Anyone who cares about kids wants to know: Why are so many young people intent on destroying themselves? And what can schools do to save them?

BY REBECCA JONES

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On Dec. 1, 2000, a 17-year-old boy set up a video camera in the parking lot of Granada Hills High School just outside Los Angeles. Then he turned up his car radio and shot himself in the head.

Dozens, maybe hundreds, of students witnessed the shooting. It was the second suicide among the school’s 3,700 students in three weeks. Another Granada Hills student had weighted herself down and jumped into her family’s swimming pool.

Thousands of kids end it all, or try to, every year. The U.S. Centers for Disease Control and Prevention estimates 5,000 young people kill themselves each year, but suicide experts say the true toll is probably two or three times higher. No one knows the exact number of teen (and younger) suicides because so many are classified, at the family's request, as accidents. But even with coroners hesitating over death certificates, the teen suicide rate has tripled over the past 35 years, and suicide has climbed to the second leading cause of death, after accidents, among 15- to 19-year-olds.

As grim as these numbers are, consider this: Suicide experts estimate that only one out of every 100 suicide attempts is successful. Which means schools are filled with children who are intent on destroying themselves.

The situation is so alarming that many school districts—but not enough, experts say—have set up suicide-prevention programs, mostly out of a heartfelt desire to help troubled kids. Additional motivation comes from the growing number of lawsuits filed by grieving parents—and from every school’s fear of being the next Columbine. According to a U.S. Secret Service report issued this past fall, more than three-quarters of the school shooters in recent years have been on suicide missions, either saving a bullet for themselves or counting on police to kill them.

Several states have mandated suicide-prevention programs in schools, but most districts don’t get serious about it until a child dies. “Very few school districts have anything official in writing,” says Scott Poland, president of the National Association of School Psychologists (NASP) and author of *Suicide Intervention in the Schools* (Guilford Press, 1989). “But when a suicide *does* happen, that’s the worst possible [time] to try to fly by the seat of your pants.”

Now is the time, he and other experts say, to identify vulnerable children and protect them from themselves. But how? Several federal agencies are collaborating to develop suicide-prevention guidelines for school districts, based on guidelines developed in New Zealand. Work has been slow because the research in this area isn’t always clear and the experts don’t always agree. But researchers, experts, and attorneys agree on the importance of a few principles:

**KNOW WHAT YOU’RE DEALING WITH**

A Los Angeles principal calls Richard Lieberman—known as the school district’s Suicide Man—and says, “I have 15 suicidal seventh-graders in my office! Send everyone you have!”

“You’re talking to everybody I have,” Lieberman says—his only colleague in the suicide-prevention office is out just now, training staff members at a school. Lieberman calmly tells the principal what he should do with the students sent to his office by worried staffers. (It boils down to this: Assess and supervise the kids, call the parents, and provide them with information about mental-health facilities.) At the end of the day, all 15 children are still alive.

Lieberman is an old hand at suicide prevention and has no idea how many threats he’s heard in his 26 years as a school psychologist. At this point, he’s even lost track of the number of completed suicides he’s dealt with. “It’s an epidemic,” he says.

Ask school psychologists why so many young people are trying to kill themselves, and they talk about everything from the stress of growing up today to the accessibility of guns. Each suicide is unique, they say, and “the answer dies with the student.”

But researchers are more willing to answer the why of suicide. “Psychological autopsies,” based on extensive interviews with victims’ families and friends, reveal that 90 percent of adolescent suicide victims had a mental illness—usually clinical depression, almost always untreated—or a substance-abuse problem at the time of their deaths.

The best way to prevent suicide, they say, is to find and treat kids with depression and substance-abuse problems.

**IDENTIFY VULNERABLE KIDS**

“If you ask kids [about suicidal thoughts], they will tell you,” says Columbia University suicide researcher Dr. David Shaffer. “In fact, they’re inclined to tell you far more than a comparable adult will tell you.”

Shaffer has developed a sophisticated, precise screening method, called Columbia TeenScreen, that uses paper-and-pencil questionnaires, computerized tests, and clinical interviews to query students about their state of mind. Schools are now being trained in the 10-year-old method. (For contact in-
Suicide-prevention experts have mixed feelings about screening. While recognizing the importance of identifying suicidal students, some worry about privacy issues and the impact of labeling students. Another concern is the lack of adequate mental-health facilities for making referrals. Every school screening project has identified more at-risk students than researchers expected, says Dr. Jane Pearson, chair of the National Institute of Mental Health’s Suicide Research Consortium. “You could argue that it’s unethical to identify these kids and then have no place to refer them,” she says.

The draft proposal of suicide-prevention guidelines making the rounds at press time recommended against screening students in schools, but the U.S. Center for Mental Health Services, along with several school-health organizations, has approved a screening program developed by Dr. Douglas Jacobs, the Harvard Medical School researcher who founded National Depression Screening Day.

The program, called SOS, provides a screening questionnaire and a video that demonstrates the right and wrong ways to talk with friends about suicide. Jacobs says the idea is to teach students that “suicide is the outcome of depression. ... We’re medicalizing the whole suicide concept and teaching what to do if you recognize signs of suicide in another student.”

SOS is designed to make the “signs of suicide as familiar as the signs of choking,” says Barbara Kopans, vice president and managing director of Screening for Mental Health, the Wellesley Hills, Mass., organization that distributes SOS. “Right now you have a much better chance of surviving if you’re choking to death in the cafeteria than if you tell the person sitting across from you that you’re thinking about killing yourself.”

It’s too soon to tell whether SOS is effective in preventing suicide, but it’s been tested in 220 schools with no negative effects. Dr. Robert DeMartino of the Center for Mental Health Services says, “We know it’s safe”—and that’s not something you can say about every suicide-prevention strategy being used in schools today.

**WHAT ABOUT A POLICY?**

School boards should have policies about suicide prevention, and in some states, it’s a requirement. What should the policy include?

Most of the psychologists ASBJ contacted want boards to lay out exactly what the district will do to prevent suicides, to intervene with students plottting their deaths, and to deal with the aftermath of a student suicide. They recommend policies that mandate crisis-management teams at each school site, suicide-prevention training for staff members, and automatic parental notification and referrals to mental-health facilities whenever staff members think children might be depressed or might pose danger to themselves or others.

But many attorneys caution against creating suicide-prevention plans that are too specific. Deirdre Smith, a Portland, Maine, attorney who successfully defended a school district in a student-suicide lawsuit that reached the U.S. 1st Circuit Court of Appeals, says some school districts create detailed 18-point programs that seem to call for “suicide SWAT teams if any kid’s grades start to slip.”

These ambitious policies are “admirable and have the best of motivations,” she says, but are used by courts to define the standard of care— a standard that might be impossible to meet. “The reality is,” she says, “that the social worker or the assistant principal or the teacher had 3 million other things to do that day, and maybe they went through steps one through 17 and didn’t quite get to 18.”

Suicide-prevention policy is tricky to write, acknowledges Michael Wessely of the National School Boards Association’s National Education Policy Network. He advises stating the district’s commitment to suicide prevention as part of its safe-schools policy and leaving the details for administrative regulations.

Those details might still expose the district to a lawsuit if every step isn’t followed exactly, he says, The board’s attorney should be consulted to help minimize the risk, but in the end, Wessely says, “I would hope that a district would rather risk getting sued than have a kid die.”—R.J.

**MAKE CURRICULUM DECISIONS CAUTIOUSLY**

Research shows that at least 80 percent of young suicide victims tell someone about their plans beforehand. After a child dies, friends often step forward with stories of previous suicide threats and attempts. The question is how to get kids to tell these stories—to a responsible adult who can get help—before it’s too late.

To help kids recognize and report suicidal thinking in themselves and their friends, some schools have added suicide prevention to their health curriculum. The most successful curriculum programs start young and focus on mental health. A K-12 program developed in Miami-Dade County that emphasizes curriculum and staff training is credited with reducing the district’s student suicide rate from 7.7 per 100,000 students in 1987 to 1.7 students per 100,000 in 1999. Frank Zenere of the Miami-Dade County schools’ Department of Crisis Management says before sixth grade, the program focuses on communication and problem solving. “Gatekeeper training”—learning the warning signs of suicidal thinking and how to get help—occurs in middle school and high school.

But adding suicide prevention to the curriculum has backfired in some districts. One superintendent says his district never had a student suicide until suicide prevention was added to the high school health curriculum; then there were several.
The tragedies might have been coincidental, but researchers have noted similar experiences in other districts. On investigation, they found the schools with increased suicides had used a curriculum that “normalized” suicide, presenting it as a choice some people make when dealing with disappointment, loss, or embarrassment, rather than presenting it as the result of an untreated medical condition.

Another problem with putting suicide prevention in the curriculum is that individual teachers sometimes show unfortunate creativity in their approach. Poland tells of a teacher in his home district of Cypress-Fairbanks (Texas) who showed a made-for-TV movie about suicide, in two parts, to her health class. After the first installment—and before the ending that emphasized alternatives to suicide—one student went home and shot herself in the head.

Poland would like to ban commercial movies from suicide-prevention programs. Those movies always seem to feature popular, attractive star athletes or cheerleaders killing themselves. It’s enough, he says, to make a depressed teen wonder, “What the hell do I have to live for?”

Another mistake is turning prevention programs into how-to-do-its for the suicidal. One teacher was so proud of a student’s video project that she encouraged him to enter a national contest, where he won an honorable mention. When Poland saw the video, he was horrified at the photographic tricks used to show kids hanging themselves, shooting themselves, throwing themselves in front of automobiles, and slashing their wrists. “I was absolutely appalled,” he says. “It was essentially a videotape on how to commit suicide.” The teacher was reprimanded and reassigned.

**TRAIN STAFF MEMBERS TO BE DETECTIVES**

Teachers, coaches, bus drivers—any district employee who has regular contact with students—should know the symptoms of suicidal thinking and be ready to report them to a school psychologist or counselor. Symptoms include such danger signals as prolonged depression, dramatic changes in behavior or personality, and disposal of personal property.

One of the most serious symptoms—one calling for immediate action—is having a suicide plan. Poland says kids have told him, “I’ll tell you how I’d do it. I’d shoot myself with a .38. I had it out last night and pointed it at my head.” That’s an example of a kid we cannot let out of our sight.

Psychologists say staff members often wait too long before reporting symptoms of suicidal thinking. “Teachers leave notes in school psychologists’ offices, saying, ‘Timmy wrote this note last Wednesday. Could you see him?’” Lieberman says. “If anything were to happen to that child, that note would definitely come to the attention of the parents. Parents always find out”—and their discoveries often lead to lawsuits.

Because some of the most troubling thoughts by students show up in their journals, both attorneys and psychologists caution teachers against guaranteeing confidentiality to students about what they write. “Teachers need to understand that there is no confidentiality,” says Rosemary Rubin, a school counselor in L.A.’s Suicide Prevention Unit. “When students write something, we need to follow through on it, because we don’t want to take a chance.”

When students are questioned about something they’ve said or written, they sometimes say, “Oh, I was only joking.” But some children who have said that have later been found dead. “So we still call home,” Rubin says, “and we still let the parent know, and we ask some questions, because we want the kids to know that this is something that we do take seriously.”

**STAY OUT OF COURT: NOTIFY PARENTS**

In 1989, a Polk County, Fla., boy told his mother he’d found Shawn Wyke trying to hang himself with a football jersey in their junior high school restroom. The mother told the school’s dean of students, who called 13-year-old Shawn into his office, read and discussed some Bible verses with him, and thought the problem was taken care of. The dean did not call Shawn’s mother.

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**Between 1980 and 1996, the suicide rate among 10- to 14-year-olds increased by 100 percent.**

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**Males are four times more likely to die from suicide than females, even though females are more likely to attempt suicide.**

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**The suicide rate for African-American males between the ages of 15 and 19 increased 105 percent between 1980 and 1996.**

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**There are approximately 14 suicides for every 100,000 adolescents.**
The next day, Shawn hanged himself at home. When his mother later learned about Shawn’s earlier attempt, she sued the school district for failing to tell her. The case ended up in the 11th U.S. Circuit Court of Appeals, which ruled that school officials had erred in not notifying Shawn’s mother and in not making sure he got help.

“The workings of the human mind are truly an enigma,” the court wrote, “but we do not believe ... that a prudent person would have needed a crystal ball to see that Shawn needed help and that if he didn’t get it soon, he might attempt suicide again.”

Attorneys say the lesson of *Wyke v. Polk County School Board* is clear: School employees must tell the parents if they suspect a child is depressed and/or thinking about suicide. "That's probably the single biggest thing schools can do to prevent a lawsuit—and to prevent a suicide, of course," says Deirdre Smith, a Portland, Maine, lawyer who successfully defended a school district in another suicide lawsuit. “Failure to notify parents is the common denominator in what turns a tragedy into a lawsuit.”

**MAKE SURE THE CHILD GETS HELP**

In Los Angeles, it’s Rosemary Rubin’s turn to answer the suicide-prevention hotline. A teacher overheard a first-grader saying that he was going to kill himself. “The teacher could have just sloughed it off when she heard a kid talking about killing himself,” Rubin says. “But she didn’t, and she referred this child [to the school psychologist]. And it turns out that not only was this child suicidal, he had a plan ... that involved a knife.”

Perhaps the boy was just kidding or trying to impress his classmates. But another possibility is that he is depressed or even suicidal. Rubin isn’t taking chances: Children as young as 5 have been known to attempt suicide. She recommends contacting the child’s parents and taking him—today—to a mental health clinic.

What if the parents don’t want him to go? Notifying parents might take care of the district’s legal obligations, but there’s no guarantee it will help the child. Ned Julian, attorney for Seminole County, Fla., schools and a frequent lecturer on the legal aspects of suicide prevention, says some parents are oblivious to their child’s pain. Others might be the source of the child’s problems, perhaps as a result of abuse or molestation.

If parents don’t seem to care, or if school officials have reason to believe that telling the parents might endanger the child, Julian advises treating the child’s predicament as a medical emergency. “We might call 911, or we might put the child in the principal’s car and take the child down to a local crisis center,” says Julian. “It just depends how imminent you think the danger is.”

Doesn’t such action without the parent’s approval open the district to a lawsuit? "Our position is that we’d rather be sued for trying to help a child in distress than be sued for not helping a child and having a tragic ending," Julian says. “We’re willing to stand before any judge and any jury, and say, ‘Look, this situation required immediate action.’”

**AFTER A SUICIDE: LOOK AFTER THE LIVING**

Brian Bauer was just starting his second day as principal of Granada Hills—his first principalship—when he heard something had happened in the parking lot. At first, he heard a student had been hit by a car. But when he ran outside, Bauer saw the boy with the gunshot wound, still alive and being helped by teachers. He later died at a hospital.

The school stayed open that day and through the following weeks, as psychologists and counselors met with students and staff members who had witnessed—or who were haunted by—the shooting. This was the second suicide in the school year, and the district didn’t want to see a third. An extra counselor was hired.

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*Firearms are the most commonly used suicide method among youth, regardless of race or gender, and account for two of every three completed suicides.*

— American Association of Suicidology

In 1999, 20 percent of American high school students reported having seriously considered or attempted suicide during the previous 12 months.

— American Foundation for Suicide Prevention

Suicide is the eighth leading cause of death among all Americans, the third leading cause of death among those aged 15 to 24, and the second leading cause of death among those aged 15 to 19.

— U.S. Centers for Disease Control and Prevention

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Five days after the shooting, Bauer went on the P.A. and asked students to write letters telling him how they felt about the shooting. About 3,600 students wrote, and the psychologists and counselors read their letters, looking for clues as to how kids were handling the shooting.

Some wrote about why the boy had done it, some wrote about how the school was handling the situation, some criticized the media for descending on the school. About 400 wrote something that indicated they or a friend were having serious problems. Between 50 and 60 letters pointed school officials to students who needed immediate attention. Two students were placed in 72-hour lockdown, for their own safety, at a mental-health facility.

The worry, of course, was that they would try to take their own lives. It was a reasonable worry: Schools where a student suicide has occurred sometimes report other attempts in the aftermath, and several schools around the country live with the nickname “Suicide High.”

It’s tempting to think of suicide contagion as a postmodern affliction of disaffected teens. But the phenomenon dates back centuries. A 1774 novel, *The Sorrows of Young Werther,* set off such a spate of imitative suicides by young men that several European countries banned the book.

For years, psychologists believed friends of a suicide victim were most susceptible to what’s become known as the Werther Effect. But Dr. Madelyn Gould, whose research at Columbia University focuses on schools in the aftermath of a student suicide, says she’s found the most vulnerable children are the ones with histories of clinical depression or substance abuse—who perhaps never even met their dead schoolmate. Which means grief-crisis efforts that focus on close friends and witnesses might miss the children who need it most.

Three months after the Granada Hills shooting, Bauer had not heard of any more suicide attempts, and he guessed the school was beginning to recover. Following the advice of suicide-prevention counselors, the school has not put up a memorial or planted a tree in memory of the students who killed themselves.

This no-memorial policy is generally accepted among suicide-prevention experts—even though it often seems cruel to grieving families who want something to show their child passed this way. There’s been no research on memorials to suicide victims, so there’s no evidence that having one on school property would encourage other children to plot their own deaths. Still, reasonable adults don’t want to take the chance of romanticizing suicide in a way that beckons another young Werther.

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FOR MORE INFORMATION

Columbia TeenScreen Program. For information, contact Leslie Craft at craft@child.cpmc.columbia.edu.

These books are also helpful: