Our knowledge of youth suicide risk factors has burgeoned during the past twenty years. In a cumulative effort, the scientific community has identified risk factors for suicide attempts and completed suicide among youth. National mortality data, psychological autopsy studies, community surveys, and clinic-based studies have been conducted; findings have been replicated, extended, and validated. The result is an empirically-based consensus concerning risk factors for suicide attempts and completed suicide. Unfortunately, as noted by Eggert and her colleagues several years ago (Eggert, Thompson, Herting, & Nicholas, 1994), our knowledge of how to identify at-risk youth and intervene lags substantially behind our knowledge of risk factors.

Key risk factors for completed youth suicide are a past suicide attempt, mood disorder, alcohol or substance abuse, a pattern of aggressive or conduct disorder behavior, and availability of the means (e.g., King, 1997). Approximately ninety percent of youth suicide victims are known to have struggled with serious and identifiable psychopathology or mental disorder prior to their death (Brent, Perper, et al., 1988; Brent et al., 1993a; Marttunen, Aro, Henriksson, & Lonquiquist, 1991; Shaffer & Craft, 1999; Shafii Carrigan, Whittinghill, & Derrick, 1985). These same types of psychopathology have been associated with adolescent suicide attempts in a multitude of clinic-based (reviewed in King, 1997) and community-based studies (e.g., Lewinsohn, Rohde & Seeley, 1996), with depression being the most commonly diagnosed psychopathology among suicidal adolescents in treatment (deWilde, Kienhorst, Diekstra, & Wolters, 1993).
Thus, from a mental health perspective, the identification or recognition and referral of youth at risk -- those with serious psychopathology related to risk of suicidal behavior -- is central to suicide prevention efforts. Recognition and referral, however, cannot stand alone as a suicide prevention strategy. Early intervention and treatment are also essential components. This chapter will begin with a brief review of the status of our progress in these areas. This will provide background for a discussion of next steps and new directions. The emphasis is on broadening our research directions.

**CURRENT STATUS OF RECOGNITION AND REFERRAL STRATEGIES**

The recognition and referral of youth at risk requires an awareness of suicide risk factors, a willingness to attend to individual youth, and a willingness to take action. Many such recognition efforts are described in the guide to youth suicide prevention published by the Centers for Disease Control (CDC, 1992). This guide reviews prevention strategies, highlighting the status of development and evaluation efforts at the time of its publication. A number of suicide prevention specialists -- many with well-established, longstanding programs of research on youth suicide prevention -- have summarized the status of recognition and referral efforts more recently (e.g., Eggert, Thompson, Herting, & Nicholas, 1994; Kalafat & Ryerson, 1999; Mazza, 1997; Shaffer 1999). The review in this chapter will be brief, and readers are referred to these other sources for additional information.

**Gatekeeper Training and Student Education/Awareness Programs**

Gatekeeper training involves efforts to teach gatekeepers -- those in regular contact with youth -- about youth suicide risk and the "how to" of recognition and referral. Student-focused education and awareness programs are a variant of gatekeeper training, and are often combined with gatekeeper training for teachers, counselors, and others in school settings. As reviewed by Garland Shaffer & Whittle (1989), these programs have generally been targeted for entire school populations. They teach students about suicide risk factors, facts and myths about suicide, suicide warning signs, help-seeking strategies, and mental health resources. Although they have been described as "first-generation" prevention efforts (Eggert, Thompson, Herting, & Nicholas, 1995), the systematic development of such programs has continued (e.g., Kalafat & Ryerson, 1999; Washington State Youth Suicide Prevention Program, 1997). Goals are to reduce stigma, increase awareness of suicide risk factors, and promote self-referrals as well as the referral of peers at risk.

There have been relatively few evaluations of these efforts and findings have been mixed (as reviewed in Mazza, 1997). Some gatekeeper training efforts have resulted in an increase in both gatekeepers' knowledge of risk factors and in their likelihood of making referrals for mental health services. For instance, Kalafat and Elias (1994) evaluated the efficacy of a high school curriculum designed to increase the likelihood that the peers of potentially suicidal students will take appropriate action. In a comprehensive school-based suicide prevention program, education sessions were held for faculty, staff, and parents; procedures were shared for responding to at-risk students, and linkages were established with community