

# PUBLICATION SERIES

Office of Mental Health and Substance Abuse Services

## PREVENTING YOUTH SUICIDE: Risk Factors, Implications, and Strategies

**By Mary Margaret Kerr, Ed. D. and Emily K. Traupman**  
with additional reprints from the *PA CASSP Newsletter*

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## PUBLICATION SERIES

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## YOUTH SUICIDE PREVENTION: Risks, Implications, and Strategies<sup>1</sup>

By Mary Margaret Kerr, Ed. D. and Emily Traupman  
with additional reprints from the *PA CASSP Newsletter*

Suicide is the third leading cause of death for young people ages 10-14 and 15-19 years, killing 1,600 teenagers each year in our country. The rapid increase of suicide deaths from the 1950s to the mid-1980s led to a national clarion call for more effective prevention. Thereafter, the general rate of youth suicide declined dramatically. Nevertheless, *5-8% of teenagers will attempt suicide, while one in five teenagers will seriously consider suicide, each year* (Gould, 2003).

In writing this article, our goals are to provide a general understanding of the risk factors for youth suicide completion and attempts, and to highlight the implications of these risk factors for prevention efforts. We begin with an overview of youth suicide completion (i.e., suicidal behavior that results in death) and suicide attempts, then focus on the most significant risk factors, linking them to contemporary prevention approaches.

### **An Overview of Youth Suicide Completion and Attempts**

#### **Age**

The rates of *completed* youth suicides are low (1.5 per 100,000 among 10-14 year olds and 8.2 per 100,000 among 15-19 year-olds). However, the Youth Risk Behavior Survey reported that 19% of high schoolers seriously considered a suicide attempt during the past year, while 15 % made a specific suicide plan, 8.8% reported a suicide attempt, and 2.6% made an attempt that required

medical treatment (Grunbaum, Kann & Kinchen 2002).

Completed suicide is rare in children under the age of 10, because children in this age group lack the access to, or information about, lethal methods. Accordingly, most prevention strategies focus on adolescents.

#### **Gender, Race, and Sexual Orientation**

Females experience suicidal ideation (thoughts about suicide) and make more suicide attempts than males, although completed suicide is more common among males (Grunbaum et al., 2002). In the United States, youth suicides are more common among whites than African-Americans, while highest among Native Americans and lowest among Asian/Pacific Islanders (Anderson, 2002). A review of research on sexual orientation and youth suicide found higher rates of attempted suicide among homosexual youths compared to their heterosexual counterparts (Remafedi, 1999). More recent studies have identified “a two-to six-fold increased risk of non-lethal suicidal behavior for homosexual and bisexual youths” (Gould et al., 2003, p. 390).

#### **Method**

Firearms, the leading cause of suicide completion in the U. S., account for almost 60% of all suicides in both males and females. For those ages 15-19, suicide by firearms accounted for 63% of the increase in the overall rate from 1980 to 1996

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<sup>1</sup> Services for Teens at Risk (STAR-Center) was founded in 1986 by a Pennsylvania General Assembly subcommittee to investigate teen suicide. The STAR-Center specializes in preventing and treating suicidal behaviors, depression, and interpersonal violence in teens through research efforts, educational outreach, professional training, support groups, and clinical services.

(Surgeon General, 1999). Other methods include hanging and overdose. Some prevention approaches have as their goal the reduction of access to lethal means such as firearms.

## **Risk Factors and Precipitants<sup>2</sup> Associated with Youth Suicide**

### **Mental Illness**

Without a doubt, mental illness is the most significant risk factor for suicidal behavior. In over 80% of community and referred cases of *suicide attempts*, there are associated mental health disorders, most often depressive, anxiety, conduct or substance abuse disorders. Psychiatric diagnoses (most often mood disorders, substance abuse, conduct disorder, bipolar disorder with mixed state), often in combination, are present in about 90% of teen *suicide completions*. This dramatic link between mental illness and suicidal behavior explains why many prevention approaches have screening as a part of their program. For example, the Columbia TeenScreen® Program uses a multi-stage screening program that (1) teaches teens about depression and treatment, to encourage them to identify and refer themselves, and (2) systematically screens each teen for anxiety, depression, substance abuse, and suicidality. In another example, the SOS: Signs of Suicide Program combines a curriculum for high school students with a brief screening. Help-seeking is a goal of both programs.

Teens who do access psychiatric treatment usually find it effective. A combination of

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<sup>2</sup> In reviewing suicides, researchers have identified events that took place immediately before the suicides. While these “precipitant” events may not have caused the death, they co-occurred in a significant number of cases. Precipitating events include interpersonal loss, pending disciplinary or legal crisis, not attending school or work, failing grades, and chronic illness, which can “trigger” depression.

psychotherapy (e.g., Cognitive Behavior Therapy) and medication treatment often works best.

Sadly, in the month before suicidal behavior, many young people will seek some medical care, but their need for psychiatric treatment goes unrecognized by their primary care providers. Educating primary care providers about the warning signs of depression, mental illness, and suicide risk is of paramount importance.

**Depression.** Depression, with its accompanying hopelessness, anxiety, and cognitive distortions is a major risk factor for suicide and suicide attempts. Consider this example:

*A teenager has experienced repeated episodes of depression and feels hopeless, despite some sessions with a school counselor. After encountering a former romantic partner on the street, she breaks down and isolates herself for days. Ultimately, she concludes that she has nothing to live for, and would be better off dead. She then overdoses.*

**Anxiety Disorders.** Co-existing with a mood disorder, these conditions can interfere with a person’s treatment and recovery. If not identified and treated, these disorders can increase the risk for suicidal thoughts and/or behaviors in depressed individuals. Consider this illustration:

*A gifted teenager experienced anxiety for several years. Despite help from his family and school counselors, he continued to be self-critical and overly concerned about his performance and others’ approval of him. When he was caught parking his car on school campus without a student permit, he faced a suspension. Panicked, he drove the car to a bridge and jumped.*

As illustrated in this case, a significant number of suicide completers faced a pending disciplinary crisis. Discipline should occur as soon as possible after misbehavior to decrease the feelings of

anticipatory anxiety. If the student in trouble is highly anxious, school or law enforcement officials should take steps to reduce anxiety and get immediate assistance.

**Drug or Alcohol Abuse.** An increased prevalence of drugs or alcohol is a factor accounting for why older adolescents are more likely to attempt and complete suicide compared to younger adolescents. Some adolescents use drugs and alcohol to cope with depressive feelings. Alcohol acts as a disinhibitor to suicidal behavior.

A link seems to exist between alcohol abuse and suicide by firearms: adolescents who are depressed and use alcohol are more than five times more likely to use a firearm. Consider this illustration:

*Diagnosed at age 8 with Conduct Disorder and ADHD, this 14 year-old struggled academically. He compensated for his poor academic status by being the class clown and taking risks to gain the attention of his friends. One night at a friend's house, he drank with the other kids and then played a fatal game of Russian Roulette.*

Since suicidal individuals are often impulsive, restricting access during critical times may reduce suicides. In addition, even if means substitution does occur, the chance of survival may be greater with less lethal methods. Educating parents of high-risk youth about injury prevention may also aid in reducing access to lethal means.

## Family Characteristics

**Family mental illness.** A family history of suicidality significantly increases the likelihood that a teenager will take his own life (Gould, et al., 2003). Children of depressed parents appear to be at substantially increased risk for completed suicide, as do children of parents with substance abuse problems (Brent, et al., 1994).

Consider, for example, how a parent's own struggles might hinder attempts to help her child. A depressed parent might be overwhelmed by suggestions offered by professionals, feel anxious and guilty, lack confidence in parenting, have trouble setting limits for a teen's use of alcohol or other drugs, or lack the energy to follow through with treatment suggestions. Outreach to parents struggling with their own mental health challenges, including depression and substance abuse, is an important element of the prevention of youth suicide.

**Family discord.** Child sexual or physical abuse is a significant risk factor for youth suicide. One study revealed that “discordant, hostile family interactions predisposed [youth] to suicidal thoughts” (Kosky et al., 1986, p. 527). Gould and her colleagues (1996) reported that suicide victims had less frequent and less satisfying communications with their parents. These findings support the need to incorporate the family in treatment efforts for a young person who is at risk for suicide. STAR-Center (described later in this paper), for example, offers parent education groups and handbooks to help families understand depression and other mental illnesses.

## Exposure to the Suicidality of Others

**Media exposure.** Research supports a contagion factor associated with suicidal behavior in adolescents. Exposure to TV programs and news stories on suicide may prompt suicidal behavior in vulnerable adolescents. Prevention involves educating reporters, editors, and producers about contagion to minimize harm and emphasize the media's positive role in educating and shaping attitudes about suicide.

**Direct exposure.** Exposure to a classmate's suicide attempt may prompt suicidal behavior in other students. Young people most vulnerable to “contagion” *immediately* following a suicide are generally characterized as more isolated, not close to the suicide victims, and exhibiting the risk factors identified earlier. Research has shown that exposure to suicide usually does not result in an *immediate*

increased risk of suicidal behavior among close friends and acquaintances of adolescent victims, although exposure *does* increase the incidence of depression, anxiety and PTSD in this group, beginning about six months after the suicide. For this reason, postvention efforts in schools and other groups should closely monitor not only those at immediate risk for contagion but should track and support the close friends and siblings for a longer period. Screening those at risk for suicide and related mental illness is an important component of postvention following a suicide.

### **Behavioral Indicators**

Suicidal teens may begin writing or talking about death and suicide. Clues may also appear in art and music projects, diaries, or journals. Occasionally, suicidal teens begin giving away prized possessions, writing “wills” or suicide notes or saying “good-bye” in an untimely way. Youth considering suicide also may:

- begin talking or writing about death or suicide.
- complain that they are feeling really hopeless or trapped in a bad situation.
- become more aggressive or talk of wanting to harm others.
- begin using or increase their use of drugs or alcohol.
- suddenly become cheerful for no apparent reason after a period of depression.
- have just had a bad fight with their parents, boyfriend, or girlfriend.
- have recently lost someone they cared about.

Tragically, the stigma associated with mental health problems, substance abuse problems, and their treatment, prevents many youth (and their parents) from seeking help. Fearing prejudice or

embarrassment, many teens never receive the treatment that would release them from their despair.

“Gatekeeper” community or school-based prevention approaches teach adults and peers to watch for and refer teens exhibiting these behaviors. Gatekeeper programs also attempt to minimize the stigma associated with seeking psychiatric treatment. For example, hot lines and crisis centers (which research has shown are used more often by females than males) train their staff to listen for warning signs and assist at-risk callers to access treatment. In Pennsylvania, the Student Assistance Program trains school-based staff and faculty to serve as gatekeepers who meet to review their observations and concerns about students who may be at risk.

### **Summary**

Suicide researchers have discovered significant risk factors and precipitants, warning signs for which we must be vigilant observers. Yet, there can be different pathways to a completed suicide, as highlighted by the illustrations throughout this article. No single approach can be universally successful in preventing the often-tragic consequences of suicidal behavior.

Organizations such as the American Foundation for Suicide Prevention and the Suicide Prevention Advocacy Network link researchers and funders with community providers, survivors, and families in an attempt to strengthen the safety net for teens at risk for suicide. One of their goals must be the continued refinement of guidelines that enable providers and families to assess the effectiveness of the many suicide prevention programs now available.

University’s youth suicide and violence prevention center, STAR-Center. This Center provides crisis response services, training, and consultation to school districts and communities across Pennsylvania. She received her Bachelor’s and Master’s degrees from Duke University and her doctorate from The American University in Washington, D.C. Trained in special education and developmental psychology, Dr. Kerr has devoted her career to working with troubled children and adolescents and to teaching those who help them. The author of six textbooks and many articles, she has taught in special education and alternative education classrooms and continues to consult with school districts across the country. In 1996 Dr. Kerr was appointed by the United States Court for the Central District of California as a Consent Decree Administrator for Los Angeles Unified School District. In this capacity, Dr. Kerr worked for eight years with educators and parents to improve services for 81,000 students with disabilities.

Emily Traupman is a graduate student at Duke University in Durham, North Carolina.

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## Reprints from the *PA CASSP Newsletter*, December 2002

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### Youth Suicide Prevention in Pennsylvania

By Harriet S. Bicksler

The statistics regarding youth suicide are disturbing, to say the least. Suicide is the third leading cause of death among youth ages 15-24, accounting for more deaths than cancer, heart disease, AIDS, birth defects, stroke, pneumonia, the flu and chronic lung disease combined. During the past half century, the incidence of suicide among adolescents and young adults has nearly tripled. The cost of suicide is described by Kay Redfield Jamison, a psychologist at Johns Hopkins University:

The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description.

For more than 15 years, the Student Assistance Program in Pennsylvania's 501 school districts has helped identify students at risk for suicide. The Services for Teens at Risk (STAR-Center) program at the University of Pittsburgh has addressed suicide, depression and youth violence with mental health treatment for youth and consultation and training for agencies and schools. However, there was no formal suicide prevention plan in Pennsylvania. In the summer of 2001, a group of stakeholders from across the Commonwealth convened to develop a state plan for youth suicide prevention. The plan was completed in 1992, and several public forums on the proposed plan were held later in the year.

The Pennsylvania Youth Suicide Prevention Plan is based on the United States Surgeon

General's National Strategy for Suicide Prevention, and adapts the 11 goals from the plan to be specific for youth. The goals are:

1. Promote awareness that youth suicide is a public health problem that is preventable.
2. Develop broad-based support for youth suicide prevention.
3. Design and implement strategies to reduce the stigma associated with being a youth consumer of mental health, substance abuse and suicide prevention services.
4. Identify, develop, implement and evaluate youth suicide prevention programs.
5. Promote efforts to reduce access to lethal means and methods of self-harm.
6. Implement training for recognition of at-risk behavior and delivery of effective treatment.
7. Develop and promote effective clinical and professional practices.
8. Improve access to community linkages with mental health and substance abuse services.
9. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in media and entertainment.
10. Promote and support research on youth suicide and youth suicide prevention.
11. Improve and expand surveillance systems.

A monitoring committee is meeting regularly to oversee the implementation of the action plan. In addition, an advisory committee meets twice a year. Workgroups are being formed to develop specific projects related to the implementation of the plan. The Pennsylvania Youth Suicide Prevention Plan is available on the web at <http://www.dpw.state.pa.us/Omhsas/omhyspp.asp>.

*Harriet S. Bicksler is the editor of the PA CASSP Newsletter, and publications specialist for the PA CASSP Training and Technical Assistance Institute.*

## **The STAR Center: A Revolution in Youth Suicide Prevention and Treatment**

By Michele Tedder

Madison had been a model student from elementary school through middle school. She loved sports and maintained high honor roll despite her busy schedule. In recent months her mother had noticed that she seemed more withdrawn, irritable and not as interested in her school work. Her teachers had also taken note that she didn't seem to be as focused and her grades had dropped. At first Madison's mother thought she was being a typical teenager. After all, she thought that most teenagers get moody. It wasn't until she found a note in Madison's room indicating she didn't feel life was worth living and maybe she should just end it that she realized Madison was experiencing more than normal teenage moodiness. This fictitious example about Madison is the kind of patient that Services for Teens at Risk has treated for the past 16 years.

Suicide has been a leading cause of death in the U.S. for many years. According to the National Institutes of Mental Health in 1999, suicide was the 11<sup>th</sup> leading cause of death. It was the third leading cause of death among young people 15-24 years of age following unintentional injuries and homicide.

On October 28, 1986, Services for Teens at Risk was birthed to address the increasing problems related to adolescent suicide and depression. Founded by Drs. David Brent and Mary Margaret Kerr, the program's mission is to provide high quality clinical treatment and cutting edge research in the area of adolescent suicide prevention. The program is funded by the Pennsylvania's General Assembly which makes it a unique program in that it is able to offer free treatment to youths at risk for depression and suicide. It is proudly Pennsylvania's first comprehensive program to prevent teen suicide.

Treatment is offered on several levels including prevention, identification, assessment and early intervention. The primary treatment modality is that

of individual cognitive behavioral psychotherapy. The program also offers psychoeducational programming for parents; a maintenance group for teens who have shown a significant improvement in their treatment; bereavement counseling to children, teens and adult survivors of suicide; and on-site community training designed specifically for schools, mental health agencies and community organizations. The STAR Center also offers medication treatment.

STAR's school and community outreach program offers intensive training programs to educators, mental health professionals and concerned citizens in the recognition and referral of youth who are at risk. In the aftermath of a suicide or tragedy in a school district or the community, the outreach staff responds by providing postvention services. These services are designed to help individuals cope with loss through individual screenings, small group discussions and education on bereavement. In addition to the STAR Center's high quality clinical offerings, it serves as an elite training ground for psychiatric residents, master's level interns and Ph. D. candidates.

Once an individual is identified as "at-risk" and referred to STAR, he or she is given a comprehensive assessment that explores all areas of possible mental health diagnoses. One of the program's hallmarks is its thorough assessment and precise diagnosing, which is critical when determining appropriate treatment options. The average treatment course of a STAR patient from their acute phase to maintenance is approximately 16 weeks. This varies from individual to individual depending on the severity of their illness. Patients often benefit from multiple modalities of treatment including individual therapy, family therapy and medication therapy.

STAR's clinicians are all highly trained and specialize in the treatment of adolescents suffering from depression and thoughts of suicide. Their disciplines include bachelor's and master's prepared nurses, licensed social workers, psychiatrists and clinical psychologists.

STAR’s effectiveness in improving treatment to individuals suffering from depression and suicidal thoughts is well known and respected throughout the region. Each year the program offers three conferences providing up-to-date information on teen suicide and related topics. The conferences are offered in the Philadelphia area, Harrisburg and Pittsburgh. All are well attended by educators, community leaders and various mental health professionals.

Since STAR’s inception in 1986 the program has practically revolutionized the identification and treatment of adolescents suffering from depression and suicide. While STAR has achieved in this very important health area, it recognizes that there is still more to be done. For this reason STAR continues to seek opportunities to provide more community focused and culturally sensitive care and psychoeducation in non-traditional settings to heighten the public’s awareness in preventing teen suicide.

*Michele Tedder is a clinical nurse specialist with Services for Teens at Risk at the University of Pittsburgh Medical Center. She specializes in the treatment of youth with mood disorders, and her area of expertise is assessment and medication therapy.*

## **Yellow Ribbon Program: Preventing Teen Suicide**

By Tina Henderson

September 29, 1996 was a beautiful sunny day; not even a jacket was needed. My family did our usual Sunday morning routine. My two oldest sons, Frank and Chris, were both away at college, my only daughter Angela was preparing to go to a birthday party, and Eric and Sean were playing with the dog, going outside in the woods, doing typical “guy” stuff. Eric talked to friends about the upcoming football games (he was in seventh grade and playing football); Sean was eight years old and followed Eric around everywhere.

We went to the grocery store about 10:00 a.m. and bought gum for the next day—just in case. We ate dinner and decided to go for a ride to get ice cream on what was sure to be one of the last nice days. Angela had already gone to her friend’s party so it was just my husband, my two youngest sons and me. Eric decided he couldn’t go along because he had math homework to do. This wasn’t unusual, because all of my kids wait until the last minute to do their homework; I guess we all work better under pressure because that’s the way I was in school. I gave him the “Mom talk”: don’t let anyone in, don’t go out, get your homework done, I love you.

We went for ice cream and stopped briefly at an uncle’s house, bragged about how well Eric was doing in football and in school, discussed Frank’s and Chris’ futures after college and how Angela, our only girl, was growing into a beautiful young lady when she had been such a “tom-boy,” and of course, Sean was taking center stage as he did cartwheels in their yard.

When we arrived home, the dog was at the door as usual, and I went upstairs to make sure Eric’s homework was done. I could hear his stereo long before I got there. I looked to the right into his room and saw his TV on but mute. As I walked further into his room, I saw him lying on the floor. My beautiful, happy, popular, athletic son had taken his life while we were gone for one hour. Eric was three weeks from his 14<sup>th</sup> birthday. Why did he do it? Because he had pain deep inside and he didn’t know how to ask for help.

I did not know that suicide is such an epidemic. I thought the kind of kid who did this was a real loser, into drugs or alcohol, but I was wrong. We are losing seemingly happy, normal kids. I have since educated myself and anyone that I come in contact with about this epidemic that is taking too many of our kids. Please don’t allow this killer to continue.

Did you know that suicide is the third leading cause of death in young people ages 15-24? Did you know that the fastest growing age group is 10-14

year olds? We are not doing enough about it because there has always been a stigma attached to anything or anyone having pain inside—the pain of losing a favorite aunt or uncle or grandparent, the pain of the break-up of a romance or of leaving friends to move to another town or state, the pain of parents divorcing, or the pain of not doing well on a test or not being picked for a sport. Sounds like regular “kid stuff,” doesn’t it? But what happens when that “stuff” causes pain inside that hurts so bad you’ll do anything to end it? Too many times in this country, a young person ends the pain by attempting or completing suicide. Suicide is not about death; it is about ending the pain.

What can we do to stop this epidemic? Talk, talk, talk, and then talk some more. We can prevent over 90 percent of the youth suicides by talking and letting our youth know that it’s okay to ask for help. If your child or one of your child’s friends had a cut on their hand or a broken bone, would you get them help? Why then when our children have pain inside do we pass it off as just normal kid stuff and part of growing up? We have programs to prevent teen smoking, teen pregnancy, teen drinking and drug use; we have programs for our young people that raise money for awareness of all kinds of diseases and we need these programs. But we also need suicide prevention and it needs to be in the community and the schools and not hidden in the closet anymore. I have been to schools all across the country and talked to students about this subject—unfortunately, usually after a suicide has already happened in the school. Kids want to talk; they want information on everything from where they can get help, to how they can help a friend or family member, or what they can do to prevent youth suicide. Too many kids have been affected by suicide and have no one to talk to about it.

The Yellow Ribbon Program is a teen suicide prevention program started in 1994 in Westminster, Colorado by Dale and Dar Emme, following the death of their 17-year-old son, Mike. The program is used in all 50 states, Canadian provinces, and in 47 foreign countries. I started a chapter in Bedford, Pennsylvania in 1997 and am part of the many

people who speak out about youth suicide prevention. Please visit the Bedford County Chapter web site at [www.yellowribbon-pa.org](http://www.yellowribbon-pa.org). There is a link to the international web site and many other helpful sites. Please don’t read this and think you have nothing to worry about. We all have something to worry about....our future, our youth.

*Tina Henderson is the founder and director of the Bedford County, Pennsylvania, Chapter of the Yellow Ribbon Program.*

### **The Yellow Ribbon Program**

A well-known life skill during a fire emergency is “Stop, drop and roll.” The Yellow Ribbon Program teaches an important life skill for another life-threatening emergency, suicide: “Stay, listen and get.” The Yellow Ribbon Program distributes cards like the one below that young people can simply hand to someone if they are feeling suicidal and need help immediately.

The Yellow Ribbon Program’s main goal is prevention. The program provides suicide prevention gatekeeper training and post-prevention services. In association with teachers, counselors, and top suicide experts, the program has developed a simple *effective* program that empowers children, youth and adults to ask for help in times of crisis. It teaches how to respond to a crisis to help prevent suicide.

## **Child Death Review Teams as a Suicide Prevention Strategy**

By Vick Zittle

The Pennsylvania Child Death Review functions with two key objectives: to promote the safety and well-being of children and to reduce preventable child death. Fifty-three of the 67 counties in Pennsylvania convene Local Child Death Review Teams (CDRTs). They look for the answers to the following questions: why do children die in Pennsylvania and what strategies could be used to prevent another death?

These teams are comprised of local agencies and disciplines that routinely and systematically examine circumstances surrounding the deaths of Pennsylvania’s children ages 0-19. The experience of CDRT is a powerful testimony to the importance of understanding why children die and what efforts need to be undertaken to prevent future deaths. The mission of preventing childhood deaths is not only for public health agencies and child protective services, but also for all citizens.

Early this year, PA CDRT was one of many agencies, disciplines and citizens to work on a prevention plan focused on youth suicide. Through this process Pennsylvania will foster a continuous collaboration that will focus on 11 goals that were adapted from the National Strategy for Suicide Prevention. This collaboration also gave us an opportunity to meet with the entire team from Pennsylvania and to participate in sessions where they were requested to give input to the Pennsylvania Plan.

During this trip around the Commonwealth, we had the privilege of working with some very dynamic individuals and communities who are already working on local initiatives of the prevention of youth suicide. Most of these initiatives were developed because of just one child’s death. By talking to those involved with these initiatives, one soon realizes that their goal is to prevent another parent, family, friend or

community from experiencing this tragic event. They spoke about why the death occurred and what could have been done, but mostly they spoke about what they are doing now. They are truly committed to the process of prevention. Their motivation is seen in their words, actions, and diligence in their effort to have others hear them and never have to experience the tragedy that they have lived through.

One objective of CDRT is the collection and dissemination of data from CDRT reviews. The following is a brief summary of information from this data. As of September 2002, the state and local CDRTs reviewed 373 suicide deaths from 1997 through 2001. Of these 373 suicide deaths, 81% were males, 19% were females, 49% involved firearms, 36% were the result of hanging or other self-asphyxiation. For males, 55% used firearms, 35% were the result of hangings or other self-asphyxiation, and 10% used other methods. Twenty-seven percent of the females used firearms, 52% hanged or asphyxiated themselves, and 30% used other methods. The ages range from less than 10 to 19 years of age (CDRT only reviewed one death of someone over 20 years old).

At this time, the Pennsylvania CDRT does not offer any conclusion to the data collected and acknowledges that there continues to be a need for research and analysis on all data available. In 1999, the Surgeon General’s Call to Action to prevent suicide, which provided information from 1980 to 1996, reported that the rate of suicide among youth ages 15 to 19 years increased by 14 percent and among youth ages 10-14 by 100 percent.

Another objective is to create recommendations for prevention. Early this year, the state CDRT prioritized their prevention recommendations into four areas: infant deaths, agriculture safety, motor vehicle safety and suicide prevention. One of the recommendations for suicide prevention is to identify both state and local resources for suicide prevention: treatment, intervention, counseling programs, and grieving programs. We ask for your assistance in this project. Please forward information about suicide prevention programs to

me at [vzittle@paaap.org](mailto:vzittle@paaap.org) and include a contact person name, address, e-mail or phone number. If you have questions or need to share other information, please call us at (800) 916-9776. Remember, we are all partners in suicide prevention efforts.

*Vick Zittle is program director of the Pennsylvania Child Death Review Team sponsored by the Pennsylvania chapter of the American Academy of Pediatrics.*

## **Website Resources**

[www.samhsa.gov/centers/cmhs/cmhs.html](http://www.samhsa.gov/centers/cmhs/cmhs.html)

At the site of SAMHSA—the federal agency whose mission is to improve the quality and availability of prevention, treatment, and rehabilitative services—you can find additional information about national suicide initiatives.

[www.cdc.gov/ncipc/factsheets/suifacts.htm](http://www.cdc.gov/ncipc/factsheets/suifacts.htm)

The National Center for Injury Prevention and Control (NCIPC) is a branch of the Centers for Disease Control and Prevention. Its mission is to educate the public about suicide as a serious public health problem. Statistics, recent research briefs, and publications are available on this web site.

[www.afsp.org/index-1.htm](http://www.afsp.org/index-1.htm)

This is the site of the American Foundation for Suicide Prevention, which funds suicide prevention research and services for those affected by suicide.

[www.spanusa.org/](http://www.spanusa.org/)

The Suicide Prevention Advocacy Network supports those who have lost a loved one to suicide.

[www.mentalhealth.org/suicideprevention/calltoaction.asp](http://www.mentalhealth.org/suicideprevention/calltoaction.asp)

Here you can read the Surgeon General’s Call to Action to Prevent Suicide and find other useful links.

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