Forms	# Completed Forms	% of Pre
A1	13	100%	3	23%
A2*	*	*	*	*
OK1	133	100%	57	43%
OK2	39	98%	4	11%
L1	8	88%	5	71%
L2	19	100%	8	42%
TOTAL	210	99%	77	37%

*= This school did not administer the parent questionnaires.

B. RESULTS

1. Knowledge of Treatment Resources and Referral Procedures/Policies:

Fewer than half (47%)of the parents who completed forms at time 1 said they knew where they could refer a troubled teenager (#17). Only 12% said they knew of any school policy concerning suicide threats or attempts by students.This is not surprisingly low, considering only 29% of the teacher group knew the school policy before the prevention program was implemented.

The (most likely unrepresentative) group of parents who attended the programs was well informed. They could list on average 3.9 warning signs, slightly more than the teachers. Only 9% subscribed to the opinion that people who talk about suicide do not

commit suicide(compared with 18% of pupils). Parents are more likely than their children to believe that people who commit suicide are mentally ill (22% as opposed to 11% of the students) and less likely to believe the falsehood that people who talk about suicide do not commit suicide. Only 3% took the view that a youngsters suicide is always the parents' fault (Item #23).

Just under half (42%) felt that suicide was a major teen problem in their community.

They hold generally very positive views about mental health professionals: 96% believe that they are good at helping teenagers cope with personal problems; 92% said they would let their child see a mental health professional for help and only 4% expressed the view that people should learn to handle their own problems without outside help.Only 7% believed that it cost more than it is worth to see a mental health professional. These parents were more positive about mental health treatment than the students (96% believe it is helpful while 81% of the students believe it is helpful).

Their attitudes towards confidentiality were, as expected somewhat different to teachers or peers, and they were more likely than either group to declare themselves prepared to inform someone else if their child made some verbal indication that they were thinking about committing suicide(89%)(Item # 13) .

56% said they would be concerned about their teen children forming friendships with another youngster who had been suicidal (Item #21).85% said they would be comfortable discussing the subject of suicide with their teenager .75% said they felt that suicide should be discussed in the classroom leaving a sizeable minority of 25% who believe that it should not .

SECTION V

Screening for At-Risk Students:

Although the main task of this exercise was to evaluate the prevention programs, the evaluation process also involved screening for at-risk adolescents in 7 of the schools (two Demonstration schools would not allow the question to be included and the items were omitted from their matched control schools) and we feel that it is worthwhile to report on this potentially valuable technique. Embedded in the questionnaires administered to students at those schools were two sets of questions. The first was designed to assess current suicidal feelings.The second set of items provided an opportunity for students to identify themselves and request help.

The questions designed to assess current suicidal feelings started with the question: *If you have ever thought about killing yourself or you have tried, what helped you to stop feeling that way?* Several options were listed - The last being *I haven't stopped feeling that way* . The procedure (see table 28), applied twice, identified a total of 72 students.

Table 28

Screening for students

currently feeling suicidal

	Pre	Post	Overlap
Control	16	16	4
Demonstration	23	23	2
Total	39	39	6

Students who responded to this item were identified. The name was given to the school principal and the child was contacted by the school guidance team. Principals and counselors reported that the majority of the referrals were appropriate and that the majority acknowledged that they were feeling suicidal.

Feedback from the control schools was especially positive as the screening procedure was the only immediate benefit of their participation in the study.

Students were asked on the time 2 assessment if they had been contacted as a result of the response to the time 1 assessment, and if so, how they felt about it? Most answered that they were pleased, although a small number said that they were embarrassed or angry.

At the end of the questionnaire given to the same 7 schools the following statement was inserted: *If you have been thinking about killing yourself and would like someone to help you with your problems, please write your name on the line and someone trained to help will contact you privately.* Responses to that item are shown in table 28.

Table 28

Screening for students

currently wanting help

	Pre	Post
Control	8	3
Demonstration	14	7
Total	22	10

Although the number of students responding to this item is relatively low, we feel it allowed students to ask for help in a relatively non-threatening way. These students were contacted immediately by guidance counselors who reported in general terms that the referrals were appropriate.

The decrease from time 1 to time 2 can perhaps be explained by the fact that the number of students seeking help would have been affected by therapeutic contacts made after the initial survey. There was no overlap in these cases from time 1 to time 2.

Neither of these screening items yielded any evidence of an increase in suicidal ideation resulting from participation in the program.

SECTION VI

SUMMARY AND RECOMMENDATIONS

A. FINDINGS

1. How Were the Programs Received?

The programs were well received . Most of the students found them interesting and helpful and, with some exceptions, so did the teachers and the rather unrepresentative group of parents who attended their special sessions in 5 of the 6 schools. A great majority of both educators and pupils recommended that the programs be delivered at other schools and almost all of the educators stated that they would want their children to participate in a similar program.

One of the goals of the program was to deliver services to urban teenagers. This proved to be rewarding.The students in the three urban schools gave the highest proportion of positive ratings.

There were consistent sex differences in how well the programs were received; girls generally found the programs more interesting and helpful.

2. Did the Programs Encourage Students to Seek Help for Emotional Problems?

A generally accepted goal for school based suicide prevention programs would be to reach out to the suicidal teenager to encourage him/her to share their intentions and problems with someone else . Most programs acknowledge that in most cases this will be either another student or a teacher i.e. someone without professional helping skills. Because of this, the programs also set out to prepare untrained individuals, both educators and students to receive and manage a suicidal confidence in such a way that the suicidal youth's needs will eventually be met professionally . This sequence of events is in a sense an adaptation to young peoples' deficient *psychological* help seeking skills (it is unlikely that a teenager would manage a physical complaint in such a circuitous way).

Our first question was whether the programs were justified in taking the view that a teenager's capacity to recognise his own problems and to directly seek the best available help for them was limited. Our survey suggests that they are. Before participating in a program only 13% of the students said they would contact a mental health professional and a fifth of the teenagers said they would consult a teacher or counselor at their school if they were experiencing emotional difficulties.Parents did little better - only a third of the students said they would approach their parents for advice; but the majority of students said they would first turn to a friend. This is in keeping with the prevention programs strategy of working with the teenagers natural helpers, their friends.

It would be a misrepresentation to say that the programs were limited to these restricted goals. There were elements in the programs that addressed other components of the help seeking process.They sought to train non-suicidal students and educators to be on the lookout for suicidal youngsters teaching them a set of warning signs that they might show. They also informed educators and students about how to access help from community resources and tried to convey to students, who might one day find themselves

in a suicidal state, that there were other ways of dealing with such situations. Not all of these areas were covered with equal thoroughness and each program carried a somewhat different emphasis.

The process of seeking help for a problem is a complex one with many components. *For the purposes of this examination we thought it might be valuable to break* it down and to see whether we could determine whether the programs had been affected it in a positive way.

Help seeking requires motivation and resources to meet its cost.There should be a belief that the help will be effective, recognition by the individual that they are suffering from a condition that can be helped, a preparedness to ignore any social barriers or stigma that might be present, and either the knowledge of where to obtain help or at least who to ask for it.

We did not design our survey instrument to determine individual motivation nor to examine whether students had the resources to pay for help. Belief in the effectiveness of mental health professionals did not appear to be a problem. Most students, regardless of whether they attended a program , thought that professionals were good at helping people in trouble and that they could be trusted to maintain confidences.

Our surveys only addressed the question of whether teenagers who have been through a program are better able to recognize that they have problems that could benefit from help,indirectly. Had the programs succeeded in raising self awareness we might have seen an increase in the number of requests for help at the time of the follow up evaluation among students who had attended a demonstration program, with no increase among controls. Instead, we found that fewer teenagers from either group indicated that they wanted help at the time of the follow up inquiry. This reduction was almost certainly due to the fact that help was given to all who self identified at the first evaluation thus depleting the pool of needy teenagers without help. There is no suggestion from this analysis that the programs greatly facilitated self identification. However, a more satisfactory way of looking at this question would be to monitor referrals to teachers, counselors and other identified helpers before and after the program. This was beyond the scope of the present project.

If it were to be confirmed that there had been no increase in self identification of problems this might have been because of the emphasis on suicide. There are many emotionally troubled teenagers who would benefit from help but who, recognizing that they are not suicidal, may not identify with the problems presented in the program. This would be one argument for decoupling mental health programs from the narrow domain of suicide prevention.

Did the programs reduce some of the reluctance attached to seeking help from mental health professionals? Seemingly not. Before attending the programs the great majority of students (this applied somewhat more to boys than girls) said they would not seek help for emotional problems from teachers, counsellors or mental health professionals and the distribution of replies was generally unaffected by attendance at a program. (See Table 12, page 14) The only exception to this was a modest increase (from a quarter to a third, most of the increase being in girls) in the proportion of program participants who said they would use a hotline or mental health center to seek help. Attendance at a program resulted in no increase in the number of students who would ask their parents or a teacher or a counsellor for help and did not reduce the two thirds of the students who did not know how to get help outside of school.

Educators could play a key role in providing help for troubled teenagers. However, approximately one half of them indicated that they felt poorly supported in this type of activity by their own schools, even though over 90% of them felt that the helping services available at their school were adequate (See Section 5, Page 31). The development of professional counselling services within schools seems a fruitful area for further activity by outside mental health centers programs.

The reluctance of students to make use of professional help for emotional problems is clearly widespread and should probably be a major goal of future prevention research. In the meanwhile, emphasis and experimentation by programs in this area should be encouraged. Resistance to use of school counselling services seems particularly strong (only 23% of the students would see a counselor for emotional problems-Table 12) and it is important for programs to decide whether to accept this and to concentrate on facilitating outside referrals or to address it directly.

3. Do the Programs Encourage Disclosure of Suicidal Preoccupations?

Most teenagers hold responsible and sensible views on disclosure regardless of whether or not they attend a suicide prevention program. Most believe that it is best not to keep depressed feelings to oneself , and that suicidal preoccupations and confidences should be disclosed to others.They would tell an adult if a friend were having severe problems and would take such problems seriously.

However, approximately 10 to 15% of teenagers do not hold these views and the programs did not change their minds. They believe, or at least report that they believe, that a suicidal or depressed person should not disclose or share their opinions and that any confidences received from another suicidal teenager should be maintained. An ominous finding from our survey was that these views were much more common among teenagers who have made a previous suicide attempt (Table 17 & 18).

Further research is needed to understand what lies behind the beliefs of those teenagers who are so mistrustful of help. Have they already had some professional contact and not been helped by it? Do they have mistaken ideas about what professional contacts might involve? These are some of the possibilities that could be examined in such research.

A finding of general interest in the area of school based prevention was that approximately half of the parents who returned forms to us indicated their reluctance to have their children be friends with other teenagers who had made a suicide attempt. Attitudes of this sort should perhaps be taken into account when using peers for counselling, assuming that they can be shown to be effective in this role.

4. Do the Programs Promote Attitudes and Knowledge Favorable to Prevention?

Educators who participated in programs significantly increased their knowledge of mental health treatment resources and of "warning signs" for potentially suicidal students. They also significantly increased their knowledge of school policies and procedures regarding identifying and referring suicidal teens, thus fulfilling important goals of the programs.

Once again, the situation with the students was that most held quite sound views on and were knowledgeable about suicide before attending any program. 85% stated it was best to share depressed thoughts and 90% said if they had suicidal preoccupations they

would want to talk about them; 86% said that suicide is never a solution to problems; 80% that it is *not* true that suicide threats do not precede a suicide and 90% that suicide threats need to be taken seriously. Approximately 85% of the students not attending a program said that suicide threats and prior suicide attempts *are* a warning sign; 74% that drug abuse and suicide are related. These findings are reassuring and may account for the fact that suicide completion is actually quite a rare phenomenon in teenagers. What is a matter of concern, however, is that in nearly every instance the minority who held the reciprocal views to those listed above were unaffected and unchanged by attending a program.

Thus, there was no significant reduction in the 33% of students who would counsel a suicidal friend without obtaining help from someone else; there was no reduction in the 10% who would not take suicide threats seriously and the similar number who would keep suicidal confidences a secret or in the 18% who believe that people who talk about suicide never attempt suicide; there was no reduction in the 10% who feel it is best to keep depressed thoughts to oneself or in the 16% who said they would not talk to anyone else if they felt suicidal;there was no reduction in the 15% who feel that suicide can be a good or possible thing to do. These are the proper target audience for suicide prevention programs and the evidence from this survey is that the programs are ineffective in reaching them or in altering their views. One of the goals of future research must be to better understand this resistant minority that hold views that are clearly incompatible with effective prevention.

There were *some* gains in knowledge. Students who had participated in a program could identify more behaviors as warning signs than controls and were more knowledgeable about how to contact a mental health professional through a hotline than either controls or than they themselves had been before the program (there was a 10% increase in the number who would use a hotline) but as indicated above only one third of the students felt able to do this.

One piece of information that was imparted was the view that drugs and alcohol are a good way to cope with depression. This belief increased markedly among those who had participated in a program but did not change in the control students. A higher proportion of boys and students who had made a previous attempt responded in this way.The idea that drugs and alcohol are sometimes taken as an attempt to self medicate for depression is widely held (although scientifically unsubstantiated). It is not clear whether the impact of this idea (and it had more impact than many of the other ideas contained in the programs) reflects the students own experience that had then been put into words by others or whether it provided a convenient (and memorable) rationalization for otherwise unacceptable behavior. Attempters are both more likely to have experienced some dysphoria and hence to have noted a beneficial change on their mood had it occurred, but they are also more likely to have associated drug and alcohol problems and thus to seek a rationalization for their habit.

The generalization that most teenagers hold sensible or accurate views does not apply to views on whether or not suicide is a manifestation of mental illness. Very few of the teenagers (around 12%), either before or after exposure to a program believed that this was true. We are in no doubt that the weight of research indicates that suicide is strongly related to other manifestations of psychiatric disturbance but this information was not used in the prevention programs.

The reluctance of suicide prevention programs to advance the mental illness model of suicide is deliberate. As indicated above, the goal of most programs is to encourage self-disclosure and given that view, is reasonable to take the view that associating suicide with mental illness will discourage self-disclosure.However it is not improbable that presenting a medical model of mental illness might actually increase self and parent generated referral

rates.It is not implausible that the destigmatization of mental illness will not come from continuing to deny its existence, but rather by understanding its origins, which are in many instances biological, its treatability and its broad similarities to other forms of illness.

5. Is One Program Better than Another?

The general level of acceptance and interest in the programs was very high but variation was noted between different schools and programs.

The ASAP program was rated favorably (that is to say more interesting and more clearly presented) by a higher proportion of both students and educators than were the other programs although the program seemed no more effective than the others in increasing student knowledge or changing attitudes.

It would be valuable to investigate what element of the ASAP program accounts for this preference because if it is a matter of technique rather than content, it could be profitably employed by other programs.We have identified four distinguishing characteristics of the ASAP program that might contribute to its higher acceptability:

a)It has a small group format. This is likely to encourage participation and our survey shows that it does so for significantly more students asked questions or made comments in this program than in the others. The small group format not only increases pupil involvement but it provides feedback to the group organizer of where the teenager is "coming from." The organizer can then tailor their interventions to make it most appropriate.

b)The program employs experienced personnel from the community who have had considerable practice in presenting the program to high school students. This contrasts with the use of either classroom teachers who have received only brief training or professionals who usually work as therapists or counselors rather and who have had only limited experience as educators .

c)The program is given to older students than the other programs. They may be more receptive to program content.This is unlikely to be a deciding factor because it would not explain the better reception given to ASAP by educators.

d) There was a confounding between program and pupil type; both ASAP programs were given to urban school children. This possibility deserves serious consideration because the one urban school (OK1) that did not receive the ASAP program also responded very favorably to the programs, significantly more so than the suburban school that received the same program (although this may have been because of an element of repetition at that school - see below). This possibility could be resolved by comparing ASAP with other models in a variety of settings.

It is also worth examining two school settings that appeared to respond less positively to the programs. We say they did badly because the post evaluations on a number of global items were markedly less favorable than the anticipatory ratings that educators gave the programs before they were delivered.

The program at school OK1 fared very well, however the program at school OK 2 fared somewhat poorly in the many of the overall ratings. Comments from educators suggested that this was because of an element of repetition.A similar program had been

given at that school within the recent past, possibly as part of a postvention exercise following the suicide of a pupil.

Fewer of the educator staff at both schools that were to receive the Lifeline program looked forward to it with enthusiasm and response to the program was generally less possitive than the other programs. The reasons for this are not clear but it suggests that preparatory work may not have been adequate. Other evidence for inadequate preparatory work was the performance of one Lifeline presenter who appeared to be underrehearsed and had to read his presentation.

In spite of the marked differences in how interesting the different programs were perceived to be, knowledge acquisition and attitude change was strikingly similar in all programs.

6. Are the Programs Dangerous?

We are very aware of the dangers of imitation of suicidal behavior in the young and we were concerned that open discussion of suicide could lead to an increase in suicidal preoccupations and even behavior among some of the youngsters. We approached this in two ways. Firstly at the time of the post examination we asked pupils if they had been distressed by the program. A small proportion (7%) reported that they had been and a similar proportion indicated that they had friends or knew other pupils who had been upset. Although there were some reports that could be interpreted as showing that the programs had triggered reflective concern about bad experiences, most of the reports of distress were because they had led students to think of missed prevention opportunities in the past.

We found no evidence that either had induced suicide behavior. However our principal strategy in looking for unwanted effects was to determine whether the rate of suicidal preoccupations or attempts had increased between the time of the initial and the follow up evaluations. Although we were able to follow this strategy with the OK and the Lifeline programs we were not able to do so with the schools that were taking the ASAP program. Our observations are therefore confined to the Lifeline and OK programs. Although there were a number of youngsters who had not admitted to suicidal attempts initially who did so at the time of the follow up, it seems unlikely that these represented new attempts which had occurred during or shortly after the programs because there was a similar shift in the control group who had not been exposed to a program. Rather, it seems to represent general unreliability in replying to an item of this sort.This unreliability could arise through such mechanisms as:

a) Attending the program encouraged participants to disclose experiences that they would otherwise keep to themselves.This would be a desirable outcome, but is unlikely to be the true explanation because there were similar changes in students from the control schools.

b) Attending the program or second thoughts allowed the subject to redefine a behavior. This could allow for either a reduction or an increase in reports at time 2.

A more valid way of examining this question is by direct examination of death, suicide attempt and suicide referral records in the communities served by the high schools and we strongly recommend that this type of research be undertaken.

7. Do Suicidal or Distressed Students Identify Themselves?

Two screening procedures were uysed in 7 of the 11 schools to identify students at risk for suicide and students requesting help for emotional or personal problems. Of the 1300 students participating in the screening approximately 100 were referred to guidance staff in the school for evaluation (See Section V, page 33). Guidance staff reported that these referrals were generally appropriate.

This screening technique is a valuable and relatively simple method of identifying students who are in need of help. Neither of these screening items indicated an increase in suicidal ideation after participation in a suicide awareness program.

8. Do the Programs Help Suicidal Teens?

11.4% of the students surveyed admitted to having made a previous suicide attempt. This group was older and had proportionately fewer blacks, more hispanics and more females than the non-attempter group. Although they were somewhat more knowledgeable and more inclined to avail themselves of hotline services than non-attempters, they were also more likely to hold unusual or undesirable views.Nearly twice as many said they would not disclose their suicidal intentions.They were twice as likely to believe that it is best to keep depressed ideas to oneself. Twice as many believed that suicide was a good or only solution to problems.They were less likely to believe that mental health professionals could be helpful and half of them said they would not visit a mental health professional for help.

Although this group is clearly an appropriate target for preventive interventions, the help they received from the programs was marginal. Attempters were more likely to be critical or hostile to the programs.They reported more distress after attending a program, and a higher proportion found them boring, unclear, lacking novelty and teaching them nothing new.There was a tendency for their undesirable attitudes to become more prevalent after exposure to a program.

The only beneficial change noted among attempters was an increased willingness to recommend a hotline or mental health center to a suicidal friend. This was not paralleled by any increased willingness to use a hotline or mental themselves.

B. RECOMMENDATIONS

Regardless of the impact of these programs, the problem of teen suicide remains and with it the need for prevention. We believe that the present study revealed some important facts for future program planning:

a) Teenagers can reveal a history of suicidality, unhelpful attitudes and beliefs, etc. in an appropriate self report form;

b) Didactic programs of the sort we have studied have some effect on improving knowledge about resources and school policies, and willingness to use hotlines and mental health centers, but do very little to alter damaging and dangerous attitudes.

We believe that the most sensible next steps would be to implement a demonstration screening program, in which teenagers would be asked about suicidal feelings and experiences, other risk factors for suicide and about their attitudes to help and

disclosure.Teenagers who screened positively would be referred to therapeutic programs which might be school or community based (we have evidence from other work that compliance is much greater when school based programs can be provided) and decisions about further management would then be made on an individual basis.

Two types of Educational demonstration programs should be piloted and researched:

i) A program in a small group format designed to further explore and address the attitudes of those who are mistrustful of help;

ii) A general mental health educational program which would provide students with advice on coping skills and with a framework for understanding mental illness in much the same way as an understanding of physical illness is taught in many special classes.

Further research to investigate the element leading to the superiority of the ASAP format would be worthwhile and might take the form of assessing ASAP against another program format in different types of student body or by systematically varying the programs' distinguishing features.

Finally we believe that outside research (i.e. research that is independent of the implementor) should always accompany demonstration projects and special projects because it is only with such research that we can learn what is appropriate and what is not .helpful in trying to advance the cause of preventive mental health. Further research that is needed for the present programs is to determine whether suicidal behavior is increased or decreased by the programs through direct examination of death and attempt records in the communities served by the high schools. This would be more valid than the methods we have used in the present survey.

These preliminary analyses show a need to focus more on determining the effects of the programs on the true target population - those students who are at the highest risk for suicidal behavior. Further analyses will provide greater insight into this issue by separating the attempter groups to make a comparison between consistent and inconsistent categories and by looking at differences in responding by sex and race.

Appendix I

Protocol

Administration of Student Questionnaires

Announce to students:

This form is designed to find out how young people deal with emotional or personal problems like depression, suicidal thoughts, or problems getting along with other people. We also want to know how you feel about mental health professionals. Mental health professionals are people who are specially trained to help people deal with personal or emotional problems. These professionals include, psychiatrists, counsellors, psychologists, social workers and psychotherapists.

You are being asked to write your name on the tear-off cover sheet so that we can assign an identification number to your questionnaire. Your name will not be on the questionnaire. Someone in your school may contact you only if we feel you could benefit from speaking to someone about any problems you might have.

There are no right or wrong answers to these questions.

Please read the questions carefully. Many questions have several parts. For example, if the second part of a question starts with "If yes," you only have to answer it if you circled yes for the first part of the question.

Please ignore the numbers and lines on the far right side of the page; those marks are for computer coding purposes only.

It is important that everyone complete all of the questions, although this is not mandatory. If you don't understand something just raise your hand and I (we) will try to help you. Does anyone have any questions before you begin?

Please write your name on the cover sheet of the questionnaire now, then tear the cover sheet off and hand it to the person who is collecting the cover sheets.

Collect all cover sheets at this time.

Possible questions:

Who wrote the questionnaire?

Some researchers from Columbia University who are trying to find out more about how students feel about these issues.

Why do we have to fill this out?

It is not mandatory that you fill this out. We feel that it will help us to understand how students feel about these kinds of issues and may help to design more interesting and effective school programs in the future.

What kinds of personal problems are they talking about?

Personal Problems = Being very upset, depressed, worried or anxious, not being able to get along with other people, feeling like you're going crazy, feeling like you want to kill yourself, or any other psychological or emotional problem.

Why do they need to know my age, sex, ethnicity?

They can use this information to see if different groups of people feel differently about these issues based on their age, sex, or ethnicity.
(This information is not absolutely mandatory, if someone is opposed to recording it, it is not necessary to pressure them.)

Can we find out the results of this study?

When the study is completed, we will tell you about the results if you are interested.

Student Pre-Program Appendix 2

I.D. #____

Write Your Name Here_____

Tear off this sheet and hand it to the Monitor.

Student Questionnaire

1

Case# ___ (01-03)

I.D.# ___ (04-07)

Form ___ (08)

___ (09) ___ (10)

___ (11) ___ (12)

Before completing the questionnaire, please give us the following information.

Your age_____

Your sex: Male_____ Female_____

Your ethnicity: White_____ Black_____ Hispanic_____ Asian_____
Amer. Indian____ Other_____

Please check your answers on the space provided.
You may check more than one answer.

1. When you feel very upset, sad, or unable to cope, do you...?

1a. Talk to someone in your family	1a.____	____(13)
1b. Talk to an adult	1b.____	____(14)
1c. Talk to a friend	1c.____	____(15)
1d. Exercise or play sports	1d.____	____(16)
1e. Listen to music, read, or watch TV	1e.____	____(17)
1f. Go out with friends to a movie or elsewhere	1f.____	____(18)
1g. Take drugs or drink alcohol	1g.____	____(19)
1h. Never felt that way	1h.____	____(20)
1i. Other_____		____(21)

If you have a bad emotional or personal problem, do you talk it over with a ...?

2a. Teacher	2a.____	____(22)
2b. High School Counsellor	2b.____	____(23)
2c. Mental Health Professional (Psychologist, Social Worker, Psychiatrist)	2c.____	____(24)
2d. Family Doctor	2d.____	____(25)
2e. Nurse	2e.____	____(26)
2f. Minister, Priest, Rabbi	2f.____	____(27)
2g. Friend	2g.____	____(28)
2h. Parent	2h.____	____(29)
2i. Brother or Sister	2i.____	____(30)
2j. Other family member	2j.____	____(31)
2k. Other adult	2k.____	____(32)
2l. No one	2l.____	____(33)

Do you agree or disagree with the following statements?
(Please circle your answer)

Yes = Agree
No = Disagree

3. Mental health professionals (Psychologist, Counsellor, Social Worker, Psychiatrist) are good at helping people cope with personal problems ..... 3. **Yes** **No** ____(34)

4. Only people who are "crazy" go to see a mental health professional..... 4. **Yes** **No** ____(35)

5. Mental health professionals can "read your mind" and find out all your secrets.....5. **Yes** **No**

6. Mental health professionals only break a secret when they feel it is a matter of life or death.....6. **Yes** **No**

7. I would be willing to go to a mental health professional if I were having personal problems.....7. **Yes** **No** **Maybe**

8. My parents would let me go to see a mental health professional.....8. **Yes** **No** **Maybe**

9. Who would you talk to <u>in your school</u> if you were having emotional problems? (You can check more than one answer)

9a. Teacher.....9a.____
9b. Counsellor, Psychologist.....9b.____
9c. Nurse.....9c.____
9d. Coach.....9d.____
9e. Other School Staff (Secretaries, Bus Drivers, Cafeteria staff, etc.).....9e.____
9f. Principal or Vice Principal.....9f.____
9g. No one.....9g.____

9h. Other_____

10. Do you know of any place <u>other than school</u> where you could talk to a <u>mental health professional</u> about personal problems that were troubling you?.....10. **Y** **N**

11. If you needed to contact a mental health professional <u>outside of school</u> how would you find out where to go or who to call? (Please check the first thing you would do.)

11a. Ask your parent.....11a.____
11b. Ask another family member.....11b.____
11c. Ask a teacher, counsellor or other adult at school..11c.____
11d. Ask a friend.....11d.____
11e. Look in the Phone book or call "Information".....11e.____
11f. Ask a doctor.....11f.____
11g. Call a hotline or emergency number.....11g.____

12. Have you ever called a hotline or telephone crisis/counseling service?.....12. **Yes** **No**

<u>If yes,</u> what for?_____

Which one did you call?_____

13. What should you do if a friend tells you he/she is thinking about killing himself/herself? (You can check more than one answer)

13a. Tell my friend to call a hotline or mental health center.....13a.____ (59)
13b. Talk to an adult about my friend.....13b.____ (60)
13c. Talk to my friend without getting anyone else's help.....13c.____ (61)
13d. Get advice from another friend.....13d.____ (62)
13e. I wouldn't take it seriously.....13e.____ (63)
13f. I would keep it a secret.....13f.____ (64)

13g. Other_____ (65)

14. How would you be able to tell if a person was thinking about killing himself/herself? (Please list as many warning signs as you can think of)

1._____ 5._____ (66) (67)
2._____ 6._____ (68) (69)
3._____ 7._____ (70) (71)
(72) (73)
4._____ 8._____ (74) (75)

15. Do you know anyone who has killed himself/herself?...15. **Yes** **No** (76)

16. Do you know anyone who has <u>tried</u> to kill himself/herself?.....16. **Yes** **No** (77)

17. Has any one ever told you they were thinking about killing themselves?.....17. **Yes** **No** (78)

<u>If yes</u>, what did you do? (You can check more than one answer)

17a. Told my friend to call a hotline or mental health center.....17a.____ (79)
17b. Talked to an adult about my friend.....17b.____ (80)
17c. Talked to my friend without getting anyone else's help.....17c.____ (81)
17d. Got advice from another friend.....17d.____ (82)
17e. I didn't take it seriously.....17e.____ (83)
17f. I kept it a secret.....17f.____ (84)

17g. Other_____ (85)

18. Does talking about suicide in class... (Circle your answer)

18a. make it o.k. to talk about suicide?.....18a. **Yes** **No**

18b. make some kids more likely to try to kill themselves?.....18b. **Yes** **No**

18c. make it easier for some kids to ask for help?...18c. **Yes** **No**

18d. make it easier for some kids to spot signs of suicide in other people?.....18d. **Yes** **No**

18e. stop some kids from trying to kill themselves?..18e. **Yes** **No**

Do you think the following statements are **TRUE (T)** or **FALSE (F)**? **(Circle your answer)**

19. Most kids who kill themselves are normal but they have had a lot of bad things happen to them.....19. **T** **F**

20. People should not discuss very personal problems with strangers.....20. **T** **F**

21. People who talk about suicide do <u>not</u> commit suicide...21. **T** **F**

22. People should be able to handle their own problems without outside help.....22. **T** **F**

23. Suicide should be talked about in the classroom.....23. **T** **F**

24. Almost all kids who kill themselves are mentally ill..24. **T** **F**

25. Drugs and alcohol are a good way to help someone stop feeling depressed.....25. **T** **F**

26. The main thing that adolescents have to do is to become more independent.....26. **T** **F**

27. It would be unusual for a teenager to never get depressed.....27. **T** **F**

28. If you are depressed, it is a good idea to keep these feelings to yourself.....28. **T** **F**

29. Drugs and alcohol can cause depression to become so bad it can lead people to try to hurt or kill themselves.....29. **T** **F**

30. People who do risky things, like always driving very fast, may be trying to hurt or kill themselves, and could use some help.....30. **T** **F**

Complete the following sentences and write the number of your answer in the space provided.

. For people who have a lot of problems in their lives, I think suicide is.....31. ____ (103)

1. Never a solution to problems
2. A possible solution to problems
3. A good solution to problems
4. The only solution to problems

32. If I felt like I wanted to kill myself, I would.....32. ____ (104)

1. Tell someone how I felt
2. Maybe tell someone how I felt
3. Not tell anyone how I felt

33. In the past month, have you sometimes thought that you had nothing to look forward to in the future, or that your family would be better off without you?.....33. **Y** **N** (105)

34. Have you ever thought about killing yourself?.....34. ____ (106)

1. Never
2. Once or twice
3. Occasionally (A few times a year)
4. Frequently (At least once a month)
5. All the time (Almost every day)

35. Have you ever tried to kill yourself?.....35. ____ (107)

1. No
2. Once
3. More than once

<u>If you have ever thought about killing yourself or you have tried</u>, what helped you to stop feeling that way?
(You may check more than one answer)

35a. Talking to someone.....35a. ____ (108)
35b. Staying by yourself.....35b. ____ (109)
35c. Going out with friends.....35c. ____ (110)
35d. Taking drugs or drinking alcohol.....35d. ____ (111)
35e. I haven't stopped feeling that way.....35e. ____ (112)

35f. Other_____ (113)

If you have been thinking about killing yourself and would like someone to help you with your problems, please write your name on the line and someone trained to help will contact you privately.

_____ (114)

Students Pre-Program Form #1

Warning Signs

Code: 0 = Not Listed, 1 = Listed

Categories

1.	Change Non-specific.....1.____	-67
2.	Sudden Change Specific.....2.____	-68
3.	Social Withdrawal/Isolation.....3.____	-69
4.	Depression/Anhedonia.....4.____	-70
5.	Apathy/Indif./Lethargy/Lack of attention..5.____	-71
6.	Decreased educational performance.....6.____	-72
7.	Impaired school attendance.....7.____	-73
8.	Making final arrangements.....8.____	-74
9.	Specific suicidal threat/warning or statement.....9.____	-75

Key Punch Start here ↓

10.	Morbid preoccupations.....10.____	(115)
11.	Irritable/aggressive behavior.....11.____	(116)
12.	Risky Behavior.....12.____	(117)
13.	Substance Abuse.....13.____	(118)
14.	Eating Habits/Weight loss or gain.....14.____	(119)
15.	Sleeping Problems.....15.____	(120)
16.	Health Problems.....16.____	(121)
17.	**Special Experiences (Precipitating Events).....17.____**	(122)
18.	**General family problems.....18.____**	(123)
19.	**Attempted/Completed Suicide of Family Members/Peers.19.____**	(124)
20.	**Psychiatric history.....20.____**	(125)
21.	**Previous Suicide Attempt.....21.____**	(126)
22.	**Miscellaneous.....22.____**	(127)

Student Post-program

I.D. # 209

Write Your Name Here_____

Tear off this sheet and hand it to the Monitor.

Student Questionnaire

Before completing the questionnaire, please give us the following information.

Your age_____

Your sex: Male_____ Female_____

Your ethnicity: White_____ Black_____ Hispanic_____ Asian_____
Amer. Indian____ Other_____

For questions #1-4, please circle the number representing how you felt about the suicide awareness program.

1. Was the suicide awareness program interesting? — Very Interesting 1 2 3 4 5 Average — Very Boring

2. Did you learn anything new? — Learned A lot 1 2 3 4 5 Learned Nothing

3. Was the information presented clearly? — Very Clear 1 2 3 4 5 Very Unclear

4. Do you think that the information will help you? — Help A Lot 1 2 3 4 5 Never Help

5. Do you think other high school students in your area should participate in the same program? (Please circle your answer).....5. **Yes No**

If no, why not? (You may check more than one answer)

- 5a. The program was boring.....5a.____
- 5b. Suicide should not be talked about in school...5b.____
- 5c. The program was too confusing or disorganized..5c.____
- 5d. The program was not long enough.....5d.____
- 5e. Talking about suicide upsets some people too much.....5e.____
- 5f. Other_____

1 209

Case# (01-03)

I.D.# (04-07)

Form (08)

(09) (10)

(11) (12)

6. Did you ask any questions or make comments during the suicide awareness program?.....6. **Yes No**

If no, why not? (You may check more than one answer)

- 6a. Not enough time.....6a.____
- 6b. Nothing to ask/say.....6b.____
- 6c. Presenter/Leader did not ask for questions or comments.....6c.____
- 6d. Other_____

7. Did you miss any of the suicide awareness classes? .....7. **Yes No**

- 7a. **If yes**, how many?.....7a._____

If yes, why? (Please check any that apply)

- 7b. Other things to do.....7b.____
- 7c. Too upset by the program.....7c.____
- 7d. Program was too boring.....7d.____
- 7e. You were absent.....7e.____
- 7f. Other_____

Please check your answers on the space provided. You may check more than one answer.

8. When you feel very upset, sad, or unable to cope, do you...?

- 8a. Talk to someone in your family.....8a.____
- 8b. Talk to an adult.....8b.____
- 8c. Talk to a friend.....8c.____
- 8d. Exercise or play sports.....8d.____
- 8e. Listen to music, read, or watch TV.....8e.____
- 8f. Go out with friends to a movie or elsewhere.....8f.____
- 8g. Take drugs or drink alcohol.....8g.____
- 8h. Never felt that way.....8h.____
- 8i. Other_____

9. If you have a bad emotional or personal problem, do you talk it over with a ...?

- 9a. Teacher.....9a.____
- 9b. High School Counsellor.....9b.____
- 9c. Mental Health Professional (Psychologist, Social Worker, Psychiatrist).....9c.____
- 9d. Family Doctor.....9d.____
- 9e. Nurse.....9e.____
- 9f. Minister, Priest, Rabbi.....9f.____
- 9g. Friend.....9g.____
- 9h. Parent.....9h.____
- 9i. Brother or Sister.....9i.____
- 9j. Other family member.....9j.____
- 9k. Other adult.....9k.____
- 9l. No one.....9l.____

Do you agree or disagree with the following statements?
(Please circle your answer)

Yes = Agree
No = Disagree

10. Mental health professionals (Psychologist, Counsellor, Social Worker, Psychiatrist) are good at helping people cope with personal problems .....10. **Yes** **No**

11. Only people who are "crazy" go to see a mental health professional.....11. **Yes** **No**

12. Mental health professionals can "read your mind" and find out all your secrets.....12. **Yes** **No**

13. Mental health professionals only break a secret when they feel it is a matter of life or death.....13. **Yes** **No**

14. I would be willing to go to a mental health professional if I were having personal problems....14. **Yes** **No** **Maybe**

15. My parents would let me go to see a mental health professional.....15. **Yes** **No** **Maybe**

16. Who would you talk to <u>in your school</u> if you were having emotional problems? (You can check more than one answer)

16a. Teacher.....16a.____
16b. Counselor, Psychologist.....16b.____
16c. Nurse.....16c.____
16d. Coach.....16d.____
16e. Other School Staff (Secretaries, Bus Drivers, Cafeteria staff, etc.).....16e.____
16f. Principal or Vice Principal.....16f.____
16g. No one.....16g.____

16h. Other_____

17. Do you know of any place <u>other than school</u> where you could talk to a <u>mental health professional</u> about personal problems that were troubling you?.....17.**Yes** **No**

18. If you needed to contact a mental health professional <u>outside of school</u> how would you find out where to go or who to call? (Please check the first thing you would do.)

18a. Ask your parent.....18a.____
18b. Ask another family member.....18b.____
18c. Ask a teacher, counselor or other adult at school...18c.____
18d. Ask a friend.....18d.____
18e. Look in the Phone book or call "Information".....18e.____
18f. Ask a doctor.....18f.____
18g. Call a hotline or emergency number.....18g.____

19. Have you ever called a hotline or telephone crisis/counseling service?.....19. **Yes** **No**

<u>If yes.</u> Which one?_____

20. What should you do if a friend tells you he/she is thinking about killing himself/herself? (You can check more than one answer)

20a. Tell my friend to call a hotline or mental health center.....20a.____ (81)
20b. Talk to an adult about my friend.....20b.____ (82)
20c. Talk to my friend without getting anyone else's help.....20c.____ (83)
20d. Get advice from another friend.....20d.____ (84)
20e. I wouldn't take it seriously.....20e.____ (85)
20f. I would keep it a secret.....20f.____ (86)

20g. Other_____ (87)

21. Which of the following do you think may be <u>warning signs</u> for suicide? (You may check more than one answer)

a. Recent break up with a boy/girl friend.....a. ____ (88)
b. Using drugs a lot.....b. ____ (89)
c. Not caring about the future.....c. ____ (90)
d. Acting very crazy.....d. ____ (91)
e. Has tried to kill himself/herself before.....e. ____ (92)
f. Very bad family problems.....f. ____ (93)
g. Collecting guns.....g. ____ (94)
h. Always being tired or sleeping too much.....h. ____ (95)
i. Being sad or depressed.....i. ____ (96)
j. Talking a lot about people who have died.....j. ____ (97)
k. Losing a lot of weight.....k. ____ (98)
l. Doing very badly in school.....l. ____ (99)
m. Not caring about how they look.....m. ____ (100)
n. Keeping to himself/herself most of the time.....n. ____ (101)
o. Being absent from school a lot.....o. ____ (102)
p. Getting into a lot of trouble .....p. ____ (103)
q. Worrying too much about doing things perfectly.....q. ____ (104)
r. Joking about killing himself/herself.....r. ____ (105)
s. Having trouble talking to other people.....s. ____ (106)
t. Always blaming other people for problems.....t. ____ (107)

u. Saying he/she wants to kill himself/herself.....u. ____

v. Losing his/her temper a lot.....v. ____

w. Not enjoying anything.....w. ____

x. Drinking too much.....x. ____

y. Not getting along with mother or father.....y. ____

z. Being sick all the time.....z. ____

22. Do you know anyone who has killed himself/herself?...22. **Yes** **No**

23. Do you know anyone who has <u>tried</u> to kill himself/herself?.....23. **Yes** **No**

24. Has any one ever told you they were thinking about killing themselves?.....24. **Yes** **No**

<u>If yes</u>, what did you do? (You can check more than one answer)

24a. Told my friend to call a hotline or mental health center.....24a. ____
24b. Talked to an adult about my friend.....24b. ____
24c. Talked to my friend without getting anyone else's help.....24c. ____
24d. Got advice from another friend.....24d. ____
24e. I didn't take it seriously.....24e. ____
24f. I kept it a secret.....24f. ____

24g. Other_____

25. Does talking about suicide in class... (Circle your answer)

25a. make it o.k. to talk about suicide?.....25a. **Yes** **No**

25b. make some kids more likely to try to kill themselves?.....25b. **Yes** **No**

25c. make it easier for some kids to ask for help?...25c. **Yes** **No**

25d. make it easier for some kids to spot signs of suicide in other people?.....25d. **Yes** **No**

25e. stop some kids from trying to kill themselves?..25e. **Yes** **No**

Do you think the following statements are **TRUE (T)** or **FALSE (F)**? **(Circle your answer)**

26. Most kids who kill themselves are normal but they have had a lot of bad things happen to them.....26. **T** **F**

27. People should not discuss very personal problems with strangers.....27. **T** **F**

28. People who talk about suicide do <u>not</u> commit suicide...28. **T** **F**

29. People should be able to handle their own problems without outside help.....29. **T** **F**

30. Suicide should be talked about in the classroom.....30. **T** **F**

31. Almost all kids who kill themselves are mentally ill..31. **T** **F**

32. Drugs and alcohol are a good way to help someone stop feeling depressed.....32. **T** **F**

33. The main thing that adolescents have to do is to become more independent.....33. **T** **F**

34. It would be unusual for a teenager to never get depressed.....34. **T** **F**

35. If you are depressed, it is a good idea to keep these feelings to yourself.....35. **T** **F**

36. Drugs and alcohol can cause depression to become so bad it can lead people to try to hurt or kill themselves.....36. **T** **F**

37. People who do risky things, like always driving very fast, may be trying to hurt or kill themselves, and could use some help.....37. **T** **F**

Complete the following sentences and write the number of your answer in the space provided.

38. For people who have a lot of problems in their lives, I think suicide is.....38. ____

1. Never a solution to problems
2. A possible solution to problems
3. A good solution to problems
4. The only solution to problems

39. If I felt like I wanted to kill myself, I would.....39. ____

1. Tell someone how I felt
2. Maybe tell someone how I felt
3. Not tell anyone how I felt

40. In the past month, have you sometimes thought that you had nothing to look forward to in the future, or that your family would be better off without you?.....40. **Yes** **No**

41. Have you ever thought about killing yourself?.....41. ____

1. Never
2. Once or twice
3. Occasionally (A few times a year)
4. Frequently (At least once a month)
5. All the time (Almost every day)

42. Have you ever tried to kill yourself?.....42. ____

1. No
2. Once
3. More than once

If you have ever thought about killing yourself or you have tried, what helped you to stop feeling that way?
(You may check more than one answer)

42a. Talking to someone.....42a. ____
42b. Staying by yourself.....42b. ____
42c. Going out with friends.....42c. ____
42d. Taking drugs or drinking alcohol .....42d. ____
42e. I haven't stopped feeling that way.....42e. ____

42f. Other_____

43. Did you answer a questionnaire like this one about a month ago?.....43. **Yes** **No**

If yes, were you personally contacted by anyone after filling out that questionnaire?.....43b. **Yes** **No**

If yes, how did you feel about that?
(You may check more than one answer)

43b. I was pleased.....43c. ____
43c. I felt it was unnecessary.....43d. ____
43d. I was embarrassed.....43e. ____
43e. I was angry.....43f. ____

43f. Other_____

If you have been thinking about killing yourself and would like someone to help you with your problems, please write your name on the line and someone trained to help will contact you privately.

_____

Educators

1

Pre-program Evaluation Questionnaire

Case # ____ (01 - 03)
I.D. # ____ (04 - 07)
Form ____ (08)

Name or last 4 digits of Social Security #_____

Date ___/___/___ (09-14) School_____

1. Please record your job category.....1.____ (15)

1. Teacher
2. Guidance Counselor
3. Nurse
4. Psychologist
5. Administrator
6. Parent/PTA Representative
7. Other School Staff

8. Other_____

2. Have you ever participated in a suicide awareness or suicide prevention program before? 2. Y N (16)

3. Was your personal participation in this suicide awareness program 3.____ (17)
1. optional, or
2. required as part of your duties?

3a. If required, were you pleased to participate? 3a. Y N (18)

If you were not pleased to participate, why not?
3b. Time constraints or prior commitments..... 3b. Y N (19)
3c. Opposed to the program.....3c. Y N (20)

3d. Other_____ (21)

4. Do you think suicidal behavior is a major problem in your school? 4. Y N DK (22)

5. How would you rate your attitude towards the suicide awareness program? 5.____ (23)
1. Totally favorable
2. Mostly favorable with some specific concerns or reservations
3. Significant concerns about the program, but not entirely negative
4. Totally opposed to the implementation of the program in your school
5. Other_____ (24)

6. What, if any, are your reservations or concerns about having the suicide awareness program in your school? Total # listed:

_____

_____

_____

_____

7. Please list all the "warning signs" or symptoms which could indicate that an adolescent may be suicidal. Total # listed:

1. _____ (32)
2. _____ (33)
3. _____ (34)
4. _____ (35)
5. _____ (36)
6. _____ (37)
7. _____ (38)
8. _____ (39)
9. _____ (40)
10. _____ (41)

8. In the past, if you have identified a student who may be at risk for suicidal behavior, or if a student has identified himself/herself to you as such, have you

8. Had a confidential talk with the student and not taken it any further.....8. Y N

8a. Suggested to the student that they see someone specially trained to handle such problems (Guidance staff, Child Study Team member, etc.)..8a. Y N

8b. Discussed the problem with a Guidance person or Child Study Team member and left it with them....8b. Y N

8c. Suggested to the student that they see a mental health professional outside the school.....8c. Y N

8d. Suggested to the student that they see a non-mental health professional (e.g., Clergy, Police, Community person) outside the school.....8d. Y N

8e. Discusssed the problem with the student's parents.8e.Y N

8f. Consulted another member of the faculty to discuss the students behavior.....8f. Y N

8g. Other_____ 8g. Y N

8h. The problem has never arisen.....8h. Y N

(25) (26) (27) (28) (29)

9. If a student confided in you that he/she was thinking about suicide, but asked you not to tell anyone, what would you do? (See choices below).....9._____ (51)

1. Break the confidence immediately and tell someone
2. Respect the confidence (for at least a few days) while trying to convince the student to tell someone else
3. Respect the confidence for as long as the student asks

4. Other_____ (52)

(30) (31)

10. Do you feel that any of the following are appropriate responsibilities for you?

10. Identifying students at risk for suicidal behavior and recommending to them that they seek special help..10.Y N (53)

10a. Telling a Counselor or Child Study Team Member about a student who may be at risk for suicidal behavior...10a.Y N (54)

10b. Talking to students directly about their suicidal thoughts or intentions.....10b.Y N (55)

10c. Contacting a mental health professional (outside your school) about a student who may be at risk for suicidal behavior.....10c.Y N (56)

10d. Contacting the parents of a potentially suicidal student.....10d.Y N (57)

(42)

11. Please rate you level of concern about each of the following issues regarding identifying and/or referring a student for special help.

(43) (44) (45) (46) (47) (48) (49) (50)

0= Not Concerned
1= Slightly Concerned
2= Significantly Concerned
3= Extremely Concerned

11. Student may be wrongly labeled or identified.11. 0 1 2 3 (58)
11a. Student will not receive adequate help.....11a. 0 1 2 3 (59)
11b. It may involve you in some legal responsibility.....11b. 0 1 2 3 (60)
11c. Other_____ (62) 11c. 0 1 2 3 (61)

12. Do you know your school's policy or procedures regarding response to a student's suicide threat or attempt?.....12. Y N (63)

12a. If yes, have you used this policy 12a. Y N DK (64)

12b. If yes, is this a written policy? 12b. Y N DK (65)

12c. If no, does your school have any such policy? 12c. Y N DK (66)

13. In the last 12 months, approximately how many students have you identified as at risk for suicidal behavior? 13._____

14. Are there any professionals <u>within</u> your school with whom you can discuss difficult student problems and/or ask for consultation? 14. Y N

15. Are there any professionals <u>outside</u> your school with whom you can discuss difficult student problems and/or ask for consultation? 15. Y N

16. If yes to either #15 or #16 above, do you prefer to consult someone within or outside your school? (Circle preference please) 16.1. Within 2. Outside

17. How satisfied are you with the administrative and peer support you have within your school in terms of consultation and/or supervision on difficult student problems? 17._____
    1. Very unsatisfied
    2. Mildly unsatisfied
    3. Satisfied
    4. Very Satisfied

18. To your knowledge, have any students with whom you've come into personal contact attempted suicide in the last 12 months? 18. Y N DK

    17a. <u>If yes,</u> how many?.....18a._____

19. Are you aware of any off-site services where you could refer a troubled student? 19. Y N

    <u>If yes</u>, please list the name of the agency or center.

    1._____

    2._____

    3._____

THANK YOU VERY MUCH FOR COMPLETING THIS FORM

Educators

Post-program Evaluation Questionnaire

Case # ___ (01 - 03)
I.D. # ____ (04 - 07)
Form _____ (08)

Name or last 4 digits of Social Security #_____
(Please use the same I.D. as you used on the pre-program form)

Date __/__/__ (09-14) School_____

1. Please record your job category.....1._____ (15)
    1. Teacher
    2. Guidance Counselor
    3. Nurse
    4. Psychologist
    5. Administrator
    6. Parent/PTA Representative
    7. Other School Staff

    8. Other_____

2. How would you now rate your overall response to the suicide awareness program?.....2._____ (16)
    1. Totally favorable
    2. Mostly favorable with some specific concerns or reservations
    3. Significant concerns about the program, but not entirely negative
    4. Totally unfavorable
    5. Other_____ (17)

3. Would you recommend that other schools in your area receive the same suicide awareness training program? 3. Y N (18)

    <u>If no</u>, why not?
    1. Program is not relevant to the student population in this area.....3a.Y N (19)
    2. Program was poorly presented.....3b.Y N (20)
    3. Topic of youth suicide raises too much anxiety....3c.Y N (21)
    4. Topic is too important or too complex to be adequately covered during a 2-3 hour meeting.....3d.Y N (22)
    5. Other health/mental health issues are more serious problems and should be addressed before suicide...3e.Y N (23)

    6. Other_____ (24)

4. Was the information presented clearly? Very Clear 1 2 3 4 Very Unclear 5 (25)

5. Was the information new to you, (ie., did you learn something?) Learned a Lot 1 2 3 4 Learned Nothing 5 (26)

6. Were the purpose and goals of the program clear to you? Very Clear 1 2 3 4 Very Unclear 5 (27)

7. Do you feel that the information presented will be useful to you? Very Useful 1 2 3 4 Not at All 5

8. Did you ask any questions or make comments during the suicide awareness program?.....8. Y N

If no, why not?
1. Not enough time.....8a. Y N
2. Nothing to ask/say.....8b. Y N
3. Did not feel qualified.....8c. Y N
4. Presenter/Leader did not encourage questions or comments.....8d. Y N

5. Other_____

9. The following criticisms have been raised about youth suicide prevention programs. Please rate your level of concern about each.

0= No concern
1= Slight concern
2= Significant concern

9. A discussion of suicide in the classroom may give students ideas or break down established taboos against suicide.....9. 0 1 2

9a. A discussion of emotional/psychological issues such as suicide detracts from the main pursuit of education and is not an appropriate classroom activity.....9a. 0 1 2

9b. The school is not prepared to deal with the onslaught of problems a discussion of suicide may bring about.....9b. 0 1 2

9c. The programs may be a waste of money and time since there is a lack of evidence to suggest that these programs actually do prevent suicide.....9c. 0 1 2

9d. Other_____ 9d. 0 1 2

10. Please list all the "warning signs" or symptoms which could indicate that an adolescent may be suicidal. Total # listed:

1._____ (42)
2._____ (43)
3._____ (44)
4._____ (45)
5._____ (46)
6._____ (47)
7._____ (48)
8._____ (49)
9._____ (50)
10._____ (51)

11. If a student confided in you that he/she was thinking about suicide, but asked you not to tell anyone, what would you do? (See choices below).....11._____ (52)

1. Break the confidence immediately and tell someone
2. Respect the confidence (for at least a few days) while trying to convince the student to tell someone else
3. Respect the confidence for as long as the student asks
4. Other_____ (53)

12. Do you feel that any of the following are appropriate responsibilities for you?

12. Identifying students at risk for suicidal behavior and recommending to them that they seek special help.12.Y N (54)

12a. Telling a Counselor or Child Study Team Member about a student who may be at risk for suicidal behavior..12a.Y N (55)

12b. Talking to students directly about their suicidal thoughts or intentions.....12b.Y N (56)

12c. Contacting a mental health professional (outside your school) about a student who may be at risk for suicidal behavior.....12c.Y N (57)

12d. Contacting the parents of a potentially suicidal student.....12d.Y N (58)

13. Please rate your level of concern about each of the following issues regarding identifying and/or referring a student for special help.

0= Not Concerned
1= Slightly Concerned
2= Significantly Concerned
3= Extremely Concerned

13. Student may be wrongly labeled or identified. 13.0 1 2 3 (59)
13a. Student will not receive adequate help.....13a.0 1 2 3 (60)
13b. It may involve you in some legal responsibility.....13b.0 1 2 3 (61)

13c. Other_____13c.0 1 2 3 (62)

14. Do you know your school's policy or procedures regarding response to a student's suicide threat or attempt?.....14. Y N (63)

14a. If yes, have you used this policy? 14a. Y N DK (64)
14b. If yes, is this a written policy? 14b. Y N DK (65)
14c. If no, does your school have any such policy? 14c. Y N DK (66)

15. Since the suicide awareness presentation, have you identified any students as potentially at risk for suicidal behavior? 15. Y N (67)

15a. If yes, how many?.....15a._____ (68)

16. Since the suicide awareness presentation, have you referred any students to the Guidance Counseling Office for special help or counseling.....16. Y N

16a. If yes, how many?.....16a._____

17. Since the suicide awareness presentation, have you referred any students to other mental health services of any kind?.....17. Y N

17a. If yes, how many?.....17a._____

17b. If yes, where did you refer them?

1._____

2._____

18. Are there any professionals within your school (Counselors, Psychologists) with whom you can discuss difficult student problems and/or ask for consultation? 18. Y N

19. Are there any professionals outside your school with whom you can discuss difficult student problems and/or ask for consultation? 19. Y N

20. If yes to both #18 and #19 above, do you prefer to consult someone within or outside your school? (Circle preference please) 20.1. Within 2. Outside

21. How satisfied are you with the administrative and peer support you have within your school in terms of consultation and/or supervision on difficult student problems? 21._____
   1. Very unsatisfied
   2. Mildly unsatisfied
   3. Satisfied
   4. Very Satisfied

22. Are you aware of any off-site services where you could refer a troubled student?.....22. Y N

22a. If yes, please list the name of the agency or center.

1._____

2._____

3._____

23. If you are a parent (if not, please answer hypothetically), would you want your child (at high school age) to participate in a suicide awareness program similar to that which you participated in?.....23a. Y N

Parent

1

Case# ___ ___ ___ (01-03)
I.D.# ___ ___ ___ (04-06)
Form ___ (07)

Pre-program Evaluation Questionnaire

Please write the last 4 digits of your Social Security Number_____

---

1. Have you ever participated in a suicide awareness/ prevention program before? (Circle your answer).....1. **Yes** **No** ___ (08)

2. How do you feel about attending this program? (Check the answer which best describes your feelings)

   a. I look forward to attending this program.....2a._____ ___ (09)

   b. I feel it's my duty as a parent, but I have some concerns about the program.....2b._____

   c. I have no opinion .....2c._____

   d. Other_____

3. Did you have to miss work or other duties to attend this program?.....3. **Yes** **No** ___ (10)

4. Do you think suicidal behavior is a major problem among adolescents in your community?.....4. **Yes** **No** ___ (11)

5. How would you rate your attitude toward having a suicide awareness program presented to your child's class?

   1. I am very much in favor of my child participating
   2. I think it's a good idea, but I want to know more about it
   3. I am a little worried about the program
   4. I am not in favor of my child participating in the program
   5. Other _____

   (Please write the number of your answer on the space).... 5._____ ___ (12)

6. What, if any, are your concerns about having the suicide awareness program in your child's school? ___ (13)

_____ ___ (14)

_____ ___ (15)

_____ ___ (16)

7. Please list all the "warning signs" or symptoms which could indicate that an adolescent may be suicidal.

1. _____ (19)
2. _____ (20)
3. _____ (21)
4. _____ (22)
5. _____ (23)
6. _____ (24)
7. _____ (25)
8. _____ (26)
9. _____ (27)
10. _____ (28)

8. Have you ever known a teenager who may be at risk for suicidal behavior?.....8. **Yes** **No**

If yes, did you....?

8a. Talk privately with him/her and not take it any further.....8a. **Yes** **No**

8b. Suggest he/she see someone trained to handle such situations (Guidance Counselor, Psychologist, Clergy person, etc.).....8b. **Yes** **No**

8c. Discuss the situation with a Guidance Counselor at the teenager's school and leave it with them....8c. **Yes** **No**

8d. Discuss it with another adult (Parent, Relative, Spouse).....8d. **Yes** **No**

8e. Do nothing because you did not feel it was you responsibility.....8e. **Yes** **No**

8f. Do nothing because you did not know what to do.....8f. **Yes** **No**

8g. Other_____

9. If a teenager told you that he/she was thinking about suicide, but asked you not to tell anyone else, what would you do?

1. **Tell someone who could offer help**
2. Not tell anyone
3. Other_____

(Please write the number of your answer on the space)...9. _____

10. Please rate your level of concern about each of the following issues regarding identifying and/or referring a potentially suicidal teenager for special help.

0 = Not Concerned
1 = Slightly Concerned
2 = Significantly Concerned
3 = Extremely Concerned

10a. Teenager may get a bad reputation.....10a. 0 1 2 3
10b. Teenager will not receive adequate help.....10b. 0 1 2 3
10c. Paying attention to the student may encourage suicidal behavior.....10c. 0 1 2 3
10d. Other.....10d. 0 1 2 3

11. Do you know the policy or procedures of your child's school regarding response to a student's suicide threat or attempt?.....11. **Yes** **No**

12. How satisfied are you with the way potentially suicidal students are helped in your child's school?

1. Very satisfied
2. Mildly satisfied
3. Unsatisfied
4. Very Unsatisfied
5. Don't Know

(Please write the number of your answer on the space)..12._____

13. Do you know of any place where you could refer a troubled teenager?.....13. **Yes** **No**

If yes, please list the name of the agency or center.

1. _____
2. _____
3. _____

14. Do you agree with the following statements?

Yes = Agree
No = Disagree

14a. Mental health professionals (Psychologist, Counsellor, Psychiatrist) are good at helping people cope with personal problems.....14a. **Yes** **No**

14b. Only people who are "crazy" go to see a mental health professional.....14b. **Yes** **No**

14c. It costs more than it's worth to go to see a mental health professional.....14c. **Yes** **No**

14d. A mental health professional could help a teenager with his/her personal problems.....14d. **Yes** **No**

14e. I know what a mental health professional does....14e. **Yes** **No**

14f. I would let my child go to a mental health professional.....14f. **Yes** **No**

14g. Mental health professionals only break a secret if they feel it is a matter of life or death.....14g. **Yes** **No**

14h. It would be unusual for a teenager to never get depressed.....14h. **Yes** **No**

Do you agree with the following statements? Circle the number representing how you feel.

1 = Strongly Agree
2 = Agree
3 = Disagree
4 = Strongly Disagree

		Strongly Agree			Strongly Disagree
15.	When there is a suicide attempt or completion by a student, it is best to cover it up.....1	1	2	3	4
16.	Suicidal teens can be helped by any concerned person.....1	1	2	3	4
17.	I would have some concerns about my son/daughter being friends with another teenager who had attempted suicide.....1	1	2	3	4
18.	I'd feel comfortable discussing suicide with my son/daughter.....1	1	2	3	4
19.	Parents of a suicidal teenager are always to blame for their child's problems.....1	1	2	3	4
20.	A person who commits suicide is likely to be mentally ill.....1	1	2	3	4
21.	People should be able to handle their own problems without outside help.....1	1	2	3	4
22.	Suicide should be discussed in the classroom.....1	1	2	3	4
23.	People who talk about suicide do <u>not</u> commit suicide.....1	1	2	3	4

Parent

1

Case#__ __ __ (01-03)
I.D.#__ __ __ (04-06)
Form __ (07)

Post-program Evaluation Questionnaire

Please write the last 4 digits of your Social Security Number_____

---

1. How would you rate your overall response to the suicide awareness program?.....1. _____ (08)
   1. Totally favorable
   2. Mostly favorable with some specific concerns or reservations
   3. Significant concerns about the program, but not entirely negative
   4. Totally unfavorable
   5. Other_____ (09)

2. Would you recommend that other schools in your area receive the same suicide awareness training program? 2. **Yes** **No** (10)

   <u>If no</u>, why not?
   1. Program is not relevant to the student population in this area.....2a. **Yes** **No** (11)
   2. Program was poorly presented.....2b. **Yes** **No** (12)
   3. Topic of youth suicide raises too much anxiety..2c. **Yes** **No** (13)
   4. Topic is too important or too complex to be adequately covered during a 2-3 hour meeting....2d. **Yes** **No** (14)
   5. Other health/mental health issues are more serious problems and should be addressed instead.....2e. **Yes** **No** (15)
   6. Other_____ (16)

		Very Clear			Very Unclear	
3.	Was the information presented clearly?	1	2	3	4	5 (17)
4.	Was the information new to you?	Learned A Lot 1	2	3	4	Learned Nothing 5 (18)
5.	Were the purposes and goals of the program clear to you?	Very Clear 1	2	3	4	Very Unclear 5 (19)
6.	Do you feel that the information will be useful to you?	Very Useful 1	2	3	4	Not At All 5 (20)

. Do you agree or disagree with the following statements about youth suicide awareness programs in high schools?

Yes = Agree
No = Disagree

7a. The programs are very important because they teach students to recognize warning signs of suicide among their peers.....7a. **Yes** **No**

7b. A discussion of suicide in the classroom may give students ideas or break down established taboos against suicide.....7b. **Yes** **No**

7c. The programs are very beneficial because they encourage students to seek help from an adult if they are worried about a friend.....7c. **Yes** **No**

7d. A discussion of emotional/psychological issues such as suicide detracts from the main pursuit of education and is not an appropriate classroom activity.....7d. **Yes** **No**

7e. Students should be encouraged to talk about suicide in school so that they may discuss their own suicidal thoughts or intentions more openly.....7e. **Yes** **No**

7f. The school is not prepared to deal with the onslaught of problems a discussion of suicide may bring about.....7f. **Yes** **No**

7g. The programs may be a waste of money and time since there is a lack of evidence to suggest that these programs actually do prevent suicide...7g. **Yes** **No**

8. Do you think suicidal behavior is a major problem among adolescents in your community?.....8. **Yes** **No**

9. How would you rate your attitude toward having a suicide awareness program presented to your child's class?

1. I am very much in favor of my child participating
2. I think it's a good idea, but I want to know more about it
3. I am a little worried about the program
4. I am not in favor of my child participating in the program
5. Other _____

(Please write the number of your answer on the space)....9._____

10. What, if any, are your concerns about having the suicide awareness program in your child's school?

_____

_____

1. Please list all the "warning signs" or symptoms which could indicate that an adolescent may be suicidal.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

2. Have you ever known a teenager who may be at risk for suicidal behavior?.....12. **Yes** **No**

If yes, did you....?

12a. Talk privately with him/her and not take it any further.....12a. **Yes** **No**

12b. Suggest he/she see someone trained to handle such situations (Guidance Counselor, Psychologist, Clergy person, etc.).....12b. **Yes** **No**

12c. Discuss the situation with a Guidance Counselor at the teenager's school and leave it with them..12c. **Yes** **No**

12d. Discuss it with another adult (Parent, Relative, Spouse).....12d. **Yes** **No**

12e. Do nothing because you did not feel it was you responsibility.....12e. **Yes** **No**

12f. Do nothing because you did not know what to do...12f. **Yes** **No**

12g. Other _____

3. If a teenager told you that he/she was thinking about suicide, but asked you not to tell anyone else, what would you do?

1. Tell someone who could offer help
2. Not tell anyone

3. Other _____

(Please write the number of your answer on the space)...13. _____

14. Please rate your level of concern about each of the following issues regarding identifying and/or referring a potentially suicidal teenager for special help.

0 = Not Concerned
1 = Slightly Concerned
2 = Significantly Concerned
3 = Extremely Concerned

14a. Teenager may get a bad reputation.....14a. 0 1 2 3
14b. Teenager will not receive adequate help.....14b. 0 1 2 3
14c. Paying attention to the student may encourage suicidal behavior.....14c. 0 1 2 3
14d. Other.....14d. 0 1 2 3

15. Do you know the policy or procedures of your child's school regarding response to a student's suicide threat or attempt?.....15. **Yes** **No**

16. How satisfied are you with the way potentially suicidal students are helped in your child's school?

1. Very satisfied
2. Mildly satisfied
3. Unsatisfied
4. Very Unsatisfied
5. Don't Know

(Please write the number of your answer on the space)..16.____

17. Do you know of any place where you could refer a troubled teenager?.....17. **Yes** **No**

If yes, please list the name of the agency or center.

1. _____
2. _____
3. _____

18. Do you agree with the following statements?

Yes = Agree
No = Disagree

18a. Mental health professionals (Psychologist, Counsellor, Psychiatrist) are good at helping people cope with personal problems.....18a. **Yes** **No**

18b. Only people who are "crazy" go to see a mental health professional.....18b. **Yes** **No**

18c. It costs more than it's worth to go to see a mental health professional.....18c. **Yes** **No**

A mental health professional could help a teenager with his/her personal problems.....18d. **Yes** **No**

. I know what a mental health professional does....18e. **Yes** **No**

. I would let my child go to a mental health professional.....18f. **Yes** **No**

. Mental health professionals only break a secret if they feel it is a matter of life or death.....18g. **Yes** **No**

. It would be unusual for a teenager to never get depressed.....18h. **Yes** **No**

agree with the following statements? Circle the number nting how you feel.

1 = Strongly Agree
2 = Agree
3 = Disagree
4 = Strongly Disagree

		Strongly Agree			Strongly Disagree
19.	When there is a suicide attempt or completion by a student, it is best to cover it up.....19.	1	2	3	4
20.	Suicidal teens can be helped by any concerned person.....20.	1	2	3	4
21.	I would have some concerns about my son/ daughter being friends with another teenager who had attempted suicide.....21.	1	2	3	4
22.	I'd feel comfortable discussing suicide with my son/daughter.....22.	1	2	3	4
23.	Parents of a suicidal teenager are always to blame for their child's problems.....23.	1	2	3	4
24.	A person who commits suicide is likely to be mentally ill.....24.	1	2	3	4
25.	People should be able to handle their own problems without outside help.....25.	1	2	3	4
26.	Suicide should be discussed in the classroom.....26.	1	2	3	4
27.	People who talk about suicide do not commit suicide.....27.	1	2	3	4

Appendix 3

TABLES NOT INCLUDED IN REPORT:

8. Do you know anyone who was helped a lot by the program?

	YES
%TOTAL STUDENTS	8%

11. Did you ask any questions or make comments during the suicide awareness program?

	YES
%TOTAL STUDENTS	49%

If no, why not?

	%resp
11a. Not enough time	7
11b. Nothing to ask/say	75
11c. Presenter/leader did not ask for questions	5
11d. Everything was covered	24

12. Did you miss any of the suicide awareness classes? 16

12a. If yes, how many? MEAN # MISSED = 1.6

If yes, why?

	%resp
12b. Other things to do	20
12c. Too upset by program	5
12d. Program too boring	16
12e. You were absent	61

13. When you feel very upset, sad, or unable to cope, do you...?

13a. Talk to someone in your family

	PRE	POST
CONTROL	38	35
EXPERIMENTAL	35	37

13b. Talk to an adult

	PRE	POST
CONTROL	14	13
EXPERIMENTAL	16	16

13c. Talk to a friend

	PRE	POST
CONTROL	59	59
EXPERIMENTAL	60	61

13d. Exercise or play sports

	PRE	POST
CONTROL	23	24
EXPERIMENTAL	25	33

13e. Listen to music, read, or watch TV

	PRE	POST
CONTROL	59	56
EXPERIMENTAL	61	68

13f. Go out with friends to a movie or elsewhere

	PRE	POST
CONTROL	22	22
EXPERIMENTAL	24	28

13g. Take drugs or dring alcohol

	PRE	POST
CONTROL	4	2
EXPERIMENTAL	4	5

13h. Never felt that way

	PRE	POST
CONTROL	3	4
EXPERIMENTAL	4	4

14. If you have a bad emotional or personal problem, do you talk it over with a ...?

14c. Mental Health Professional (Psychologist, Social Worker, Psychiatrist)

	PRE	POST
CONTROL	3	3
EXPERIMENTAL	4	4

14d. Family Doctor

	PRE	POST
CONTROL	3	2
EXPERIMENTAL	3	3

14e. Nurse

	PRE	POST
CONTROL	1	1
EXPERIMENTAL	2	2

14f. Minister, Priest, Rabbi

	PRE	POST
CONTROL	2	3
EXPERIMENTAL	3	4

14i. Brother or sister

	PRE	POST
CONTROL	34	29
EXPERIMENTAL	31	32

14j. Other family member

	PRE	POST
CONTROL	19	19
EXPERIMENTAL	21	24

14l. No one

	PRE	POST
CONTROL	20	21
EXPERIMENTAL	22	21

16. Only people who are crazy" go to see a mental health professional.

	PRE	POST
CONTROL	12	11
EXPERIMENTAL	11	9

20. My parents would let me go to see a Mental Health Professional.

	YES		MAYBE		NO	
	PRE	POST	PRE	POST	PRE	POST
CONTROL	40	37	44	46	16	17
EXPERIMENTAL	35	38	50	50	15	12

21. Who would you talk to in your school if you were having emotional problems?

21d. Coach

	PRE	POST
CONTROL	11	12
EXPERIMENTAL	14	16

21e. Other School staff (Secretaries, Bus Drivers, Cafeteria Staff, etc.)

	PRE	POST
CONTROL	2	3
EXPERIMENTAL	3	4

21f. Principal or Vice Principal

	PRE	POST
CONTROL	10	7
EXPERIMENTAL	8	7

21g. No one

	PRE	POST
CONTROL	42	46
EXPERIMENTAL	42	43

23. If you needed to contact a Mental Health Professional outside of school how would you find out where to go or who to call?

23b. Ask another family member

	PRE	POST
CONTROL	8	10
EXPERIMENTAL	10	11

23d. Ask a friend

	PRE	POST
CONTROL	20	20
EXPERIMENTAL	20	24

23e. Look in the Phone book or call "information"

	PRE	POST
CONTROL	43	47
EXPERIMENTAL	49	53

23f. Ask a doctor

	PRE	POST
CONTROL	14	14
EXPERIMENTAL	15	14

24. Have you ever called a hotline or telephone crisis/counseling service?

	PRE	POST
CONTROL	5	4
EXPERIMENTAL	4	4

25. What should you do if a friend tells you he/she is thinking about killing himself/herself?

25d. Get advice from another friend

	PRE	POST
CONTROL	17	22
EXPERIMENTAL	21	29

27. Do you know anyone who has killed himself/herself?

	PRE	POST
CONTROL	26	29
EXPERIMENTAL	27	30

28. Do you know anyone who has tried to kill himself/herself?

	PRE	POST
CONTROL	50	54
EXPERIMENTAL	48	50

29. Has anyone ever told you they were thinking about killing themselves?

	PRE	POST
CONTROL	39	40
EXPERIMENTAL	38	37

If yes, what did you do?

29a. Told my friend to call a hotline or mental health center

	PRE	POST
CONTROL	18	21
EXPERIMENTAL	16	16

29b. Talked to an adult about my friend

	PRE	POST
CONTROL	40	42
EXPERIMENTAL	41	37

29c. Talked to my friend without getting anyone else's help

	PRE	POST
CONTROL	40	55
EXPERIMENTAL	52	44

29d. Got advice from another friend

	PRE	POST
CONTROL	18	23
EXPERIMENTAL	21	25

29e. I didn't take it seriously

	PRE	POST
CONTROL	18	16
EXPERIMENTAL	19	19

29f. I kept it a secret

	PRE	POST
CONTROL	18	17
EXPERIMENTAL	22	22

30. Does talking about suicide in class...

30a. Make it o.k. to talk about suicide?

	PRE	POST
CONTROL	66	71
EXPERIMENTAL	76	74

30b. Make some kids more likely to try to kill themselves?

	PRE	POST
CONTROL	13	14
EXPERIMENTAL	11	14

30c Make it easier for some kids to ask for help?

	PRE	POST
CONTROL	92	89
EXPERIMENTAL	92	91

30d. Make it easier for some kids to spot signs of suicide in other people?

	PRE	POST
CONTROL	89	89
EXPERIMENTAL	92	91

30e. Stop some kids from trying to kill themselves?

	PRE	POST
CONTROL	87	84
EXPERIMENTAL	92	86

31. Most kids who kill themselves are normal but they have had a lot of bad things happen to them

	PRE	POST
CONTROL	87	85
EXPERIMENTAL	89	89

34. People should be able to handle their own problems without outside help

	PRE	POST
CONTROL	18	16
EXPERIMENTAL	14	16

35. Suicide should be talked about in the classroom

	PRE	POST
CONTROL	76	80
EXPERIMENTAL	80	79

38. The main thing that adolescents have to do is to become more independent

	PRE	POST
CONTROL	55	60
EXPERIMENTAL	58	58

39. It would be unusual for a teenager to never get depressed

	PRE	POST
CONTROL	63	64
EXPERIMENTAL	67	68

41. Drugs and alcohol can cause depression to become so bad it can lead people to try to hurt or kill themselves

	PRE	POST
CONTROL	92	92
EXPERIMENTAL	93	88

42. People who do risky things, like always driving very fast, may be trying to hurt or kill themselves, and could use some help

	PRE	POST
CONTROL	58	60
EXPERIMENTAL	66	73

47. If you have ever thought about killing youself or you have tried, what helped you to stop feeling that way?

47a. Talking to someone

	PRE	POST
CONTROL	30	27
EXPERIMENTAL	31	34

47b. Staying by yourself

	PRE	POST
CONTROL	12	12
EXPERIMENTAL	14	12

47c. Going out with friends

	PRE	POST
CONTROL	20	20
EXPERIMENTAL	18	23

47d. Taking drugs or drinking alcohol

	PRE	POST
CONTROL	3	2
EXPERIMENTAL	2	5

47e. I haven't stopped feeling that way

	PRE	POST
CONTROL	3	3
EXPERIMENTAL	3	3

48. Did you answer a questionnaire like this one about a month ago?

	POST
CONTROL	85
EXPERIMENTAL	83

48a. If yes, were you personally contacted by anyone after filling out that questionnaire?

	POST
CONTROL	4
EXPERIMENTAL	7

If yes, how did you feel about being contacted?

48b. I was pleased

	POST
CONTROL	3
EXPERIMENTAL	11

48c. I felt it was unnecessary

	POST
CONTROL	2
EXPERIMENTAL	6

48d. I was embarrassed

	POST
CONTROL	2
EXPERIMENTAL	3

48e. I was angry

	POST
CONTROL	2
EXPERIMENTAL	3

PARENTS

OUTCOME VARIABLES

Knowledge about:

- Warning Signs
- Strategies for helping an at-risk teen
- School and community treatment resources
- School policy regarding student's suicide attempt or threat

Attitude toward:

- The programs
- Mental health professionals and help seeking
- Child's participation in suicide awareness program

Behavior:

- Referrals to mental health resources

TEACHERS

OUTCOME VARIABLES

Knowledge about:

- Warning Signs
- Strategies for helping an at-risk teen
- School and community treatment resources
- School policy regarding student's suicide attempt or threat

Attitude toward:

- The programs
- Mental health professionals and help seeking
- Peer and administrative support regarding referrals and consultation.

Behavior:

- Referrals to mental health resources

STUDENTS

OUTCOME VARIABLES

Knowledge about:

- Warning Signs
- Strategies for helping an at-risk teen
- School and community treatment resources

Attitude toward:

- The programs
- Suicidal behavior as a coping strategy
- Mental health professionals and help seeking

Behavior:

- Self reported suicidal ideation
- Self reported suicide attempts
- Referrals to mental health resources
- Number of reported suicides under age 19
- Number of attempted suicides under age 19 presenting to local emergency rooms

TABLE 1

OUTCOME VARIABLES FOR ADOLESCENT

SUICIDE PREVENTION PROJECT

	Knowledge	Attitude	Behavior
Students	• Suicidal phenomena & consequences • Warning signs • What to do with at-risk teen • School & community resources	• Toward suicidal behavior • Toward help-seeking • Toward referring an at-risk teen • Toward curricula	• Self & peer referral of at-risk teen • Reduction of suicidal behavior
Faculty (Teachers & Administrators)	• All of above, plus - • School policies & procedures • Overview of curricula rationale, goals & content	• All of above, plus • Toward school policies • Toward talking with troubled teen	• Identification & referral of at-risk teens
Parents	• All of above	• All of above	• Above
MH Personnel	• All of above, plus • Agency policies & procedures	• Toward suicidal behavior • Toward working with suicide referrals • Toward school policies • Toward agency policies • Toward curricula	• Referrals received • Contacts (consultation, education, liaison) with schools

"If I were to die before tomorrow,
I wonder if there would be any sorrow.
Living in a world of misery and pain,
I wonder if I'm normal or insane.
My family won't talk
and my friends don't understand,
Even though they want to give a hand.
It's hard to explain the way I feel,
I can't figure out if this feeling is real."

—Given by a 16-year-old girl to her best friend two weeks before her suicide attempt.

Maureen Underwood, *ACSW, is coordinator of the New Jersey Adolescent Suicide Prevention Project.*

We may not want to believe that the teenagers sitting in our junior high and high school classrooms today are experiencing the kind of hopelessness and desperation described in this poem written by a 16-year-old sophomore, but many of them are. And, in increasingly large numbers, adolescents are acting out those feelings in the form of suicide completions or attempts.

In the last 20 years, the rate of adolescent death from suicide has increased almost 300 percent, making it the third leading cause of death in the 15-24 age bracket. Only accidents and homicides claim more teenage lives, and many deaths in these two categories may, in fact, be suicides in disguise. Estimates place the number of teens who take their lives 50 to 100 percent higher than the recorded statistic of 5,000 because of inaccurate reporting procedures and the societal stigma against labeling a death as suicide. More concern is raised about the estimated 500,000 teens who attempt suicide each year.

In New Jersey, the suicide rate for teenagers is lower than the national average. The most recent figures available from the State Center for Health Statistics show New Jersey reporting 9.4 suicides per 100,000 in the 15-24 year old age bracket, with national statistics at 12.2 per 100,000. Before we congratulate ourselves too loudly, though, we need to realize that this represents an increase from 7.5

A Matter of Life or Death

BY MAUREEN M. UNDERWOOD

per 100,000 in 1983 and that suicide's rank as the leading cause of death among New Jerseyans is highest in the 15-24 age bracket, where it is tied with homicide as the second leading cause of death. These figures come closer to home when we realize a reported 115 adolescents—at least two teenagers a week—died in 1984 by their own hand. The numbers have even more impact when we think of our own school district's experiences—the teens we know who have attempted or completed their own self-destruction.

There are a variety of theories offered to explain the dramatic increase in adolescent suicides. They range from increasing competition and pressure to succeed in a non-agrarian society to the lack of structure and support available in contemporary family systems. Most experts agree that the adolescent's lack of life experience and consequent limited problem-solving abilities contribute to the trapped helplessness that often leads to the feeling that there's no way out except suicide.

Current research seems to be confirming that white males continue to have the highest rate of suicide completion, and that about one-third of teenage suicides have made a previous suicide attempt. Drug and alcohol use and a history of impulsive, aggressive behavior also figure prominently with suicide victims, as does a family history of suicide completions or attempts. Girls attempt suicide more frequently than boys, but the methods they usually choose—drug ingestion or wrist slashing—generally leave time for rescue. Firearms is the method used most frequently by suicide completers of both sexes. Depression is common in attempters and completers but may be masked in boys by aggressive or troublesome behavior and in girls by promiscuity. There may be clues in school behavior; teachers have reported academic or disciplinary problems, truancy, and isolation or withdrawal in students who have later been identified as at-risk.

When asked, teens often talk pointedly about the problems they experience. They mention specific areas of concern, including parents, peers, drinking and drugs, and also discuss more generalized worries. As one 14-year-old girl explained : "Now I see all the new responsibilities I have. Sometimes I wish I could go back to a younger age when everything was simple and all problems were trivial and easily forgotten; I never worried about anything. But then I realized that wanting to be younger is immature and is no way to solve problems. It seems rather ridiculous to want to go back, but what direction should I go in? I wish I knew."

Some teenagers are even more specific. A 15-year-old boy stated: "...I have thought about committing suicide because at once everything came down on me—my schoolwork, the athletic teams, my friends and parents."

But despite what teens tell us, and what the experts theorize, the reasons for the increase in both completed suicides and attempts remain complex and unclear. What is clear, however, is the troublesome fact that an increasingly large number of teens seem to be choosing death.

For the last five or six years, various mental health agencies and school systems in New Jersey have been active in the development of programs for reaching teens who are potentially at-risk for suicide. A coordinated, state-wide approach, however, began in 1985 when legislation sponsored by Senator Richard Codey of Essex County was signed into law. The result was an innovative project that created a partnership between the State Department of Education and the State Department of Human Services for the design, implementation, and evaluation of school-based suicide awareness programs.

From the beginning, this was a unique approach. While a large percentage of currently existing suicide awareness programs are structured by having mental health practitioners present programs or actual curricula in the school setting, the importance of a partnership between the two systems has rarely been given more than passing acknowledgement. As the institution in which teenagers spend the largest percentage of their time, the significance of the school system in adolescent growth and development has never been denied, but the uniqueness of the school community as a system with a life and resources of its own often goes unrecognized by program planners from the mental health sector. The project's official demonstration of the key function of this partnership was in the composition of the Governor's Advisory Council, mandated by the legislation to oversee the project. Educators and mental health practitioners serve side by side, evaluating program material that will be presented in September 1987 to the governor and Legislature in the form of recommendations for statewide adolescent suicide awareness programming.

The objectives of the ASPP project are to increase awareness of the problem of adolescent suicide in school administrators, teachers, students and parents; to impart skills in the identification and referral of high risk teens by these same groups; and to ensure a coordinated, easily-used system for referral of identified teens to local mental

health resources.

The project clearly recognizes that the school is not in the position to counsel potentially suicidal youth, but agrees with the position taken by most educators that school personnel do have responsibilities in the following areas:

- to identify students who are at-risk;
- to link these students and/or their families with appropriate mental health agencies;
- to work cooperatively with mental health agencies to assist with students' therapy; and
- to help others in the school community deal with the intense emotional reactions evident after an attempted or completed suicide.

A mental health agency was selected in each of the three regions of the state to work cooperatively with two school districts to design and implement suicide awareness programs. The evaluation component, one of the key elements in project design, was consistent statewide, with researchers from Columbia University College of Physicians and Surgeons, who are doing other work in the area of adolescent suicide, coordinating the evaluation team.

There are several reasons why the evaluation was so critical. Despite the fact that the number of school-based youth suicide awareness programs is increasing and support for federal and local legislation to fund such programs appears strong, there is a lack of evaluative research investigating the effect of these types of programs for students. Evaluation is essential because the efficacy of these programs, in terms of cost effectiveness and outcome, cannot be assumed. There is a wide variety in the programs for students that have been implemented in schools, but there is no general agreement on whether one is more effective than another. This is another focus of the evaluation design.

There is agreement, however, from all practitioners in the field that the foundation of any school-based suicide awareness program must begin at the administrative level with the development of school policies and procedures for handling at-risk or suicidal students and for responding in the event of a suicide. These procedures are designed to help schools quickly mobilize a coordinated support system for students in crisis and to identify resources both within the school and the local community for responding to suicidal emergencies. The emphasis in procedures is on the liaison role of the school, clearly delineating the treatment responsibility to other community resources.

There are two reasons why the establishment of policies and/or procedures is a critical first step. They represent the school's concrete recognition of the special issues presented by suicidal or at-risk teens, and in some ways, an acknowledgement of the commitment of a school system to interventions for these students. Secondly, procedures serve as a reassurance to faculty that a mechanism exists for referral of students who may be identified as at-risk; the burden will not remain with the teacher, who tends to be already overloaded with a variety of other responsibilities. Clear delineation of a response hierarchy in a suicidal crisis can begin to address faculty concern about assuming yet another duty, and may encourage cooperation and support if other program elements are subsequently presented.

While some schools routinely have such procedures in place, it is more frequent to find that awareness of the numbers of at-risk students in a given school stops at the guidance office or nurse's door. Requests for specific procedures go as unheeded as do requests for faculty inservice training in the area of suicide awareness. "Suicide can't be a problem in our school," one guidance counselor

reported a school administrator as saying, discounting her reports of the numbers of attempters in her caseload alone. "It wasn't until we had an attempt in the locker room," she continued, "that he agreed to schedule an inservice for guidance staff. It took another year before a general faculty program was presented. Does a student have to die before we can talk about it in the classroom?"

Many schools unfortunately wait until a tragedy has occurred to recognize the helpfulness of specific procedures and programs for coping with the aftermath of suicide completions or attempts. Guidelines for the development of policies and procedures do exist, and their routine implementation enhances a school district's administrative capabilities for responding in an organized, helpful manner to both at-risk students and the general school community in the unfortunate event of a crisis. Any programming in the area of suicide awareness must start here.

A part of the suicide awareness project reviews with the students the aspects of being an adolescent—including all the problems and concerns inherent to this particular age group. After reviewing a movie narrated by a teen who attempted suicide (or a friend of an attemptor) students engage in a 'rap session' to air their feelings about what they have seen and heard. Finally, students take a test to gauge their emotional level in certain situations. Possible solutions are offered to help them cope when they feel helpless or alone.

Another essential program component is a general faculty inservice. All staff who come in contact with students, from bus drivers to cafeteria workers, as well as board members and administrators, should have the opportunity to receive information about suicidal teens, a description of the warning signs of suicide, clarification of school procedures, and identification of resources available locally for referral of at-risk teens and their families.

An effective faculty inservice acknowledges potential resistance to what may be perceived as the additional responsibility of identifying at-risk students by framing the role of the educator as someone who helps students to grow and think and to learn the basic skills necessary for adult living. By viewing suicide as the dramatic failure of these so-called life skills, the program ties suicide awareness into the established function of the educational community. Indeed, initial evaluation data from the New Jersey project supports the contention that faculty generally respond favorably to suicide awareness programs, and of the 307 educators who participated in the pilot program, 84 percent indicated they wished their own children could attend similar programs.

What do programs for students look like? While the format can range from special assembly to classroom curriculum and be taught by either mental health professionals or selected and trained faculty, the content is generally consistent. Two basic premises, which should underlie any programming in this area, are the recognition that adolescence is a difficult time and that suicide is the inappropriate choice some teens make to use death as a way to deal with life. Keeping adolescent developmental issues in mind, both the positive and negative impacts of peer pressure must also be recognized. The positive aspect, of course, is that peers are usually the first to know about a friend's troubles; but in a negative sense, peer culture may often apply pressure to keep this information a secret. For students, a shift must be made so that secret-keeping is viewed as a burden and telling someone as a responsible act that requires courage. As with the faculty, this "responsible act" does not include solving a friend's problem, but simply telling someone else who is in a better position to help. Not unsurprisingly, while teachers often feel identifying an at-risk student as burdensome, the initial response of students often is to not want to tell anyone but to keep the responsibility to themselves. The task is to persuade both groups that referral is in their best interests. This may be easier to do with teachers who appropriately welcome the opportunity to pass the buck than with teens who are sometimes caught up in omnipotent fantasies of rescue.

Another critical element in the construction of a student program is to confront the developmental movement of adolescents from dependence to independence and convince them that the paradox of independence means knowing when to ask for help. From our perspective as adults, we appreciate that shuttling back and forth between dependence and independence in order to gain strength is the optimal way to negotiate this developmental challenge, but a lot of stereotypes must be broken to convince urban males in particular that help-seeking behavior is an indication of strength.

Unfortunately, the typical school community also does not reinforce the concept that asking for help is acceptable. Schools encourage competition. Sharing, collaboration, collective problem-solving are often just synonyms for "cheating" in academic vocabulary. Students are frequently led to believe early on that there are only so many As to go around that helping a peer to do well may be at their own expense. Certainly knowing how to compete appropriately is a necessary life-skill, but knowing when and how to be independent is equally important. Making students aware of resources both within the school and local community is pointless if their resistance to using them is

not addressed.

Most programs for students incorporate these principles by using creative, interactive methods that capture a student's attention and capitalize on the adolescent's current life experiences. Their counterpart is a program for parents that acknowledges the challenges that parents of teenagers face today. The program also provides information about how to recognize when teens are in trouble, and outlines local resources. All four program components—administrative guidelines, faculty inservice, and student and parent workshops—form the basis for a complete school-based suicide awareness intervention.

And your role as school board members? The key element in any program design is your responsibility—the development and adoption of administrative policies and procedures that reflect the needs and resources of local districts. But, as in other areas of administrative concern, the creation of policy isn't enough.

When asked by the New Jersey Adolescent Suicide Prevention Project prior to a faculty inservice if they were aware of school policy and procedures for suicide management, only 29 percent of 426 educators responded affirmatively. Promulgation of policy with clear delineation of responsibilities and resources is essential to demonstrate board and administrative commitment in this sensitive area.

By actualizing the Legislature's commitment to the development of programs for at-risk teens, New Jersey has become a national forerunner in addressing the tragedy of adolescent suicide. Through a coordinated approach that recognizes the need for a partnership between mental health resources and school systems, the groundwork has been laid for a comprehensive state-wide approach to provide a range of services to teenagers who are having trouble coping with life. The beginning step is not at the state level, however. It begins in your district, in your schools, with the recognition that this isn't someone else's problem . . . there are at-risk teenagers in your school, too.

As adults, we often offer long-winded explanations to make a point; the simplicity of childhood seems lost as our vocabularies expand and our need to offer complicated justifications becomes greater. So what is the simple reason to consider programming in the area of suicide awareness? As one 15-year-old boy who participated in a school-based program succinctly put it: "It might save a life or two."

Resources

New Jersey Adolescent Suicide Awareness Program, New Jersey State Department of Human Services, Division of Mental Health and Hospitals

Adolescent Suicide Awareness Training Manual, New Jersey State Department of Education, published 1984, reprinted 1985, available from: Forms, Management & Distribution Services, New Jersey State Department of Education, 225 West State Street, CN 500 Trenton, NJ 08625

"Teenage Suicide Prevention in Schools," by Valerie L. Brown, Esq. In *Administrative Guide:* A Publication of the New Jersey Association of School Administrators, June 1986. Vol. 15, -12. □

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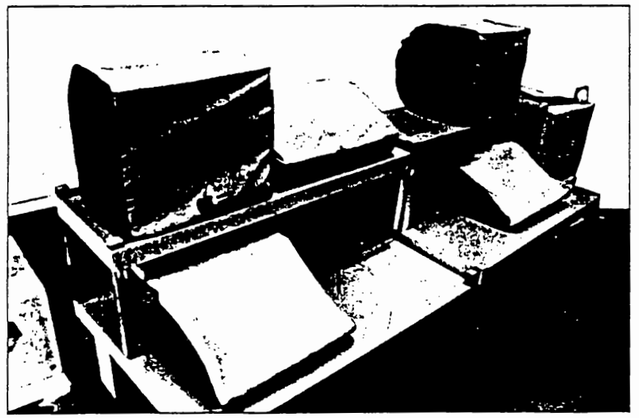

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A GANNETT NEWSPAPER SERVING SOUTH JERSEY — SUNDAY, JUNE 22, 1986

TEEN SUICIDE

Programs aim to reduce rising death rate among youth

By BERNIE WEISENFELD
Of the Courier-Post

WOODBURY — The statistics are clear. The number of adolescent suicides has tripled since 1960. More than 5,000 youths now take their lives annually in the United States.

But while the numbers are easy to discern, the solutions are not as clear cut.

So as high school students graduate and look to their futures this month, Sonia Klimoff is working to prevent teen-agers from foreclosing on their futures by suicide.

Klimoff is director of consultation and education for the Gloucester County Community Mental Health Center, where she heads development of a state-mandated pilot program for awareness and prevention of youth suicide, including a high school student curriculum and school staff training.

Meanwhile, some South Jersey school districts already have instituted their own plans to reverse the trend.

The one-year pilot project, funded by a $75,000 state grant, will be implemented starting next fall in four rural Gloucester County high schools to determine whether instruction should take regional differences into account, Klimoff said.

"It is the purpose of the state project to tailor these to fit the needs of urban and rural populations," she said.

Kingsway, Clearview, Southern Gloucester County (Delsea) and Gateway regional high schools will participate in the project.

On Tuesday, 90 health and physical education teachers from Delsea Regional will be the first to receive a six-hour training session on presenting the problem of suicide to students. The classwork was adapted from a course developed by St. Clare's Hospital, Morris County, Klimoff said.

Two other pilot projects focusing on urban areas have been funded in Bergen and Middlesex counties under state legislation approved in June 1985.

According to state Department of Health reports, suicide accounted for the deaths of 120 persons between the ages of five and 24 in New

Please see SCHOOL, Page 4A

WHAT PARENTS SHOULD LOOK FOR

- Verbal suicide threats.
- Previous suicide attempts.
- Personality changes (unusual withdrawal, aggression or moodiness).
- Depression (changes in normal appetite, sleep disturbances, sudden drop in school performance, etc.)
- Final arrangements (making a will), giving away prized possessions.

Schools enter pilot program to help despondent youths

Continued from Page 1A

Jersey in 1984, the most recent year for which figures are available.

Adolescents "are facing a lot of adult problems and feeling they do not have the experience," said Klimoff.

"Their future is not settled or determined: who are they going to be, how are they going to make a living who are they going to marry? It is a time of terrific stress."

"Also a lot of insecurities arise in the sense of what their physical image is and their relationships as they separate from their families."

"We do not know exactly what causes suicide," she added. "Speculations correlate with family breakdown."

Alcohol and drug abuse "is definitely a cause. . . . In the sense that substance abuse tends to reduce people's judgment and lower their inhibitions," she said.

"It is not just the withdrawn, depressed kid we have to worry about," Klimoff said. "A lot of times acting out/antisocial behavior — is covering an expression of despair.

"The high achievers are very vulnerable. Some of these kids go through life doing what everyone wants them to do and never feel any genuine sense of motivation in themselves."

Klimoff said Gloucester County was not chosen for the pilot program because of high suicide statistics — there were five such deaths reported in the 15-24 age group in 1984 — but because of its rural characteristics.

"But there is a desire on the part of the (county) schools to make sure there is not a problem," she added.

Mental health professionals also know that statistics in this field could underestimate the problem, she said.

"It is very hard to gather accurate statistics about the extent of adolescent self-destruction," Klimoff said.

"First of all, the way to certify a suicide is the degree of intentionality," Klimoff said. "The best way to determine intentionality is a note, and only about 25 to 30 percent of the people who kill themselves leave a note."

"There is also a hesitancy on the part of everybody — medical professionals and families — to say a death was a suicide because it creates a lot of stigmas."

"What you have to look at is the fact that for every completed death there are 10 attempts," she added.

"There are all kinds of issues, because when somebody attempts suicide, that is one of the risk factors," said Tim McFadden, one of two counseling psychologists working with Klimoff on the prevention project.

"The basic notion is suicide is a choice. It is a decision people make under severe stress as a means to escape that stress. It is an all too permanent solution to what is usually a very temporary problem."

The other center psychologist on the project is Ron Comer, who 10 years ago worked at one the nation's first suicide prevention centers in San Mateo, Calif.

"For all of it's beauty and resources, it had one of the highest suicide rates in the nation," Comer said. "Nothing was being done in the schools at that time. Only the newspapers were reporting the adolescent deaths."

PREVENTION TIPS

The following tips on suicide prevention come from the Community Mental Health Center for Gloucester County, Department of Consultation and Education.

What not to do

- Do not promise to keep a secret for a friend who feels suicidal. Keeping friends alive means more than keeping their secrets.
- Do not leave the person alone if you believe the risk for suicide is immediate.
- Do not act shocked at what the person tells you.
- Do not counsel the person yourself.
- Do not debate whether suicide is right or wrong. This may make the person feel more guilty.

What to do

- Believe or trust your suspicions that the person may be thinking about suicide or that he is self-destructive.
- Communicate your concern for the well-being of the person. Be a good listener.
- Be direct. Talk openly and freely and ask direct questions about the person's intentions. Try to determine if the person has a plan for suicide (how, where, when). The more detailed the plan, the greater the risk.
- Get professional help. Encourage the person to seek help from a school counselor, or other trusted adult who knows or will find out what to do. If the person resists seeking help, you should get professional help for them yourself.

In addition to giving teachers and students the risk factors or warning signs of suicide — such as changes in sleep and academic performance and giving away valued possessions — the prevention program will stress how to respond if the signs are found.

"We are putting a lot of emphasis on administrative procedures and making sure they are in place and known by everyone," Klimoff said. "So if a crisis should arise, they immediately know who to go to."

The 1½ hours of staff instruction will not be limited to teachers, Klimoff said. "We think everybody in the school having contact with kids should be included — people in security, maintenance and bus drivers. Often it turns out they are the people kids talk to."

The project will be evaluated by Columbia University researchers who have received several federal grants to study causes of teen suicide.

"You are really going into unknown territory developing a suicide prevention program," said Klimoff. "This is the first time a prevention program will be pretested and post-tested."

One school system that already has prevention procedures is Pennsauken, where the board of education adopted a suicide intervention policy in 1984, after a high school girl took her life with a shotgun.

Some 400 teachers and aides also were trained to recognize suicide warning signs last spring, "crisis counselors" have been assigned to the high and middle schools and one of several staff psychologists has developed a specialty in suicide prevention.

"We are satisfied wth our policy," guidance director Fred Keating said. "We've had situations since where people have had to act under that policy. Thus far, luckily, everything's worked out. We have a lot of ongoing cases but we haven't had any deaths or real serious attempts.

"We are not overly referring, but yet were still very afraid we will miss a child. There's a delicate balance.

"We look for multicharacteristics, where the student will give us two, three, maybe four, of the warning signs," said Keating.

"In the event of an actual attempt or a very serious concern we had one set of procedures and in the event of a suspected case where there's a conversation, drawings or anything that gives the counselor or teacher some indication that the child is thinking about such a thing but is not actually threatening or into the act we have another set of procedures.

"But both procedures begin with us making sure we notify the parent immediately in writing so we transfer to the parent the idea that we see a problem with your child and that it's something you had best look into, with us or without us, but look into it."

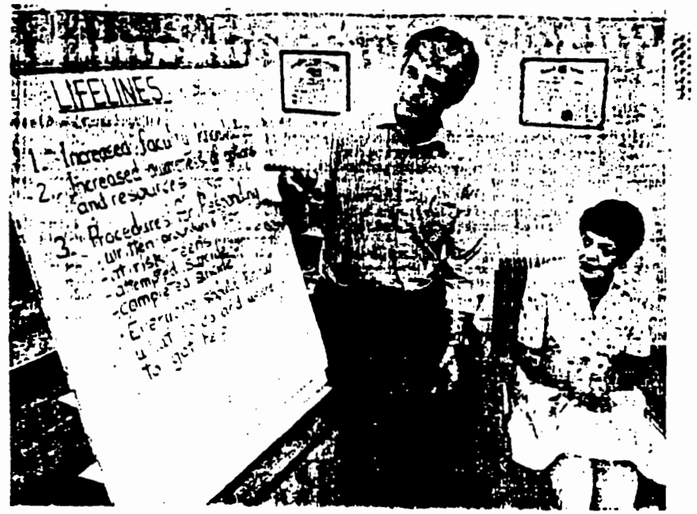
"There is some discussion of whether the curriculum should include more about suicide. I personally believe we should. Similar to drug an alcohol training, that teaching, and exploring the subject does not encourage it."

The Marlton district middle school has had no suicides but some attempts, and guidance counselors last year arranged suicide awareness sessions for teachers and sixth-through-eighth grade students.

"We handle it as a mental health education type of thing, to make the children and the teachers aware there are certain signs the children give off even if they're not directly talking about suicide," guidance director Kathy Bradley said.

"We have always had student, teacher and self-referral in this area. It's just that our main concern was for children to learn to be sensitive and pick up when somebody doesn't need to be teased or needs a shoulder," added middle school counselor Nancy O'Neal.

Said Bradley: "The children really have learned that even if someone tells them 'I don't want you to tell anyone,' that if a person is in danger it's all right to break that confidence."



Courier-Post photo by Al Schell

Lifelines
Sonia Klimoff, director of consultation and education for the Gloucester County Community Mental Health Center, goes over guidelines for the state-mandated pilot program against teen suicide with center psychologist, Ron Comer.

"In our opinion even if the child is just talking about it there's a problem," said counselor Eileen Brown.

"You don't just sit around saying I'm going to kill myself if there isn't some hurt underneath. Even if it's an attention-getting thing, there is still a problem."

In Pemberton Township, suicide awareness was added two years ago to a program called PEER (Positive Educational Experiences in Relationships), in which high school students receive credit for helping troubled younger children.

The so-called student "facilitators" are instructed in listening skills and problem-solving.

Former science teacher John Hilkevich has directed PEER in the township's two high schools for eight years.

"During field work I would encounter students talking about suicide, how life was losing worth living," said Hilkevich.

"I made sure my students were aware of the signs that would lead to suicide. Their job was to make sure they knew how to refer that student to a professional," said Hilkevich.

"A lot of times students listen more closely to a person their age than an adult."

But school officials recently became concerned about district liability if

we made a mistake," Hilkevich said. The local school board in April moved to abolish PEER, reinstated it after protests and recently received a county school superintendent's recommendation that the guidance department take over the program.

Hilkevich said he expects to be reassigned from full-time peer counseling director to a science teaching position. "It is not an easy transition to make," he said.

Teachers learn to save lives

When a 14 year-old Jersey City girl broke-up with her boyfriend, and told her parents and teachers that her life was over without him, it appeared to be nothing more than a simple case of a broken heart.

But when she tried to kill herself by swallowing a handful of barbiturates, they knew there was nothing simple about her intentions.

The girl was among some 2 million teens who tried to commit suicide in the U.S. last year. Current statistics reveal that each week over 100 youths, from various religions, ethnic and cultural backgrounds, try to take their own lives. Some come from broken homes, are victims of child abuse, or suffer from drug problems. No matter what the cause, they all share the same self-destructive goal of ending their problems by ending their lives.

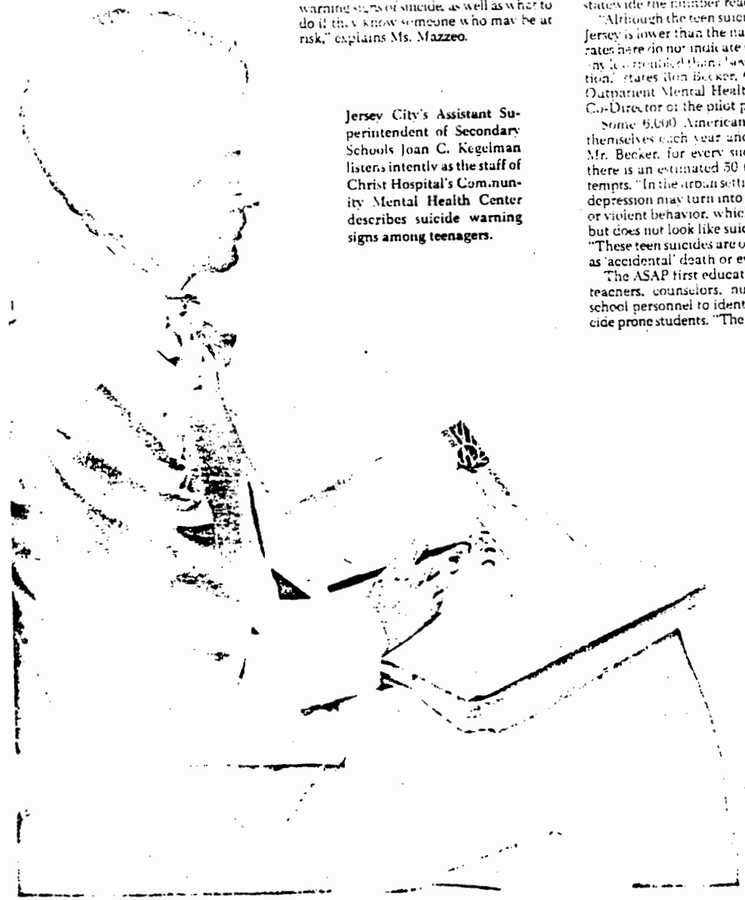
In the attempt to prevent the rise of teen suicides in New Jersey, Governor Thomas H. Kean recently approved a $300,000 State Appropriation for the formation of three Adolescent Suicide Prevention Programs. The grant was awarded to three mental health centers, in the northern, central and southern regions of the state, and also for the development of a State Youth Suicide Prevention Council.

Jersey City was selected as the urban site in the northern region. The Christ Hospital Community Mental Health Center, in collaboration with South Bergen Mental Health Center, received $80,000 in grant money to pilot programs in Ferris High School and Academic High School. Over the past five years South Bergen has developed and implemented their Adolescent Suicide Awareness Project (ASAP) for schools in many Bergen County communities. This pilot project will allow the ASAP to be tested in an urban school setting in order to identify any program modifications or adaptations.

The training workshops and seminars approach the sensitive issue in a straightforward manner with the facts about teen suicide, and the places to go for help. "For some time there has been a 'taboo' surrounding the discussion of suicide with kids," states Diane Ryerson, Coordinator of the South Bergen Mental Health Center's Consultation and Education Services, and Director of ASAP. "We're not going to place any thoughts of suicide in kids heads. We want to help them to open up and understand that there are alternatives to suicide, and that help is available," adds Ryerson.

"We're not going to place any thoughts of suicide in kids' heads. We want to help them to open up and understand that there are alternatives to suicide. . . ."

"The key to an effective program is to reach the people in a teenagers' life who can help the most and really make a difference," says Roseann Mazzeo, Director of the Christ Hospital Community Mental Health Center. "That's why the ASAP is aimed at educating teachers, students and parents about the causes and warning signs of suicide, as well as what to do if they know someone who may be at risk," explains Ms. Mazzeo.



Jersey City's Assistant Superintendent of Secondary Schools Joan C. Kegelman listens intently as the staff of Christ Hospital's Community Mental Health Center describes suicide warning signs among teenagers.

Nationally, the suicide rate for people ages 15 to 24 has tripled in the last 25 years. Suicide is now the second leading cause of death for that age group, nationally and in New Jersey. In 1984, the last year in which state Health Department statistics were available, Hudson County reported nine suicides, ages 15 to 24, while statewide the number reached 115.

"Although the teen suicide rate in New Jersey is lower than the national average, rates here do not indicate that youths are any less troubled than teachers in the nation," states Jon Becker, Coordinator of Outpatient Mental Health Services and Co-Director of the pilot project.

Some 5,000 American teenagers kill themselves each year and, according to Mr. Becker, for every successful suicide there is an estimated 50 to 100 more attempts. "In the urban setting a youngster's depression may turn into self-destructive or violent behavior, which leads to death but does not look like suicide," he added. "These teen suicides are often mislabeled as 'accidental' death or even homicide."

The ASAP first educates and instructs teachers, counselors, nurses and other school personnel to identify possible suicide prone students. "The typical warning signs include any severe change in behavior such as constant fighting, withdrawal from normal activities, depression or violent outbursts," explains Irma Rodriguez, Coordinator of Emergency Mental Health Services, and Co-Director of the pilot program.

"I encourage school officials to ask questions that could help to open up the child and begin them talking, such as, what's going on at home, or where do you spend your time after school. I also stress that it's alright to ask these social questions and to *always* take students seriously when they express *any* suicidal tendencies," she added.

A major focus of the pilot program is to help develop networks of referral between the schools and the mental health centers, and within each school which can be used whenever a student needs help. "School personnel need to know whom to go to if they believe a student is at risk," explains Roseann Mazzeo.

Parents and students receive similar instruction from mental health professionals on warning signs and the proper action to take. According to Ms. Rodriguez, some of the problems that lead to suicide are drug and alcohol abuse by the student or parent, child abuse, academic stress and family problems such as divorce, financial troubles, or emotional issues.

"Close to 50% of the teen suicide cases I've worked on have been related to some form of family problem," says Rodriguez. Parents *must* keep an open line of communication with their children, allowing all concerns and problems to surface. This prevents any problems, unkown to the parents, from building within the youth, with the impression that there is no solution," she adds.

In the fall, the program will be presented to 10th grade students at Academic High School and Ferris High School. "Classmates and friends of potential suicide victims can be the first to receive the warning signs," explains the Christ Hospital Social Worker. "Suicidal students send out messages that indicate they're troubled and considering taking their life. They may start giving away their prize possessions such as favorite records or articles of clothing. Kids also make very obvious statements such as, you won't have me to push around anymore, or what's the difference, I won't be here anyway," says Rodriguez.

According to Rodriguez, the social pressure placed on youths to grow up quicker and handle adult problems is a direct link to the rise in teen suicide across the state and country. "Not all of these kids can cope with the demands placed on them by society, family or peers," she explains.

Rodriguez encourages young people to befriend any student they suspect might be at risk, since teens will often confide in another teen rather than open up to an adult or school teacher. "I stress the importance of listening to their problems, discussing suicide openly, telling an adult, and not keeping the secret," she adds.

With some 7,600 high school students in the Jersey City school system, school officials are pleased to see the program getting underway here in Hudson County.

"We've been aware of the rise in teen suicides across the country for some time now," says Joan Kegelman, Assistant Superintendent of Secondary Schools, Jersey City. "Up until now, we would contact Christ Hospital for help on a case by case basis. But the Adolescent Suicide Awareness Program will give us an organized system that acts before the attempt is made, and will hopefully save lives," she stressed.

The pilot programs will be evaluated by researchers from Columbia University and the findings will be used by the Adolescent Suicide Prevention Council to recommend a model prevention program for schools statewide. ✠

After 4 suicides in town, right

Bergenfield leaders urge communities to prepare for emotional disaster

By JULIA DOLAN
Associated Press Writer

BERGENFIELD, N.J. — In the six months since four teenagers made a suicide pact and died in an exhaust-filled car, community leaders in this middle-class suburb say they have learned two lessons.

First, that they will never know why the four made the pact or if the tragedy could have been prevented.

And second, that just as communities prepare for physical disasters, so must they prepare for emotional ones.

It was on March 11 that Thomas Olton, 19, Thomas Rizzo, 18, and sisters Cheryl and Lisa Burress, ages 17 and 16, were found dead of carbon monoxide poisoning in Olton's idling car in a locked garage.

To explore emotions

In the days that followed, students and parents alike gathered to explore their emotions.

Counseling was offered at the high school the day the bodies were found. And more discussions took place the next night, when parents and students gathered to talk with mental health workers about the tragedy. Police set up a 24-hour hot line.

"It was a seat-of-the-pants operation," said Borough Administrator Louis Goetting 4. "In retrospect, we did a lot of things right. We also made some mistakes."

Now, members of the borough's Community Response Team, formed the day after the deaths, hope to share their experiences in a lecture tour, beginning Oct. 7 at Fairleigh Dickinson University in Rutherford, N.J.

Learned lessons

"We've lived through a traumatic time and learned lessons that we feel are valuable for others to be exposed to," said Goetting, a member of the team.

Initially, police and volunteers handled the hot line. Mental health professionals now staff the telephones, which still are at police headquarters.

When autopsies showed the four teenagers had used cocaine before they died and that the two young men had also been drinking, a counselor specializing in substance abuse was hired for students in grades seven through 12. Another psychologist has been added to the school's guidance staff, Goetting said.

A peer counseling program, for students who won't seek help from adults, begins in the schools this month, said Superintendent John Habeeb, another member of the response team.

Dropouts need help, too, the team concluded. Three of those who died had quit school and Lisa Burress had been suspended.

The team hired two counselors who have tracked down at least 40 former students. With the counselors' assistance, several are working toward high school equivalency diplomas; others have enrolled in federal job training programs; three are in vocational schools and two plan to start college in January.

'How tough it is'

"A lot of these kids just need someone to talk to," said counselor Maria Riske, who is 24. "They've found out how tough it is to be out in the world ... and they just don't know where to turn."

Said her 34-year-old partner, Jerry Cannito, "People thought we'd have doors slammed in our faces. But nobody shut the door on us."

The counselors were helped by 19-year-old Debbie Clark, who volunteered in June to be their link to the group of mostly unemployed dropouts who hang around in town, congregating most nights at a convenience store.

"I've seen a lot of the streets and drugs and all that," Clark said.

Getting word out

It was Clark who put the word out that counselors were looking for a teen-age boy living for several weeks on the streets.

When she finally caught up with him, she recalled, "I told him there are alternatives to what he was doing."

The boy eventually returned home and has sought counseling.

A $100,000 state grant covered the costs of the hot line, extra school personnel, counselors and other services inaugurated after the suicides, but it has been exhausted now. Goetting said all the programs will continue and be paid for out of the borough's coffers.

Action postponed

Proposed programs, such as workshops for teachers on how to handle crises in the schools, have been postponed pending more state or federal grants, he added.

In the months after the suicides, legislation was introduced in Congress to establish and fund suicide programs, but none has been acted upon.

The tragedies were not the first for Bergenfield.

Four other Bergenfield youths died in the year before the suicide pact. Two of those deaths were ruled alcohol-related accidents, another was deemed accidental and the fourth a suicide.

Many in Bergenfield believe all the deaths were suicides and that if something had been done sooner, Olton, Rizzo and the Burress sisters might not have died. Four days before they killed themselves, Olton told an ambulance crew that he had slit his wrists in a suicide attempt.

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