Developing a Teen Suicide Prevention Program in the Schools

Mary Jane Anderson

Augusta State University

Mary Jane Anderson, Ph.D., LPC, NCC, is an Assistant Professor at Augusta State University in Augusta, GA. She was a school counselor in the Picayune School District for three years, and helped to develop the first suicide intervention and prevention program in the southern Mississippi area. Inquiries may be directed to her at 706-667-4497 or manders9@aug.edu.

Abstract

The problem of adolescent suicide worldwide is discussed. Teen suicide is the second leading cause of death among 15-19 year olds in the United Status, and has become an increasing concern for counselors employed in schools. Contributing factors to suicide, such as cultural and socio-demographic factors, dysfunctional family patterns, cognitive style and personality, psychiatric disorders, and current negative life events as triggers of suicidal behavior are reviewed. Marginalized populations are at higher risk of low self-worth and depression, both precursors to suicidal ideation. Most authorities agree that schools should develop a written plan of action for suicide intervention and prevention. The development of a Teen Suicide Prevention Program for a school district in rural Mississippi is reviewed. Steps including negotiation with administrators and policy development, providing faculty/staff in-service, preparation of crisis teams, parent education, classroom presentations, and follow-up are delineated and additional resources are provided.

Developing a Teen Suicide Prevention Program in the Schools

Teen suicide has caused increasing alarm in recent years for school counselors worldwide. According to the World Health Organization (2000), suicide is among the top five causes of death worldwide in the 15-19 year age group. In many countries, it ranks first or second as cause of mortality. In the United States, the teen suicide rate has tripled over the last thirty-five years, and it is considered the second leading cause of death among 15-19 year-olds (Jones, 2001).

In the U.S., there are over 5000 suicides completed annually by young men and women between the ages of 15-24. Suicide methods utilized by teens vary among countries. In some countries, for example, the use of pesticides is common, whereas in other countries, overdoses of medications and car exhaust, and the use of guns are more frequent. In the United States, girls attempt suicide twice as much as boys, but boys are more likely to die from their attempts, due to their use of more violent and lethal methods of committing suicide, such as hanging, firearms, and explosives. In other countries, however, suicide is more frequent in girls than boys in the 15-19-age range, and, in the past decade, girls' use of more violent methods has risen (World Health Organization, 2000).

Contributing Factors to Suicide

Risk factors identified by the World Health Organization (2000) vary from one continent and country to another, greatly depending on cultural, political, and economic features that vary even between neighboring countries. Some of these risk factors are described below.

Depression

Depression is the most significant factor related to adolescent suicide. Feelings of being down or blue are part of being a teenager, but when they are ignored or minimized, feelings of hopelessness, worthlessness, and serious depression can set in. Teens are often more sensitive when things go wrong, leading to strong feelings of anger, disappointment, and rejection. They must also contend with peer pressure, high expectations from teachers and parents, and their changing physiology. Recent studies have shown that as many as one in five teens may suffer from clinical depression (National Mental Health Association, 2004). Unfortunately, the result for many teens is suicidal thoughts, attempts, and too often, completions.

Substance Abuse

Substance abuse is another significant risk factor for teen suicide (Gilliland & James, 2001). Teens may often turn to alcohol and other drug use in an attempt to cope with overwhelming feelings and/or situations, which they do not understand. Such responses offer only temporary relief, further exacerbating the problems and deepening feelings of hopelessness and despair.

Cultural and socio-demographic factors

Low socioeconomic status, poor education, and unemployment are risk factors (World Health Organization, 2000). Isolated groups and those that are devalued by society such as immigrants, refugees, minority populations, or people with disabilities in the U.S. are at higher risk. Research indicates that gay, lesbian, and bisexual youth have as much as a 30% higher suicide rate than the average teen population, largely due to their sense of isolation, problems with self-esteem, rejection, depression, lack of

support, and other factors related to homophobia in our society (Bagley, Wood, & Young, 1994; Elia, 1994; Remafedi, Yarrow, & Deisher, 1991).

Dysfunctional family patterns

Children whose parents have a history of mental health issues, alcohol and substance abuse, use of violence, divorce or separation of parents, high family rigidity or permissiveness are at increased risk for suicide. Family members may have poor communication and problem-solving skills, as well as a general mistrust for helping systems. In these circumstances, families may not seek the help they need, which further compounds already-existing problems.

Cognitive style and personality

Some personality traits associated with suicide attempts and/or completions include unstable mood, anger, aggressiveness, anti-social or acting-out behaviors, and high impulsivity. Persons who display rigid thinking and coping patterns, poor problem-solving skills, an inability to grasp realities, and feelings of inferiority are also at increased risk for suicide attempts and/or completions.

Psychiatric disorders

Depression and alcohol and drug abuse have been mentioned as two major risk factors. Studies have also shown consistent correlations between anxiety disorders and suicide attempts (World Health Organization, 2000). Other psychiatric disorders which may lead to suicidal ideation are eating and psychotic disorders. The suicide risk for anorexic girls is 20 times that for young people in general (World Health Organization, 2000). Having a history of previous suicide attempts is also an important risk factor for suicidal behavior.

Current negative life events as triggers of suicidal behavior

Negative life events may include any situation in which a child is physically or emotionally injured or perceives a threat to self-image, family disturbances, separation from friends or girl/boyfriends, death of a loved one, termination of a love relationship, or interpersonal conflicts or losses. Legal or school problems, bullying and victimization, peer-pressure, high demand or expectations for self or from others, unwanted pregnancy or abortion, serious physical illness, or natural disasters can also have an impact on suicidal ideation.

Given the escalating suicide rates for adolescents in the last fifty years, and the increasing stresses of the 21st century world, it is imperative that schools address the problem of teen suicide in a strategic and systemic manner.

Teen Suicide Prevention – A Model

The U.S. Surgeon General's 1999 *Call to Action to Prevent Suicide* recommends, "Developing and implementing safe and effective programs in educational settings that address adolescent distress, provide crisis intervention, and incorporate peer support for seeking help" (p. 6)." Most authorities also agree that schools should develop a written plan of action for suicide prevention, crisis management, and postvention, (Capuzzi, 1994; Rittenmeyer, 1999) thereby developing comprehensive and systematic agendas to address the problem (Malley, Kush, & Bogo, 1994). Smaby, Peterson, Bergmann, Zenter-Bacig, & Swearingen (1990) emphasize that school counselors are in key positions to lead community efforts addressing teen suicide.

The author was employed as a licensed professional counselor in a rural school district in Mississippi from 1999-2002. When approximately 5% of the teen student

population reported suicide ideation and/or attempts during the 1999-2000 year, and two students in the district had previously completed suicide, school counselors and administrators decided it was time to take a more proactive stance on the issue of suicide prevention. The teen suicide prevention model described herein was the district's response to this problem. The rural school district consisted of approximately 4000 students, including five elementary schools, one junior high school, one high school, and one alternative school. Students in grade seven and grade nine, and students in all grades at the alternative school, were targeted for suicide prevention training the first year, with other grades to follow in successive years. The model was implemented during the 2001-2002 school year.

This article will outline the key processes and components of a comprehensive prevention program based upon research and the needs of the local school district and community. The suicide prevention model being described is adapted from the approach described by Capuzzi & Gross (2000) and Capuzzi (1994). It also includes variations of materials listed in Appendix B. The following components are essential aspects to the effective school-based prevention program.

Negotiating with Administrators and Policy Development

It is essential to have the full support of school management authorities before attempting to implement a suicide prevention program. Without such backing, any prevention efforts are doomed to failure (Capuzzi & Gross, 2000; Cultice, 1992). Concerned counselors and educators have initiated efforts, only to have them cancelled at the last minute, because no collaboration with those in positions of power was done ahead of time. Fortunately, in our district, the School Superintendent requested that

school counselors form a Suicide Prevention and Intervention Committee, which had the full backing of the School Board, the school district's governing body. This committee consisted of principals, counselors, social workers, and teachers in the secondary schools in which students were targeted for prevention education.

The first order of business of the Suicide Intervention and Prevention Committee was to develop a Suicide Intervention Policy for use throughout the school district. This policy basically outlined the school district's faculty and staff responsibilities in 1) knowing warning signs of suicidal behavior and 2) reporting students who display these signs, or students who disclose information about themselves or a suicidal friend, to the school counselor, social worker or building principals. Also included are the procedural steps that appropriate personnel (teachers, counselors, social workers, and/or administrators) will follow when faced with a student threatening suicide or after a suicide attempt. Adhering to consistent procedures in every case is not only vital to ensuring student safety, but is also the best insurance against legal difficulties should a parent decide to hold the school liable after a suicide completion (Remley, 1991).

Providing Faculty/Staff In-Service

Suicide is essentially a mental health problem, not an educational problem. However, a student's depression or confusion about life can have a detrimental impact on his or her learning and functioning at school. All faculty and staff are responsible for knowing the warning signs of suicide, knowing what the necessary procedures are, and following through with referral if a student discloses intent of self-harm.

Before any prevention training can be held with students, all school employees need to be trained with the same prevention information with which the students will be

educated. After students participate in educational presentations on the topic of adolescent suicide, they may identify depressive characteristics in themselves or their friends, and may disclose their feelings to a trusted adult, as they have been taught. Teachers, bus drivers, cafeteria workers, librarians, indeed, any school employee, may have relationships with students. Therefore, it is imperative that all faculty and staff know what to do if they are approached by a student in need of help. Capuzzi and Gross (2000) believe it is unethical not to prepare school faculty and staff in advance of the presentation on suicide prevention to the students in a school.

In-service trainings for every faculty and staff person in our district were completed by department (transportation, food service, maintenance) and at individual schools. A clearly established chain of command was developed so employees would know whom to contact in their department should a student show some of the warning signs or if a disclosure of suicidal ideation was made. For example, bus drivers would immediately contact the transportation director, who would contact the school's principal, who would contact the school counselor, who would interview the student.

Preparation of Crisis Teams

Before students are trained, Crisis Teams should be formed which include those members of the Suicide Intervention and Prevention Committee who will most actively participate in the student presentations. These teams should also include a combination of school counselors, social workers, parents, teachers, school nurses, school psychologists, school administrators, as well as other local mental health providers in the area. The purpose of these teams is twofold: 1) to educate counselors and mental health agencies in the local community about the suicide prevention program which will

be conducted with secondary students, and 2) to develop a Crisis Intervention Plan, in the event of a school shooting, suicide completion, natural disaster, or other emergency situation. Local practitioners are to be recruited to assist in providing crisis mental health services at the school in the event of such an emergency. Procedural steps and phone trees are developed.

Individual and Group Counseling Options

After students are taught the warning signs of suicide through a suicide prevention program, students may disclose that they know someone at-risk of self-harm, or to refer themselves for help. It is important to recognize that providing adolescents with an opportunity to ask questions and receive accurate information, and to learn about how to help themselves or others if they are feeling depressed does not in itself precipitate suicidal preoccupation or attempts (Capuzzi, 1988). Disclosures may occur because students have learned to recognize signs in themselves or their friends of which they were previously unaware. It is important to gather referral sources ahead of time which can provide brief or long-term individual and group counseling and to alert local mental health providers that they may see a slight increase in referrals during the training period.

Parent Education

Prior to the suicide prevention training, parents in the school district should be invited to attend an informational seminar. Parents have the right to know the rationale for the training and what the components of a school-wide effort will be. They should be introduced to the same information that will be given to their children and given the

opportunity to ask questions, make suggestions, or exclude their child from the training altogether.

Classroom Presentations

The goals of the classroom training are to give students a clear and realistic picture of what suicide is about, to provide students with the knowledge to recognize dangerous patterns in themselves or others, and to familiarize them with helpful resources within the community (Capuzzi, 1994). The basic format in the suicide prevention program in our district was threefold: 1) to correct commonly-held myths about suicide (Kirk, 1993) through the *Suicide Questionnaire*; 2) to provide information on warning signs of depression (Kalafat, 1990); and 3) to help students identify a trusted adult in their lives with whom they could confide if they, or someone they know, became suicidal. (See Appendix A for the *Suicide Questionnaire* and *Warning Signs of Suicide and Depression* Handouts.) Information is presented within the context that students could help a troubled friend if they learn about suicide and some of the warning signs of depression. Students are often unaware of their own depression. The basic philosophy of this approach is that knowledge is power, and once students are informed, they are better equipped to help a friend or to manage their own emotional state.

When discussing the *Suicide Questionnaire* with students, it is important to take time to answer questions as they arise. Rather than being strictly a question/answer session, it is valuable to allow ample time for discussion and exploration of students' feelings about the topic. Students often hold romantic, idealized views about suicide which can be revealed and demystified by providing them with accurate information. Through reviewing the *Suicide Questionnaire* and *Warning Signs of Suicide and*

Depression, students learn that most people who commit suicide are depressed, that depression is not a permanent state, and it can be positively affected through proper diagnosis and treatment.

The final step in the presentation process is the message that if a student or a friend is feeling depressed or suicidal, they need to seek help by talking to a trusted adult, one who can take steps to assist the person in getting the kind of help they need. Students are informed that they are never responsible if a friend tries to hurt himself or herself, but, just as knowing CPR can help save a life, knowing some of the warning signs of suicide can place them in a position to help. Students in our presentations were shown a video on teen suicide prevention that reviewed the warning signs and provided role plays depicting teens taking a proactive stance in helping, or getting help for themselves, thereby reducing the stigma of seeking mental health assistance. (Contact information for these resources may be found in Appendix B.) Some of these produced programs also provide depression-screening forms, which can further help students identify warning signs in themselves. Students were also given a list of community resources, including crisis lines, which they could call for future assistance.

During the classroom presentations, there may be students who become overwhelmed by the material presented if they have had experience with a suicidal attempt, or if someone close to them has attempted or completed suicide. For this reason it is important to have a counselor on stand-by to whom students affected in this way could discuss their concerns.

Follow-up

Students should be asked to complete evaluation forms at the end of the training to give feedback on what they found most useful during the presentations and suggestions for improvement of future sessions. Additionally, students should be asked to write down the name of at least one person they could talk to if they knew someone who was contemplating suicide. Lastly, they should also be informed about the location and availability of counseling services in the school, if needed at any time.

Practical Implications and Limitations

Despite the many benefits to students, there are some practical implications and limitations that should be mentioned when considering the implementation of a suicide prevention program in the schools. First, as previously stated, it is of utmost importance to obtain the full support of the district's administrative body. To aid in this endeavor, it may be helpful to provide a fact sheet about teen suicide (see Appendix B), as well as additional reading material as a rationale for the program.

Second, the amount of time involved may cause some concern. Several basic tasks need to be undertaken by someone in the district: researching, compiling resources, and being the general manager for the project. This may be unfeasible for some small school districts whose personnel are already stretched to the limit. It is important for school administrators to recognize the program's value, understand the multiple steps involved, and allow release time for personnel included in its preparation and implementation. In our district, I was the chairperson of the Suicide Intervention and Prevention Committee, and was employed during the summer to prepare for the program to be implemented the upcoming year. Also, several members of the

committee attended trainings which happened to be offered in our area to learn the classroom presentation material. If training is not available, it may be helpful to attend a classroom presentation on suicide prevention at a school in your geographical region. Although this is not necessary, it can be helpful to see the flow of material and to anticipate some of the questions students may raise.

Another issue involving time is that meaningful classroom presentations for students take approximately three hours of class time. Some administrators may want counselors to implement programs that are less time-consuming, but this is not recommended. There are several commercially-prepared prevention programs available which can be conducted by showing a video school-wide. Research has suggested, however, that small group presentations of no more than 25-30 students are the most responsible and effective format for suicide prevention trainings (Capuzzi, 1994), as more in-depth discussion can occur and students having difficulty with the topic can be more easily identified. In our district we presented the program over two days in one and a half-hour blocks each. In one school we presented the topic in Science classes as a health issue, but in another we provided presentations during the Career Exploration class, only because the scheduling during this class was the most convenient. Presentations were conducted by two-person teams, which consisted of a teacher and a counselor. It will be helpful to talk with principals and teachers regarding the most appropriate time and class for presentations to be conducted, and for decisions about which counselors and teachers should be involved.

Administration may also balk at the amount of time it will take to train all employees in the system. Again, the research indicates that one can never know to

whom a student may disclose thoughts of a suicidal nature. It is, therefore, imperative that all school personnel know appropriate responses and procedures to follow.

Finally, during the classroom presentations, it is not uncommon for students to disclose stories of a personal nature related to suicide. These stories could be about themselves, a family member, or friend. If this occurs, it is best to convey to students that you appreciate their willingness to share, and suggest a later time and place during which to discuss their experience. Their story may be more personal than anticipated, and it may also take time away from the material being presented. Ask them to speak to you or the counselor after class, and remember to follow up.

Conclusion

Implementing a suicide prevention program is a time-consuming but rewarding task. While there is no quick fix to the problem of teen suicide, it is hoped that the suicide prevention measures discussed here will enable school counselors to begin talking to students about preventing suicide and further reduce the stigma of seeking help for mental health concerns. Students who complete this training are more likely to recognize if they or a friend are having problems and to take action to get help more quickly. These steps, in combination with other violence-prevention curricula, such as conflict resolution, peer mediation, bullying prevention, mentoring programs, and other developmental guidance lessons, are part of a multi-dimensional approach to reduce violence and create safer learning environments for all students.

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Appendix A

Handouts

PART I - SUICIDE QUESTIONNAIRE

Circle True (**T**) or False (**F**):

T F 1. People who talk about suicide never attempt suicide.

T F 2. Once a teenager attempts suicide, he/she has a higher risk for attempting again.

T F 3. Teenagers who use drugs or alcohol are not at a greater risk for committing suicide.

T F 4. Never use the word suicide when talking to your friend because using the word may give him/her the idea to do it.

T F 5. Women **attempt** suicide more often than men.

T F 6. A person who seems dramatically better after a period of depression is no longer at risk for suicide.

T F 7. Russian Roulette, reckless driving, and other high risk behaviors that could lead to death may be ways to attempt/commit suicide.

T F 8. There are no warning signs before suicide takes place.

T F 9. More men **complete** suicide than women.

T F 10. Gay/lesbian youth have a higher risk of attempting suicide than straight youth.

T F 11. A friend who has lost a loved one or has broken-up with their boyfriend/girlfriend would not consider suicide as an option.

T F 12. Suicide is the third most common cause of death among adolescents and young adults in the United States.

PART II - WARNING SIGNS OF SUICIDE AND DEPRESSION

A. Behavioral Clues

1. Sadness and crying
2. Lack of energy
3. Inability to concentrate, or make decisions
4. Threatening suicide or talking about suicide
5. Expressing a desire to die
6. Recurring themes of death and self-destruction in poetry composition, writing assignments or artwork
7. Making final arrangements, such as giving away possessions, expressing farewell, and writing a will
8. Feeling depressed: unhappy, hopeless, worthless, guilty, low self-esteem, loneliness, and boredom
9. Sleeping more or less than normal
10. Showing a real change in appetite - eating much less or much more
11. Pulling away from friends, hobbies, job, and social activities
12. Changing personality suddenly and having mood swings
13. Acting disruptive in class or exhibiting violent outbursts
14. Taking more risks (e.g., increase in alcohol or drug use, reckless driving
15. Abusing drugs or alcohol
16. Neglecting physical appearance
17. Lack of plans for the future
18. Drop in grades - inability to complete assignments or pay attention in class

19. Neglecting personal hygiene or appearance
20. Change in sexual behavior (e.g., promiscuity, unprotected sex, increase or decrease in sexual interest)
21. Suddenly feeling good after showing of these signs for a period of time

B. Situational Clues

1. History of suicide in the family
2. The death of a loved one and reminders of the loss (e.g., holidays, anniversaries, birthdays)
3. The end of a significant relationship
4. A recent move or transition
5. Anniversary of death or loss
6. Financial problems
7. Getting suspended or expelled from school
8. Trouble with the law
9. Confrontations
10. Sudden illness
11. An unplanned pregnancy
12. Breakdowns in communications with parents or significant others
13. Violence in the home/physical or sexual abuse
14. Alcoholism or drug abuse in the family
15. Unrealistic expectations held by parents, teachers, and oneself - perceived failure in school, family, and/or social situations
16. Alienation from the family

C. Verbal Clues

1. Direct statements, such as:

"I wish I were dead." "I'm going to kill myself." "I'm going to end it all." "The only way out for me is to die." "You won't be seeing me around anymore." "I'm getting out." "I can't go on any longer." "I'm tired of living." "If ...happens, I'll kill myself." "If ...doesn't happen, I'll kill myself."

2. Implied statements, such as:

"Life has no meaning."

"Nobody needs me anymore."

"A friend of mine is thinking about hurting/killing him/herself"

"No one cares if I live or die."

"I'm no good to anybody anymore."

"Everyone would be a lot happier if I were gone."

"They'd be better off without me."

"Why is there such unhappiness in this life?"

"You are going to regret how you treated me."

"I just can't take it anymore."

"I'm just in everybody's way."

GENERAL INFORMATION ON TEEN SUICIDE AND SCHOOLS

1. The teen suicide rate has tripled over the last 35 years, and is now considered the second leading cause of death among 15 to19 year-olds (Jones, 2001).
2. There are 5000 suicides committed annually by young men and women between the ages of 15 to 24. This number is 30% higher for gay and lesbian students, due to the sense of isolation, problems with self-esteem, rejection, depression, and other factors related to homophobia in our society (Elia, 1994).
3. The most common factors contributing to adolescent suicide attempts are serious depression and/or drug use.
4. Most authorities agree that schools should develop a written plan of action for suicide prevention, crisis management, and postvention (Capuzzi, 1994).
5. The U.S. Surgeon General's Report on Adolescent Suicide (1999), advocates suicide prevention programs for public schools.
6. The best prevention and intervention programs take the philosophical view that a student's at-risk behaviors are signs that he or she lacks the necessary skills to accomplish normal developmental tasks (Smaby et al, 1990).
7. Teachers and parents need to know that suicide prevention education does not cause students to attempt suicide (Capuzzi, 1988).
8. Suicide is the biggest area of litigation right now for school counselors. Parents sue school districts claiming that the counselor was incompetent. Developing school policies to ensure that consistent procedures are used in every case is not only vital to ensuring student safety, but is also the best insurance against legal difficulties should a parent decide to hold the school liable after a suicide completion (Remley, 1991).

Appendix B

Additional Resources

SOS High School Suicide Prevention Program™

One Washington Street, Suite 304, Wellesley Hills, MA 02481-1706

Tel. (781) 239-0071 / Fax (781) 431-7447

http://www.mentalhealthscreening.org

- Offers an excellent video and copies of the *Depression Screening Inventory* for a nominal fee to use in conjunction with suicide prevention program.

Paraclete Press and Paraclete Video Productions

P.O. Box 1568, Orleans, MA 02563

Tel. 800-451-5006 / Fax 508-255-5705

http://www.paracletepress.com

- Produces video, *A* Cry *for Help: How to Help a Friend Who is Depressed or Suicidal*

Jewish Family Service

3330 West Esplanade, Suite 600, Metairie, LA 70002

Tel. 504-831-8475 / Fax 504-831-1130

http://www.jfsneworleans.org

- Offers *Teen Life Counts*, a suicide prevention program in New Orleans area high schools. JFS staff and volunteers provided our district training of the trainers and helped in the formation of our handouts.

Biographical Statement

Mary Jane Anderson, Ph.D. is an Assistant Professor of Counselor Education at Augusta State University. She taught special education students for eleven years in the states of Maryland, New Hampshire, Massachusetts, and Louisiana. Her background also includes a wide range of counseling responsibilities in private practice, community mental health, and school settings. Dr. Anderson has offered over 30 workshops on educational and counseling topics. She has presented at local, state, national, and international conferences on counseling themes including supervision issues, counseling people with disabilities, adolescent suicide intervention and prevention, and diversity. Her current research interests include sexuality training with counseling students, suicide intervention, and increasing diversity sensitivity.

Dr. Anderson earned a Bachelor of Science degree in Special Education and Elementary Education from Bridgewater State College in Massachusetts in 1978. She earned a Master's of Education degree in Special Education in 1985 from Southeastern Louisiana University, and a Master's of Education degree in Counselor Education from the University of New Orleans in 1999. She completed the Doctor of Philosophy degree in Counselor Education in 2002 from the University of New Orleans. She is a National Certified Counselor, a Licensed Professional Counselor and Supervisor in Georgia, Louisiana, and Mississippi, and a licensed guidance counselor in Louisiana and Mississippi.