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# COMMENTARY

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## School-Based Suicide Prevention: Research Advances and Practice Implications

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The problem of adolescent suicide has vexed and perplexed social scientists for more than a century. Meeting in his living room in 1910, Sigmund Freud chaired a discussion among a distinguished panel of interdisciplinary scholars from the Vienna Psychoanalytic Society in an attempt to understand and propose solutions to an observed and alarming increase in suicides among young students (Friedman, 1967; Berman, Jobes, & Silverman, 2006). In the United States, rates of youth suicide dramatically increased between the mid-1950s and the mid-1990s, and since have declined by about a third. We have dozens of hypotheses to explain temporal shifts in the epidemiology of youth suicide, but little in the way of evidence-based findings to inform evidence-based prevention programs that would allow us to gain some degree of control over these phenomena.

This said, the science of suicidology has grown considerably over the last half century. The mere extent of research attention, no less the relative sophistication of recent efforts to better understand, control, and predict youth suicides, offers greater insight and information than ever before and presents significant hope

for the future. This special issue of *School Psychology Review* serves to further these goals by focusing our attention on five important papers intended and designed to help us better accomplish this work.

Why should we be focused on the prevention of suicide and suicidal behaviors among students in our schools when it might be, and has been, reasonably argued that the youth at greatest risk are those who are least likely to still be in school. Indeed, adolescents with risk for dropping out or being expelled (Randell, Eggert, & Pike, 2001), youth in juvenile detention facilities (cf. <http://www.chdi.org/publications.php?category=juvenile-justice>), runaway and homeless youth (U.S. Public Health Service, 2001), and those already placed in alternative schools (cf. <http://opi.mt.gov/pdf/yrbs/Altreport.pdf>) have greater risk for suicide than those in mainstream schools.

The reason we do is framed by the adage “get them where they are at.” Guided by Rose’s theorem (1992), which states that “a large number of people at small risk may give rise to more cases of disease than a small number who are at high risk,” school suicide

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prevention programs attempt, in general, to reach the greatest number of adolescents, hoping to detect the smaller number most at risk and then to identify and refer them for intervention (assessment and possible treatment) before they become acutely suicidal.

Moreover, a recent survey of members of the National Association of School Psychologists conducted by the American Association of Suicidology (American Association of Suicidology, 2008) found that 86% of school psychologists reported that they had counseled a student who had threatened or attempted suicide, 35% reported that a student in their school had died by suicide (and nearly one-half of these had more than one), and that almost two-thirds (62%) reported that they knew a student at their school who had made a nonfatal attempt.

Thus, the need for greater understanding of and a developed knowledge competency regarding adolescent suicide and school suicide prevention is well defined by the prevalence of suicidal behavior among even ostensibly well-functioning youngsters in mainstream schools. The need is further cemented by another finding reported by the American Association of Suicidology. Of those school psychologists surveyed, only 22% believed their graduate training had sufficiently prepared them to adequately intervene with suicidal youth or to contribute to school post-intervention activities were there to be a death of a student by suicide.

David Miller and Tanya Eckert's (2009) introduction to this special series makes brief mention of yet another reason why this effort is so important for school psychologists (i.e., they have an ethical and legal obligation to make reasonable and prudent efforts to prevent youth suicide where possible). Let me expand on this. Simply put, the courts have established that schools have a duty to prevent suicide; thus their agents, school psychologists, may be held responsible by the court should they not act to prevent a *foreseeable* suicide. Foreseeability is not synonymous with predictability. Rather, foreseeability refers to a reasonable assessment of a student's risk for potential harm. Ironically, that a stu-

dent's death was foreseeable is opined retrospectively by an expert in a legal proceeding (i.e., a breach in the duty to prevent suicide may be determined by expert opinion in legal cases brought before the court where there was sufficient evidence [observations, knowledge, statements, and so on] that a student, now dead by suicide or injured by a nonfatal attempt, would/should/could have been known by the average mental health professional to have risk for those actions that resulted in that death or injury). Thus, for example, a school psychologist may be sued for a failure to notify parents regarding their child's suicidal communications, or a failure to intervene in a case in which a student had communicated a suicidal plan, or a failure to follow established school policies and procedures regarding such suicidal communications. At the heart of this occupational risk, school psychologists may be charged with failing to have the requisite knowledge and skill, expected of a reasonable and prudent psychologist, to recognize and intervene with a youth at risk; hence, the singular importance of this special series.

Miller and Eckert (2009) introduce this series with a comprehensive overview of youth suicidal behavior, offering, to start, a wide-angle view of the scope of the problem and a well-framed picture of its demographics. They present data from the 2007 Youth Risk Behavior Surveillance Survey, which has surveyed between 13,000 and 16,000 high school youth every 2 years since 1991 regarding self-reported suicide ideation and attempts. The reader should note that in 2007 approximately 1 in 14 of these students stated that they had made a suicide attempt in the prior 12 months—about 2 students in the average U.S. high school homeroom. When asked whether that attempt required medical intervention, about 1 in 3 of these students said it had. This finding raises some question as to how the student interpreted the first question and whether there is some confounding in their reading of that question—that is, might they be answering yes when they were referring to a nonsuicidal self-injury behavior or an attempt, but one of very low lethality and intent? Moreover, when we look at those states where

there are data available regarding hospital emergency department admissions for suicide attempts, the Youth Risk Behavior Surveillance Survey data establishing prevalence for attempts requiring “medical intervention” is, on average, 32 times greater than those attempts being seen at the emergency department. Thus, we need to read these self-report data with some caution as to their validity.

Some youth suicide demographics speak loudly about the need for greater preventive attention. For example, noted gender differences (males die by suicide five times as often as females yet make one-third the nonfatal attempts) suggest that males are more lethal in their choice of method (and, perhaps, their intent) and that females engage in lower lethality behaviors and/or have less intent to die. But these data also convey the recognized problem that males are far less likely than females to seek or receive help when suicidal. It is imperative that we find ways to move troubled, suicidal males toward seeking and receiving help if we are ever to significantly shift male behavior toward less lethal outcomes. Similarly, the observed greater prevalence of suicide in our more rural states raises significant questions regarding the accessibility of help-giving services and personnel. With greater distance between a youth at risk and a resource for assessment and treatment (both because of geographic distance and because there are far fewer mental health professionals in these more rural states), the less likely it is that youth at risk will receive needed interventions. Here it may be imperative that school psychologists map their communities or counties with appropriately trained mental health practitioners and facilities that can adequately respond to triaged and referred students.

Miller and Eckert (2009) also offer us a succinct review of chronic and acute risk factors, noting among the latter those that were recently devised by a consensus of experts as evidence based for suicide within 12 months (Rudd et al., 2006/2008). These warning signs have been captured by the acronym *IS PATH WARM?* (see <http://www.suicidology.org>) for easy recognition and memorization; but, as the

authors note, they have not been independently validated for youth, as they are derived from studies across the life span. The need to conduct that validation study is imperative.

These authors lastly review common myths, current controversies, and research gaps. These discussions are significant to our understanding of youth suicide, notably in highlighting how much we have yet to learn and resolve. We cannot afford, however, to wait for resolutions. Youth who are more marginal in their attachments, who have been bullied or otherwise abused, who harbor deep secrets of guilt and shame, and who otherwise struggle with acute psychiatric symptoms need to be recognized and helped. This introductory article commands us to put our ears to the school grounds and our eyes on every student to better recognize and respond to their needs and problems.

Miller, Eckert, and Mazza (2009) honor us with a second comprehensive overview, this one of school suicide prevention programs framed by a public health perspective. The Suicide Prevention Resource Center (<http://www.sprc.org>) lists 11 promising or effective prevention programs, as defined by reasonable and well-conducted evaluation studies. Miller et al. appropriately highlight that few of these apply specifically to youth—thus their review of youth prevention programs leads to the undesirable conclusion that, to date, we have little evidence for programs that work.

It is notable that the great majority of these prevention efforts are universal programs, the weakest overall in their evaluated effectiveness. Most universal prevention programs tend toward curricula presentations of minimal dosage—some with as little as 1 hr of contact time. Education, for example, may improve knowledge and understanding, of the problem and its warning signs. Unto itself, however, education has no defined association with prevention, the latter requiring an attempt to produce behavior change (e.g., to increase help-seeking, referral-making, and so on). Much of what is available in the name of universal prevention programs has “feel-good” qualities and allows schools to make known that they are doing something; but, as

the authors infer, doing something without paying attention to whether that “something” has some demonstrable connection to accomplishing desired outcomes regarding suicide and suicidal behaviors (“Does this program work?”) makes little sense, especially when there are precious few resources available in most school systems to support such prevention efforts. Where there are programs with evaluated merit (e.g., the work being done by Randell, Eggert, and Pike, 2001, at the University of Washington), school psychologists must attend to the broader world of psychological journals where studies of these programs are published to be better informed of programs that should be more broadly implemented. How many of us never venture to the world of other journals?

The reader should recognize, and these authors appropriately call our attention to the fact, that the majority of public health models for youth suicide prevention are still intimately linked to the world of mental health, defined as they are by attempts to better recognize and refer youth at risk. Education programs that focus on gatekeeper training to observe and refer a student at risk, screening programs that attempt to assess depression and other acute psychiatric symptoms, and so on, are early detection models. Thus, as noted earlier, school psychologists further must recognize the need to attend better to identifying quality resources in the community to which identified youth at risk may be referred, if detected. It makes little sense to identify youth at risk and then to send them for assessment and treatment to an inadequately trained (in understanding and treating those who are suicidal) clinical professional.

School-based screening programs, although costly and relatively unacceptable to school administrators, have some promise in effectiveness. Peter Gutierrez and Augustine Osman (2009) studied a mix of psychometric issues using two widely used and well-validated self-report measures of depression and of suicide ideation. As depression is a significant chronic risk factor for suicide and suicide ideation is a significant acute risk factor for suicide, a combination of these scales offers

some hope for identifying at least a sizable subgroup of vulnerable youth. This combination offers schools one potential way to effectively screen students at risk of suicide. Both scales were found to clearly differentiate a sample of high school students from age-equivalent samples of suicide ideators and attempters. The depression scale, however, had less utility in differentiating groups, as the psychiatric sample used in this study was not particularly defined by diagnoses of depression. Not surprisingly, the measure of suicide ideation performed better as a screening instrument and, as the authors recommend, could be used as a sole screening measure where cost is a determining factor in building a screening program.

Frank Zenere and Phil Lazarus offer us a very promising example of a comprehensive, multitiered school suicide prevention strategy, one that might serve as a model for all schools who take seriously the public health of their student body. The Miami-Dade Youth Suicide Prevention and Intervention Program shares many characteristics with the evidence-based approach adopted by the U.S. Air Force (Knox, Liits, Talcott, Feig, & Caine, 2003). In common with the Air Force model, the Miami-Dade initiative is a population-oriented approach to reducing the risk of suicide built along multiple initiatives aimed at strengthening social support, promoting development of social skills, and changing norms to encourage effective school connectedness and continuity of care. Clearly, it has the support of the school system’s leadership.

This said, the jury remains deliberative regarding the program’s success based on the research data presented. Most important, no case-control study was built to allow a clear determination of intervention-caused changes in observed suicides and suicide attempts; no preintervention measure of suicide attempts was available to allow pre–post changes to be examined; no data were available or collected on student demographics or risk factors to disprove alternate explanations from potential ecological shifts, for example, temporal shifts during the years of program implementation toward greater numbers of less vulnerable

populations; and the overall number of observed cases of suicides was low. These limitations make interpretations of observable changes in suicidal outcomes open to challenge. Nevertheless, this model should be replicated. My bet is that a well-designed evaluation study would clearly demonstrate its effectiveness and allow this programmatic approach to become an evidence-based practice.

In the last article in this special series, Nickerson and Slater (2009) remind us that adolescent suicidal behavior is strongly associated with other forms of violence. Suicidal behaviors are indeed aggressive and hostile acts against the self and the body. It should not surprise us that they share common vulnerabilities and risk factors with other forms of aggression. As but one example, Kim and Leventhal (2008) recently reviewed 37 case-comparison studies of bullying and suicidal behavior from 16 countries and found increased odds for suicide ideation and suicide attempt among the victims, the perpetrators, and the victim-perpetrators of bullying. Moreover, there was increased risk for suicidal behavior among victims of bullying who were juvenile offenders, identified sexual minorities, and substance abusers.

Nickerson's study uses sophisticated methodology and her findings mirror those of Randall et al. (2001: see Miller et al., 2009) with potential school dropouts; Gray et al.'s (2002) finding of an association between youth suicide and contacts with the juvenile justice system; and the aforementioned higher rates of ideation and attempt among youth in alternative schools. The significance of these findings lies in their support for cross-prevention approaches (i.e., programs directed toward preventing school violence or substance use, for example, may also show beneficial outcomes in reduced suicidal behavior among teens). Moreover, these findings remind us to attend closely to known warning signs for suicide (Rudd et al., 2006), especially those common to multiproblem youth: a sense of purposelessness, hopelessness, impulsive aggression, and other forms of anger or rage.

School psychologists play a vital role in lowering the incidence of suicidal behavior among students and in responding to suicidal events and their effects. To accomplish that, school psychologists need to be educated with regard to risk factors and warning signs of suicidal behavior; how to formulate a risk assessment; effects of trauma on youth; differentiation between suicidal behavior and non-suicidal self-injury behavior; crisis assessment and intervention; intervention, triaging, and making referrals; legal issues and best practices regarding suicide prevention in the schools; evidence-based practices in suicide prevention; how to involve parents; how to reintegrate a student into the classroom after an attempt; suicide contagion and clusters; use of safety plans versus no-harm contracts; and how to effectively provide postintervention (after a suicide). The American Association of Suicidology has implemented a school suicide prevention accreditation program to accomplish this training (see <http://www.suicidology.org>) and school psychologists engaged in these efforts should avail themselves of this training opportunity to be better prepared to meet the challenges of preventing the next, if not the first, suicide in their schools.

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