Advancing Suicide Prevention

January 2006
Volume II Issue 1

US $14.00 CAN $19.00

Youth Suicide

Schools and Suicide
The role of schools in protecting vulnerable youths

Storm Surge
Suicides in ravaged Gulf Coast area

Barriers to treatment
Issues that impede treatment of troubled youths

also inside:

- Researcher-attempter DeQuincy Lezine helps others
- Cognitive therapy reduces suicide risk
- Landmark IOM report

A suicide may be a personal act,

BUT WE ALL FEEL ITS EFFECTS.

In the United States, we lose 87 people a day to suicide. For every suicide at least six people will be left to make sense of it. At least six people will grapple with feelings of loss, despair, and guilt.

Each year, over 180,000 individuals become suicide survivors. Suicide impacts families, communities, and society as a whole. That's why suicide is a public health problem. **That's why we all need to be part of the solution.**

OPENING MINDS. CHANGING POLICY. SAVING LIVES.

SPAN USA

SUICIDE PREVENTION ACTION NETWORK USA

1025 VERMONT AVE., NW • SUITE 1066 • WASHINGTON, DC 20005 • P (202) 449-3600 • F (202) 449-3601 • WWW.SPANUSA.ORG

Advancing Suicide Prevention™

Powerful insights driving suicide prevention forward™

Senior Editor
Denise Pazur

Art Director
Cathryn Landgraf

Circulation Director
Hervey Evans

Advertising Sales Assistant
Tammy Butzen

Web Director
Erika Hutchings

Copy Editor
Ann Bernard

Editorial Offices
629 North 8th Street, Suite 203
Sheboygan, Wisconsin 53081-4502
Phone 920-457-4033
Fax 920-457-4011
advancingsp.com

Advancing Suicide Prevention™
(ISSN 1554-4508) is published by
PDV Communications Inc.

POSTMASTER: See page 31

January 2006
Volume II Issue 1

Printed in the U.S.A.

PDV • COMMUNICATIONS Inc.

Message from the Editorial Advisory Board

The most vulnerable among us: Our children

"A child can't be depressed." It's what we adults told ourselves for years, when mood disorders and thoughts of suicide were shrouded in stigma and shame.

Today we know better. We've heard about depression. We've heard about substance abuse. We've heard about bipolar disorder and the risk factors for suicide. Yet it's still so difficult to conceive the inner torment that could spur a child to consider ending his or her life.

It's still so difficult to conceive the inner torment that could spur a child to consider ending his or her life.

It was back in the 1990s that I first became involved in working with suicidal youths when I worked in the emergency room of a hospital in the Bronx. There was very little in the scientific literature then about suicidal children.

Yet I saw so many youngsters who were so ill. Children as young as 5 who were severely psychotic with bizarre preoccupations and thoughts of suicide. A morbidly depressed 8-year-old child with a very strong genetic history of mood disorders. A 12-year-old youngster who completed suicide after enduring years of bullying. Children who experienced the worst kind of loss, including the suicide of a parent. The intensity of their response was exceptional and heartbreaking.

Preventing someone—including a child—from taking their life requires we do some key things. First, we need to identify those who are more likely to attempt or complete suicide. Once we've identified these people at risk, we may be able to intervene before they get too close to the edge.

Second, we need to know what to do to help a suicidal child back away from that abyss.

Perhaps most important, we need to recognize that children do indeed kill themselves, and many more attempt suicide. Our nation's mortality data do not lie. Rates of suicide in children age 10–14 have increased since the 1950s by 300 percent. And suicide is today the third leading killer of young people ages 10–24.

Only when we accept this difficult truth can we reduce suicide among those most vulnerable among us—our children.

Cynthia R. Pfeffer, MD
Professor of Psychiatry
Director, Childhood Bereavement Program
Weill Medical College of Cornell University

A Special Message from Charles G. Curie

Suicide is a thief that is stealing our children and our future

One young person contemplating suicide grips our hearts. Nine hundred thousand young people contemplating suicide grips our collective conscience.

Suicide is a preventable tragedy. It is a thief that seeks victims from all races, socioeconomic classes and age groups, even America's youth.

Newly released data from the 2004 National Survey on Drug Use and Health reveal that approximately 900,000 youths ages 12–17 made a plan to commit suicide during their worst or most recent episode of major depression, and 712,000 acted on that plan by attempting suicide.

One young person contemplating suicide grips our hearts. Nine hundred thousand young people contemplating suicide grips our collective conscience.

Fortunately, we have made great progress in identifying risk and protective factors for suicide. We know that mood disorders and substance-use disorders, especially in combination, increase the risk of suicide in young people, and strong family bonds and school success can foster resilience.

To put this knowledge into practice, SAMHSA supports a suicide prevention resource center, suicide prevention efforts on college campuses, and state and tribal youth suicide prevention and early intervention programs across the country. We have also launched the National Suicide Prevention Lifeline at 1-800-273-TALK and www.suicidepreventionlifeline.org.

Working together in public-private partnerships, we can help end the silence of suicide and eliminate the stigma of seeking mental health services.

Charles G. Curie, MA, ACSW
Administrator
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Advancing Suicide Prevention™

Powerful insights driving suicide prevention forward™

PREMIER PARTNER

SPAN USA
SUICIDE PREVENTION ACTION NETWORK USA

your turn

LETTERS TO THE EDITOR

Preparing psychologists to practice in underserved rural areas

Congratulations on your July/August issue devoted to rural suicide. While the gradual decline in national rates of suicide in recent years has been welcome news, it is less well-known that rates of suicide in rural areas continue to significantly exceed rates in urban areas. Rates among rural males in particular have increased substantially in the past two decades, while rates among urban males have declined, and the trend is toward *increasing* disparity in mental health services between urban and rural America. Our doctoral program in clinical psychology here at Marshall University endeavors to prepare psychologists specifically for practice in underserved rural areas. I used your special issue to bring the topic of rural suicide alive to our students in a way that would have been impossible merely using abstract epidemiological data. Thanks for providing this unique and valuable resource.

Thomas E. Ellis
PsyD, ABPP
Professor of Psychology
Marshall University
Huntington, West Virginia
ellist@marshall.edu
304-696-2776

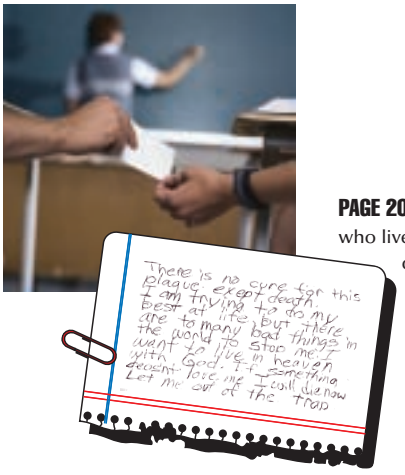
Please send your comments and letters to yourturn@advancingsp.com. Letters are published at the editor's discretion and may be edited for length. If you prefer that your letter not be published, please let us know.

CONTENTS features

January 2006 Volume II Issue 1

PAGE 8 Both emergency workers and residents of Gulf Coast areas are susceptible to psychological fallout in the wake of the hurricanes' devastation.

PAGE 25 Barriers to treating suicidal youths are staggering, formidable and can have dire and deadly consequences.



PAGE 20 Actual notes from a youngster who lived for seven years with clinical depression show the despair in a child so young.

CONTENTS departments

January 2006 Volume II Issue 1

PAGE 6 Talk therapy is shown to reduce suicide risk in a landmark study.

PAGE 12 Researcher DeQuincy Lezine survived suicide attempts to develop better prevention methods for others.

PAGE 10 Hollywood actress Margot Kidder displays not only great talent but great courage in sharing her struggle with suicidal thoughts and bipolar disorder.

PAGE 28 Mark your calendar for key upcoming events including the 39th annual conference of the American Association of Suicidology April 28–May 1 in Seattle, Washington.

RECENT RELEVANT RESEARCH

Talk therapy shown to reduce suicide risk in landmark study

Attempted suicide is one of the strongest risk factors for completed suicide in adults. Alarmingly, even one previous attempt multiplies suicide risk by 38–40 times. Yet few interventions specifically designed to prevent suicide attempts have been evaluated. This landmark study does just that, demonstrating that cognitive therapy reduced *almost by half* the risk of repeat suicide attempts in patients who recently attempted suicide. This is one of the most rigorous tests ever of a psychotherapy technique in people whose attempts to die by their own hand have been serious enough for hospitalization. Research trials typically exclude such patients, in part because they are more prone to die by suicide when compared with individuals who are not as suicidal. By including these high-risk individuals in the trial, researchers learned what worked for them—and it was cognitive therapy. This trial recruited 120 adults from the emergency department of a university hospital after trying to kill themselves. Averaging in their mid-thirties, patients had multiple problems, including substance-use disorders, depression and homelessness, and many of them were already taking drugs for depression. Participants were randomly assigned to cognitive therapy or usual care, i.e., services available within the community. Those in the cognitive group were scheduled to receive 10 outpatient weekly or biweekly cognitive therapy sessions specifically developed to prevent suicide attempts. Sessions

helped patients find more effective ways of viewing and coping with problems, and how to better handle negative thoughts and feelings of hopelessness. Because suicide is the fourth leading cause of death for adults under age 65, this ground-breaking study has important public health implications given its effectiveness for preventing repeat attempts.

Cognitive Therapy for the Prevention of Suicide Attempts: A Randomized Controlled Trial. G. K. Brown, T. Ten Have, G. R. Henriques, S. X. Xie, J. E. Hollander, A. T. Beck. JAMA. 2005 Aug 3; 294(55):563-570.

Physician education is key

Physician education in depression prevents suicide. So does restricting access to lethal means. This is borne out by a comprehensive review of research literature from 1966 to June 2005 for effectiveness of suicide-preventive interventions. Conducted by experts from 15 countries, findings show that physician education in depression recognition and treatment, and restricting access to lethal methods do indeed reduce suicide rates. Other interventions need more evidence of efficacy. This review is key for professionals to optimize use of limited resources and gauge which programs and elements are effective in reducing rates of attempted and completed suicide.

Suicide Prevention Strategies: A Systematic Review. J. J. Mann, A. Apter, J. Bertolote, A. Beautrais, D. Currier, A. Haas, U. Hegerl, J. Lonnqvist, K. Malone, A. Marusic, L. Mehlum, G. Patton, M. Phillips, W. Rutz, Z. Rihmer, A. Schmidtke, D. Shaffer, M. Silverman, Y. Takahashi, A. Varnik, D. Wasserman, P. Yip, H. Hendin. JAMA. 2005 Oct 26; 294(16):2064-74.

Cultural factors are critical

Variations in suicide rates among different regions and different racial and ethnic groups suggest the importance of cultural factors as determinants of suicide risk. Using the *Reasons for Living Inventory* (RFLI), this study examined possible protective factors for suicide in adult Latinos. Four hundred and sixty subjects with major depression, bipolar disorder or schizophrenia were recruited and divided into a Latino (N=49) and non-Latino group (N=411). Adult Latinos made less lethal attempts and reported significantly less ideation than their non-Latino counterparts. They also scored higher on scales of survival and coping beliefs, responsibility to family and moral objections to suicide than the comparison group. These constructs may represent Latino cultural norms that act as protective factors against suicide.

Protective Factors Against Suicidal Behavior in Latinos. M. A. Oquendo, D. Dragatsi, J. Harkavy-Friedman, K. Dervic, D. Currier, A. K. Burke, et al. J Nerv Ment Dis. 2005 193(7), 438-443.

Seattle. April 2006.

You need to be there.

Because preventing suicide is *everyone's business.*

Whether you're a physician or public official, social worker or pastoral counselor, family practice attorney or academic researcher, clinician or community crisis interventionist, suicide prevention is relevant to you and your work.

Cutting edge research, best practices in suicide prevention, clinical practice updates ... the art and science of suicide prevention, all at the American Association of Suicidology. It's the field's premier annual conference, drawing scores of professionals from across the globe who share their research, practice, experience, insight and successes. Learn about the leadership role that AAS takes in developing strategies, defining positions and influencing public policy to prevent suicide in our country—and our world. Join with world experts and colleagues in Seattle next spring. And make suicide and its prevention your business too.

Mark Your Calendar! Save the Date!

39th Annual AAS Conference

SCIENCE AND PRACTICE IN SUICIDOLOGY:
Promoting Collaboration, Integration and Understanding

April 28 — May 1, 2006 Seattle, Washington

Many Disciplines. Many Voices. Saving Lives Together.

For more information: www.suicidology.org

American Association of Suicidology

202-237-2280

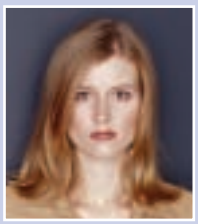
"This year's theme reflects the importance of considering multiple perspectives on suicidal behaviors, and integrating these perspectives to increase our ability to prevent suicide."

PUBLIC HEALTH SPECIALIST

SOCIAL WORKER

PHYSICIAN

RESEARCHER & POLICYMAKER



EDUCATOR

A rescued baby cries in the arms of a policewoman after being brought to land on a boat from floodwaters in New Orleans. Both the rescued and rescuers are susceptible to psychological fallout from the vast devastation that ravaged the Gulf Coast area last year, according to experts.

Storm *surge*

Rising suicides begin to ripple through battered Gulf Coast

The suicides are starting to swell. These deaths—sudden, violent and wrenching—bring a whole new wave of grief and despair to former Gulf Coast residents, some of them now back home, most still displaced in makeshift living quarters throughout the country.

These suicides also bring risk for more deaths. That's because losing someone to suicide places those close to the deceased at heightened risk for dying by suicide themselves.

"This displacement is more like from a war. People are scattered. Kids are dropped into schools," says Frank Campbell, PhD, LCSW, executive director of the Baton Rouge Crisis Intervention Center (BRCIC) Foundation. Campbell noted that phones at the center rang non-stop in the wake of Katrina. As for his staff? They're fighting compassion fatigue, according to Campbell, just like thousands of other emergency responders and caregivers, some of whom have seen more devastation and heartache than they can bear.

Among these are Paul Accardo and Lawrence Celestine, the two New Orleans police officers who died in September by their own hand, using their own guns. Their deaths, yet another emotional blow to their grieving NOPD colleagues, were only the beginning of rising suicides in the hurricanes' wake.

Flood of trouble

Louisiana survivors of suicide loss reflect on how self-inflicted death inflicts torment on others

"What kind of help do survivors need? One does not 'get over' a suicide. The effects may stabilize, but the loss is forever felt. Personal values and beliefs are shattered. The individual is changed emotionally …. All need help in understanding suicide and what it has done to their lives."

Suicide loss survivor Tony Salvatore

"The months following my father's death were unbearable. I was overwhelmed by emotions and thoughts that I didn't understand. My confusion was leading me to the exact place my father was when he decided to end his life."

Suicide loss survivor Kari Millet

"I got a call one night at midnight, that a young man, a college student, had shot and killed himself in his apartment …. Four years ago this young man's dad had killed himself, and according to the roommate … this had weighed heavily on his mind, had actually eaten him up on the inside, and he had no one to talk to or help him with his feelings. Had support and immediate response been in place four years ago, and this young man … may not have been where he was last night, cold and alone and dead by his own hand, so full of pain and hopelessness and self-hatred."

Suicide loss survivor Mark Wilson

These quotes are from survivors of suicide loss, some of whom participate in the LOSS Team, a pioneering "postvention" service developed by the Baton Rouge Crisis Intervention Center to support newly bereaved victims of suicide loss. For more see brcic.org.

On December 7 *The Washington Post* reported that the number of suicides in Jefferson Parish is more than double what it was in fall 2004. Nearly half of residents of Orleans and Jefferson Parishes were experiencing "significant distress or dysfunction" according to a survey conducted in October by the Centers for Disease Control and Prevention (CDC). Suicidal thoughts, planning and attempts also appear to be on the rise, along with symptoms suggestive of post-traumatic stress disorder, say emergency responders, state officials and crisis interventionists.

"We're seeing a substantial increase in people with suicidal ideation," notes John Draper, PhD, executive director of 1-800-273-TALK, a national suicide-prevention hotline. Calls to the network from Gulf Coast states Louisiana, Mississippi and Texas have increased more than threefold since Katrina, according to Draper. Peaking in late September, calls are now at about 300 per week—*triple* the call level from this region prior to Katrina.

Yet, in the midst of these troubling indications, the Louisiana Department of Mental Health is preparing for 2006 budget cuts of 5 percent that may go even deeper.

"I'll tell you, it's not a good forecast for the future," says the BRCIC's Campbell, an expert on surviving traumatic loss including that brought about by suicide. "The compassion fatigue is incredible. We're heading into a spiral."

Campbell's concern is consistent with research emphasizing the need for *immediate* mental health support after severe disasters. A just-released study of suicide after the 1999 Taiwan Chi-Chi earthquake, published in the December 2005 *Acta Psychiatrica Scandinavica*, found that suicide rates among the high-exposure group were more than *40 percent higher* during the 26 months following the earthquake. This points to the critical need to provide strengthened psychiatric services during the first year following major disasters.

INSIGHT

Taking a cue from cancer

Shining a light on suicide to combat stigma and aid in prevention efforts

Suicide prevention is a newly burgeoning field, and there is much to learn from other established arenas in health and prevention. These include cancer, formerly laden with stigma but now openly talked about. And while suicide isn't a "disease" as is cancer, the stigma that impeded progress in cancer research and treatment is today the same sort of detriment to progress in suicide prevention.

Actress Margot Kidder is perhaps best known for her role as Lois Lane in *Superman* (1978), costarring with Christopher Reeve. She spoke of her suicide attempt and struggle with bipolar disorder at a national conference last October for suicide attempters and their support systems.

"We can take lessons from cancer. If you turn the clock back, it was just not talked about," said Charles G. Curie, administrator of SAMHSA, the Substance Abuse and Mental Health Services Administration. Curie spoke out at the 2005 SPAN USA National Awareness Event in Washington, D.C.

"We didn't understand cancer; we were afraid to deal with it. It was one of people's greatest fears," continued Curie in an address to prevention advocates who gathered from across the country at this annual event. "Today people know more regarding what works, that cancer is not a death sentence—that there's hope."

Curie went on to talk about courageous people who step forward to acknowledge a suicide attempt, yet move on to gain help and hope.

These include gifted people such as actress Margot Kidder, psychiatrist Ken Tullis, author Susan Rose Blauner, artist Deenie Kenner McKay and researcher DeQuincy Lezine (see accompanying story on page 12). These and others who had attempted to end their lives spoke at a landmark conference last October in Memphis. Sponsored by OASSIS (oassis.org) with support from SAMHSA, the gathering was the first national conference for survivors of suicide attempts—and the people who care for them and about them.

OPINION

Suicide rate debate

Youth suicide rates have tripled since the 1950s. Why? Why do more of today's youngsters feel that life is not worth living, that death is the way out of the pain of day-to-day life? David Lester has an opinion. A noted expert on suicide and prolific author and researcher, Lester has written and edited over 70 books during his 40-year career, including *Katie's Diary: Unlocking the Mystery of a Suicide*. "It's a very different kind of life we lead today," says Lester, pointing to today's teens, many having cars and $120 sneakers. "Marginal people look at everybody else, at TV and the incredible lifestyles put forth, and they say, 'Why am I so depressed'? I think when life gets easier, those of us who are unhappy get worse. We have lots of time to sit around and think about our unhappiness." In contrast, Lester cites his own childhood, growing up in London during World War II, with both parents working 6-day weeks, 12 hours a day to make ends meet. "We say, 'Life is so hard for kids today.' But I don't think the conditions of adolescence have changed that greatly," Lester adds. "You begin to worry about issues that when life was harder, you don't worry about—you don't have time to worry about. Like life and the meaning of life. "

WHAT'S YOUR OPINION?
E-mail us at yourturn@advancingsp.com

HURDLE

Forward progress, but miles to go

Youth suicide prevention got a boost with federal grants last fall to communities, colleges and states totaling just over $7 million. It was the first time Congress had appropriated funds solely for youth suicide prevention and early intervention. This support was a step in the right direction, say advocates. But more needs to be done, including full funding of the Garrett Lee Smith Memorial Act (P.L. 108-355), authorizing $82 million over three years for youth suicide prevention and signed into law by President Bush over a year ago. "The job's not done," notes Jerry Reed, executive director of the Suicide Prevention Action Network (SPAN USA) in Washington, D.C.

"When you look at the tremendous public health burden of suicide—30,000 deaths a year, 650,000 attempts—there must be an equal or congruent response, adds Reed. "We have this in other arenas. We need it in suicide prevention, and we need it now. This is life or death. And suicide is preventable. This investment is vital."

FEDERAL FUNDING FOR YOUTH SUICIDE PREVENTION

$82 million
authorized over the next 3 years

$7 million
allocated so far

Bright Mind

DeQuincy Lezine applies a firsthand understanding of suicidal despair to develop better prevention methods for others

Perhaps no one is better-suited to help suicidal individuals than someone who has experienced the dreadful depths of suicidal despair. DeQuincy Lezine is one of those people. Raised in a family of four in Los Angeles, Lezine witnessed firsthand family members grappling with alcoholism, drug abuse, depression, mania, psychoses and suicide attempts. Overcoming tremendous odds, Lezine entered Brown University in 1995. There he attempted suicide three times before being diagnosed with bipolar disorder, or manic depression. His illness and personal experience, coupled with his insight and empathy, spurred Lezine to organize the nation's first college-based chapter of SPAN USA, the Suicide Prevention Action Network. He went on to achieve national prominence in suicide prevention advocacy, and was the only youth invited to participate in the formation of the 2001 National Strategy for Suicide Prevention. Last fall, Lezine, 28, began a new chapter in his life as a postdoctoral student at the University of Rochester. There he works with university colleagues, plus nonprofit and federal partners, to develop and evaluate sound suicide prevention programs for colleges.

Advocacy is a big part of your work in suicide prevention. When did you first take this up?
In college I saw people expelled from a dorm or forced to take a medical leave. Other students were frightened by these people's symptoms. The ACLU got involved; someone died by suicide. And the media picked up on it. All that together made me feel that more needed to be done than psychological services or what the administration was offering.

You spoke about fear. What did other students observe that made them fearful of someone with mental illness?
Self-cutting. Increased activity associated with mania, physical activity, a lot more social activity. People being more extroverted, more artistic. People sitting in the halls or in shared common areas, doing stuff throughout the night.

Why would that be frightening to others?
They didn't know what to make of it. If you are delusional, paranoid, you might think people are watching you, out to get you. Or something's happening to your body.

This fear is born in ignorance, wouldn't you say?
Yes. Some people understood what was going on because they had some psych classes. But, in orientation, we weren't told that some of our dorm mates might have depression, anxiety. So they had never seen it.

What do you think has to happen to help this situation, this lack of understanding that colleges—both students and staff—have about mental illness?
There has to be something about psychological services during orientation. College counseling centers typically focus on first, the stress of classes. Second, finding new peer networks. Third, study skills. But no explanation of mental illness, or if you experience mood disorders, that help is available and that you can recover from it. Nothing to share with your peers either. →

Bright Mind *(continued)*

Why do you think college counseling centers sometimes avoid discussing mental illness?
Counselors are more familiar with these other things. It's a fairly recent trend that more people with mental illness are popping up on their radar screens. Perhaps it's medications, treatments that enable those with mental illness to go to college. Or better screening so they're aware of their disorder and are seeking help. They're coming in because they're depressed and suicidal. Today more and more colleges are paying attention to it, particularly after a student dies by suicide. They're being proactive.

How do you manage these days with your illness?
It varies a lot. At certain times I'm doing well, so well that I question whether I have a disorder at all. I question whether I need meds. I've gone off, gone back on. I've not seen the doctor as often as I should.

Do you avoid going do the doctor when you're in a depressive episode; are you immobilized to some extent by that and don't seek help then?
No. I *definitely* go to the doctor when I'm depressed. Too depressed or too "up." That's when I know it's real; there's definitely something here I'm struggling with. I can be doing well on meds, in therapy. But it breaks through. Maybe it's the time of year, or chemically-based or too much stress, and I feel it a lot.

How do you get through these times?
I almost always can say I've seen worse days.

The most important thing is just caring. It's the inclination most people would have if someone was physically ill and felt like they were dying.

Is it trite to say to someone who may be suicidal that things can turn on a dime?
No. Things *can* change very quickly. When I lost my best friend—she was murdered—she was one of the people at Brown who helped me get through bouts of depression and feeling suicidal.

What did she do to help you?
She was just there for me. She listened to me, didn't judge me. She always believed I'd get through. That I deserved to get through, deserved to be happy. She was someone to hold the belief that my life was worth living.

Do you feel that's what kept you here, kept you from completing suicide?
Definitely. She was more instrumental than the therapy and the meds.

What can people do to help someone who may be suicidal?
The most important thing is just caring. It's the inclination most people would have if someone was physically ill and felt like they were dying. They'd be compassionate, caring, listen to them, help them out.

Does killing yourself take courage?
I'm not sure that's the right word. Is it scary? Yes. It definitely takes more willpower. It's incredibly scary to think about ending your life. A battle occurs in the mind. Is it the right thing to do? The right time? Then how to do it? When people get past that, they may practice or go over it in their mind until it feels more comfortable. Some people decide it's easier if they drink (alcohol) to facilitate it.

Is it seductive?
The very first couple of times it's more frightening. But at some point it becomes more comforting to think of death as a way out of the pain, confusion, chaos, whatever is so unbearable. Somewhere, on some level, it's a stress reliever—dying and not having to deal with everything. The pain and agony of whatever the situation is—the only time there's relief is the thought of being dead.

Is suicidal thinking addictive?
You hold it in a special relationship: This is where I can go to get some relief from the pain. Not that the majority of people would want to use death as a first way out. Some people think of death as the only way out. But if we can help them decrease the painful circumstances and increase their personal problem solving to find solutions to what is currently troubling them, it can give them hope to try that.

Would you choose to be bipolar if you could?
I have a lot of ambivalence about that question. There are definite benefits to

having it, benefits to self and to other people. I learn from my experience and use it in my work to help others. When I look at the benefits and think what would I be doing if I didn't have it, it's hard to say. I think overall I'd stay with it. But that's partially based on my philosophy to learn as much as I possibly can from life's experiences, and learn to make life better in the future and try to help other people. A

Contact DeQuincy Lezine at the University of Rochester Medical Center, 300 Crittenden Blvd., Rochester, NY 14642 or e-mail him at Dequincy_Lezine@urmc.rochester.edu. For more on his personal story, see *Children of Jonah: Personal Stories by Survivors of Suicide Attempts,* edited by James T. Clemons, PhD, and published in 2001 by Capitol Books (ISBN 1-892123-54-1).

OMISSION

Our apologies

In the last issue of *Advancing Suicide Prevention*, our State of Mind interview with Iowa farmer-psychologist Mike Rosmann was missing his contact information:

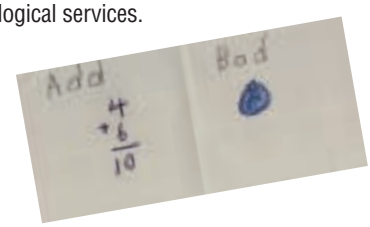
Mike Rosmann at AgriWellness, Inc., 1210 7th Street, Suite C, Harlan, IA 51537 712-235-6100 or info@agriwellnes.org. Founded in 2001, AgriWellness is a network of seven Midwestern states that promotes accessible behavioral health supports for the agricultural community. This nonprofit publicly funded corporation serves farmers, ranchers, farmworkers and the associated farm business community and their families. For more information visit agriwellness.org.

"School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge."

Carnegie Task Force
on Education

schools and suicide

As a psychologist in a New York City school district in the early 1990s, Susan Williamson saw far too many youngsters in need of psychological services.



But one story stays with her. It was that of a seven-year-old boy who talked about putting a knife into his heart. Williamson snagged the youngster by his belt as he tried to throw himself down a flight of stairs. Perhaps the event that summed up this child's despair occurred when Williamson was in her office on the phone with social services. The child was with her. "He crawled into my wastepaper basket. The symbolism struck me. He felt totally alone and worthless. Like a throwaway child," Williamson recalls. The unsettling incident happened 15 years ago. Yet it is still very present in her thoughts and work today as a school psychologist in Plymouth, Wisconsin. →

"We're talking about **millions of school-age children who are losing hope** in themselves and their future." This is youth suicide: tragic, shocking, incomprehensible.

—A. KATHRYN POWER, MEd, Director, Center for Mental Health Services, SAMHSA, U.S. Department of Health and Human Services

Jonathan Zablotny awoke at 6:45 a.m. on a Tuesday last February. The high school senior got out of bed, showered, ate breakfast, and departed for his school five blocks from his San Francisco home. He never made it. Instead he jumped from a bridge that day, his backpack, filled with schoolbooks and binders, still strapped to his back.

Jonathan's father Ray Zablotny, a clinical psychiatrist who has practiced for 25 years, served on his hospital's suicide review committee until his son's death.

"I can't do it anymore," says Zablotny of his committee role. "You do all you can to protect them. And then this happens."

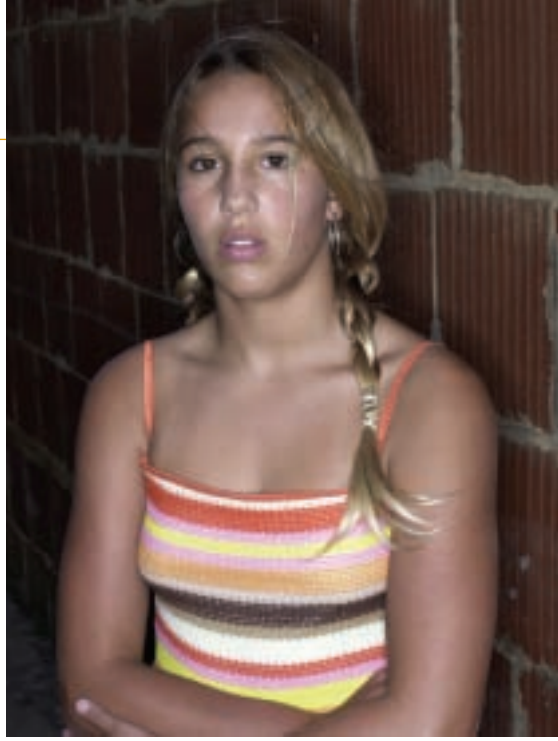
Jonathan is one of thousands of children and young adults who die tragically by their own hand each year. A heartbreaking yet often preventable tragedy, suicide is *the third leading cause* of death among 10- to 24-year-olds. Moreover, experts estimate that only 1 out of every 100 to 200 youth suicide attempts result in death.

The upshot? In a typical high school classroom, it's likely that three students have made a suicide attempt in the past year, according to the American Association of Suicidology.

Since the 1950s suicide among youths ages 15–24 has increased by **200%**

The numbers don't improve for post-high school young adults, with suicide rising to be the second leading cause of death for college students. Among them is University of Pennsylvania running back Kyle Ambrogi, a 21-year-old college senior who killed himself on October 11, two days after scoring two touchdowns in what was reported to be one of the best games of his career. Friends and teammates knew Ambrogi suffered from depression, but thought he had been getting better recently, reported *The Daily Pennsylvanian*.

"We're losing 4000 children every year to an outcome that's preventable. The ripple effect of that is huge," says psychiatrist-researcher Morton M. Silverman, MD, an expert on youth suicide and former director of the Student Counseling and Resource Service at the University of Chicago. "Research shows eight or more people are affected quite dramatically by each death. And there's the morbidity associated with suicidal behavior among hundreds of thousands of people. The cost to society is huge. For every youth suicide death, there can be 100 or more attempts; hundreds of thousands of visits to emergency rooms each year for suicidal behaviors. That's a drain on all kinds of economic systems. And a lot of people who attempt, will repeat; they have a higher risk for dying by suicide."



More than one in four Hispanic girls in grades 5–12 report symptoms of depression. And Hispanic adolescent girls have higher rates of reported suicide attempts than Non-Hispanic White and Black adolescent girls or boys. Yet because of language, cultural, economic and other barriers, far too few of these vulnerable youngsters receive the mental health services they desperately need.

These statistics—and the real people behind them—distress A. Kathryn Power, director of the Center for Mental Health Services at SAMHSA, the Substance Abuse and Mental Health Services Administration. Power addressed the topic of youth suicide at the August 2005 national conference of the U.S. Department of Education's Office of Safe and Drug-Free Schools.

"We're talking about millions of school-age children who are losing hope in themselves and their future," she said. "This is youth suicide: tragic, shocking, incomprehensible. Angry, guilty and bewildered, we find ourselves asking, 'Why are these children giving up on themselves? What signs did we miss? What can we do to prevent this tragedy from happening again?'"

Schools—a fitting place for suicide prevention?

Halting youth suicide has become a focus at federal, state, tribal and local levels. And schools are among the key settings where suicide prevention can occur, according to experts in education, pediatrics, child psychiatry and violence prevention.

"Schools have a mandate to educate and protect students. It's in the legislation state by state," says Rutgers University researcher John Kalafat, PhD, an expert in implementing and evaluating school-based suicide prevention programs. "The kids are there already—that's where you're going to find them. So that's where prevention and intervention can occur."

Because they interact with children during so much of the day, staff can pick up on changes in performance that are precursors for troubled behaviors in children. Wisconsin educator Linda Larson knows this all too well. An experienced elementary-level teacher with a master's degree in education and "tons of psychology courses," Larson was still unable to recognize early signs of mental illness in her fifth-grade son Adam, the eldest of her three children.

"I remember the principal in my elementary school had a whole lot of background on troubled adolescents," recalls Linda, with the clarity of hindsight. "He spoke to me about Adam and the signs he saw for potential trouble later. He even put an EAP (employee assistance program) slip in my mailbox at school."

Linda saw her former boss nine years later, after her son had dropped out of high school and endured years of substance abuse. He ended his own life on April 22, 1992, at age 20.

"I told my former principal, 'You saw this coming a long time ago, didn't you?' But as parents, we didn't accept it at the time. He was our first child. We didn't accept the message right away." →

By the numbers

45%
College students who reported they feel so depressed that they can barely function (American College Health Association survey)

900,000
Youths who planned suicide during their worst or most recent episode of major depression, with 712,000 attempting suicide during such episodes (SAMHSA)

124,409
Visits to U.S. emergency departments after attempted suicides or other self-harm incidents among persons ages 10–24 years (CDC)

16.9%
Students in grades 9–12 who have seriously considered attempting suicide during the past 12 months (CDC)

Emotional disturbances in young children can indicate potential for mental illness and thoughts of suicide as they grow older.

Young struggles

In its National Comorbidity Survey Replication (NCS-R) released in July 2005, the National Institute of Mental Health (NIMH) revealed the incredible prevalence of mental illnesses, the early age of onset and the tragically long delay before most individuals sought treatment.

Often emerging in childhood

The age of onset for most mental disorders is concentrated in a narrow range during the first two decades of life. Surprisingly, half of all lifetime cases of mental illness begin by age 14, and three-quarters of illnesses by age 24.

These are the sorts of red flags that parents or the community may not recognize, but schools—by virtue of their unique roles—can see. These include sexual promiscuity, substance abuse, emotional disorders and propensity for violence, turned both outward and inward.

"All the things society sort of dumps on schools," Kalafat muses. "But I think we as a society all share the failure. For better or worse, schools are the site for a lot of prevention programs."

Youths may confide in friends about feelings and thoughts, including those of suicide. Yet most peers are ill-equipped to deal with these matters of life or death.

Additionally, schools can at times be the source of bullying and other problems that can lead to suicide. Therefore it seems appropriate that schools take steps to minimize factors that lead to student alienation and despair.

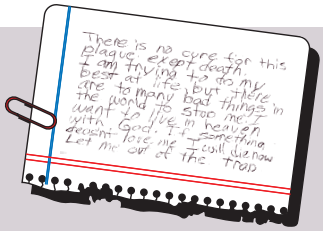
Psychiatrist-researcher Silverman agrees that schools indeed are a fitting place for suicide prevention.

"Schools have a significant role. I have no doubt about that," he says."How does that role mesh with their stated mission and goals?" asks Silverman. "Is suicide prevention an add-on or extension of what they're doing? How is it perceived, adapted, accepted and funded?"

All good questions. And with answers that vary among states and from one district to another, depending on the mind-set and priorities of those who set school policy.

Emphasis on academics

Rosemary Rubin thinks schools should be engaged in prevention so kids don't start down the continuum of self-destructive behaviors that can culminate in suicide. Co-chair of the Los Angeles County Child and Adolescent Suicide Review committee, Rubin works in the LA Unified School District and has spent a decade in its suicide prevention unit. Her experiences with suicidal children as young as 10 years



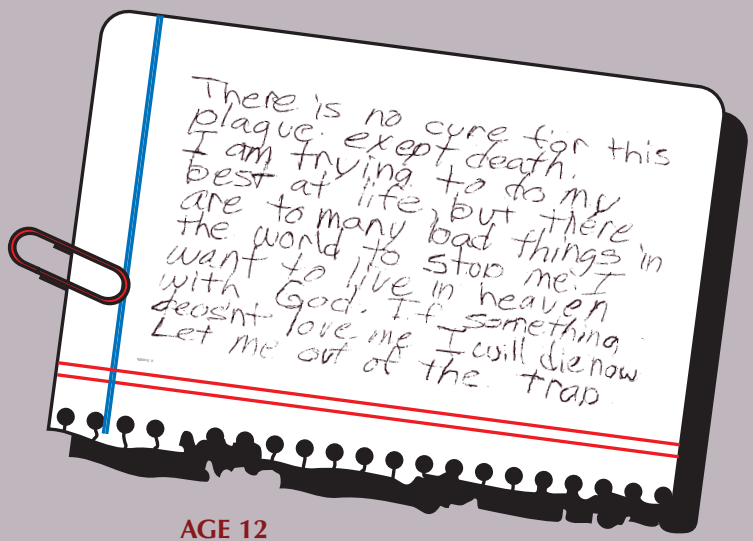
EDITOR'S NOTE: The original notes and artwork presented here were shared by parents of a child who, at age 11, was tested for ADHD when he was in the 4th grade. Instead, the diagnosis was severe clinical depression with suicidal ideation. Seven years later this child took his life. He had just turned 18, was a month into his senior year of high school, and considered studying art and architecture in college.

More common than we think

Mental disorders are highly prevalent with about half of Americans meeting the criteria for a DSM-IV diagnosis over the course of their lifetime, and with first onset usually in childhood or adolescence.

Not recognized or treated quickly enough

Documenting long delays between the onset of a mental disorder and first treatment, the NCS-R suggests that the earlier in life a disorder begins, the slower the individual is to seek therapy—and the more persistent the illness.



AGE 12
Excerpt from letter to psychotherapist

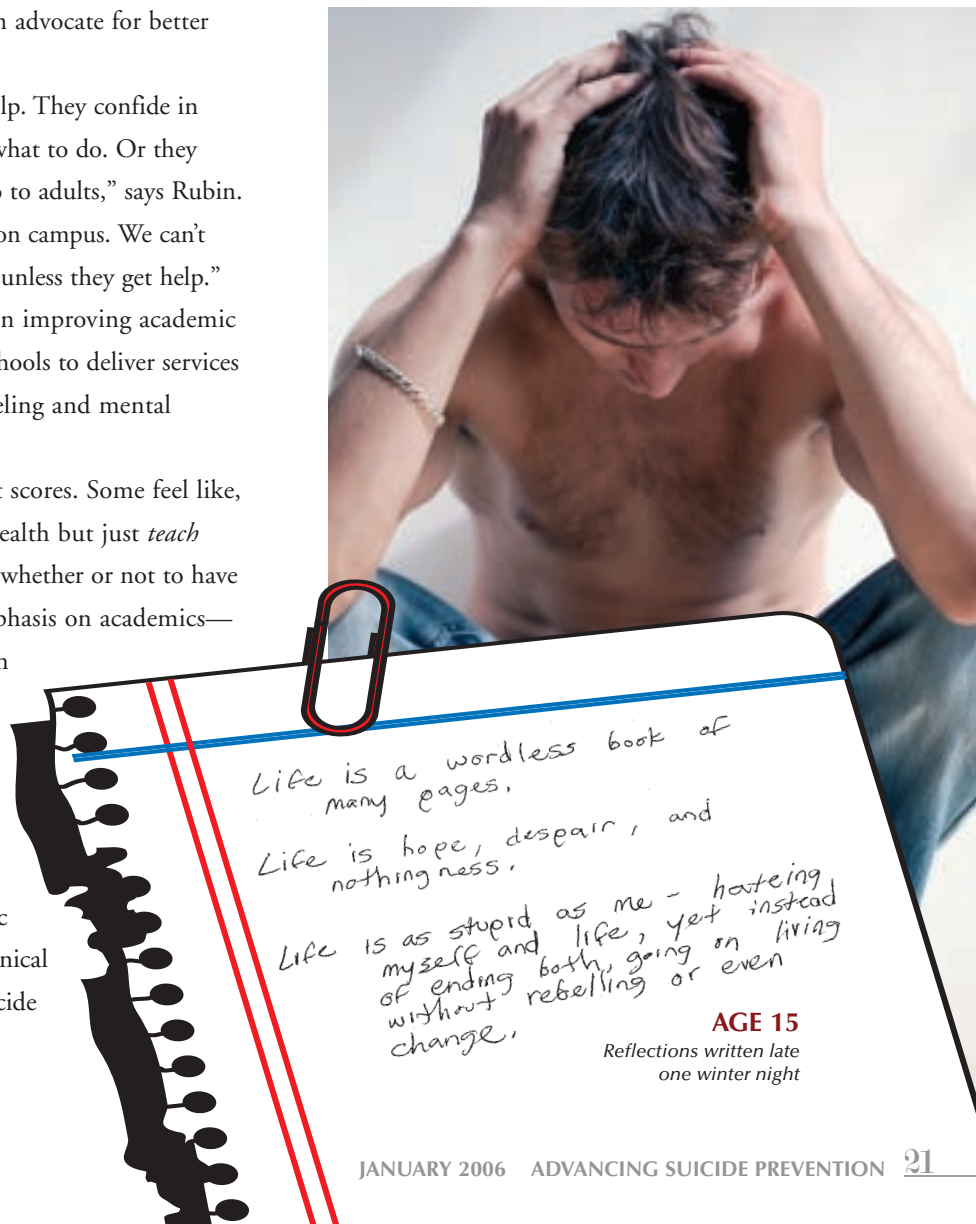
old has left its mark on Rubin and made her an advocate for better suicide prevention in schools.

"So many kids have a hard time getting help. They confide in peers, and peers for the most part don't know what to do. Or they won't break a confidence; they don't want to go to adults," says Rubin. "Administrators need to know suicidal kids are on campus. We can't ignore them. They won't benefit from learning unless they get help."

Rubin believes that the recent emphasis on improving academic performance has compromised the ability of schools to deliver services that address the whole child, including counseling and mental health services.

"Schools are so focused on improving test scores. Some feel like, 'What we need to do is *not* focus on mental health but just *teach better*,'" Rubin notes. "Schools are questioning whether or not to have mental health counselors on campus. The emphasis on academics—especially among low-achieving schools—is an outcome of the *No Child Left Behind* mentality, and it's tied to funding dollars. But these low-performing schools may be the ones who need mental health counselors most."

When a child is suicidal, involving parents can be challenging, especially in ethnic communities. Sherry Davis Molock, PhD, a clinical psychologist and researcher who focuses on suicide among diverse populations, explains why. →

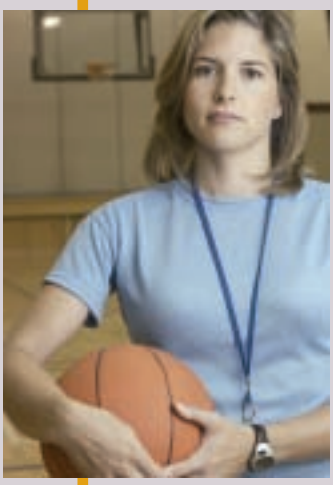


AGE 15
Reflections written late one winter night

Gatekeepers

People who can intervene to help troubled, vulnerable or suicidal youths include:

- Teachers
- Parents
- Siblings
- Relatives
- Peer friends
- Guidance counselors
- School psychologists



- Coaches
- School bus drivers
- Health-care workers
- Police officers
- Librarians

- School administrators
- Substance-use counselors
- Juvenile detention staff

Youngsters from ethnic or impoverished communities face struggles that can place them at increased risk for suicide.

"Participating in a school setting for families in communities of color can be a challenge," notes Molock. "Either they can't get off work, or they need transportation or child care. Some distrust the school system; they've felt the system has been racist or oppressive. They perceive a program as being punitive, and that puts it at a disadvantage. They may see it as a way of labeling their child as being deviant or bad. Parents sometimes feel, 'I won't trust you with my child's education, so why would I trust you with their mental health?'"

Delivering services to children in need is only one aspect of suicide prevention. Another aspect is teaching all children what good mental health is comprised of—and how to recognize signs for suicide in themselves or others.

"Schools can really help by building depression, anxiety, impulsivity into regular biology or health classes," says David Shaffer, MD, professor of psychiatry and pediatrics at Columbia University/New York State Psychiatric Institute. Shaffer is a renowned expert in youth suicide prevention. "The average child doesn't have any conception of what depression is, as an illness. They're aware of medication because a lot are on it. But they don't know what's involved in treatment. They don't know the subtle signs of depression—criticizing of self, feeling unwanted by other people. These cognitive aspects of depression are not known (by children), not talked about. I don't know why they're not being taught. We need a movement behind this, a curriculum behind it."

Shaffer notes that even more treatable than depression is anxiety—performance, separation and social in nature, and all prevalent among school and college youths. Yet if anxiety disorders go untreated, they can make one vulnerable to depression and thoughts of suicide.

"Anxiety is so common, so well understood that I think we should do more," adds Shaffer.

Scared to death

When it comes to suicide and schools, many adults are scared to death to address this, and misperceptions remain.

"Schools are very hesitant. They're afraid to talk about suicide for fear it will give students ideas," says Nora Howley, project director for HIV/School Health with the Council of Chief State School Officers (CCSSO).

Yet research shows that asking teenagers about suicide won't make them more likely to contemplate it, as some parents and school officials fear.

"This is an astounding impediment to these (suicide prevention) programs," says Madelyn Gould, PhD, MPH, a researcher at Columbia University and New York Psychiatric Institute. Gould was the lead author on an important study published last year that demonstrated no untoward effects of suicide screening emerging with two days of screening among students of New York City suburban high schools.

"Asking about suicide clearly didn't induce stress; it clearly relieved somebody in distress," adds Gould. "Kids think they can handle this on their own, yet on the other hand they're waiting for someone to ask them."

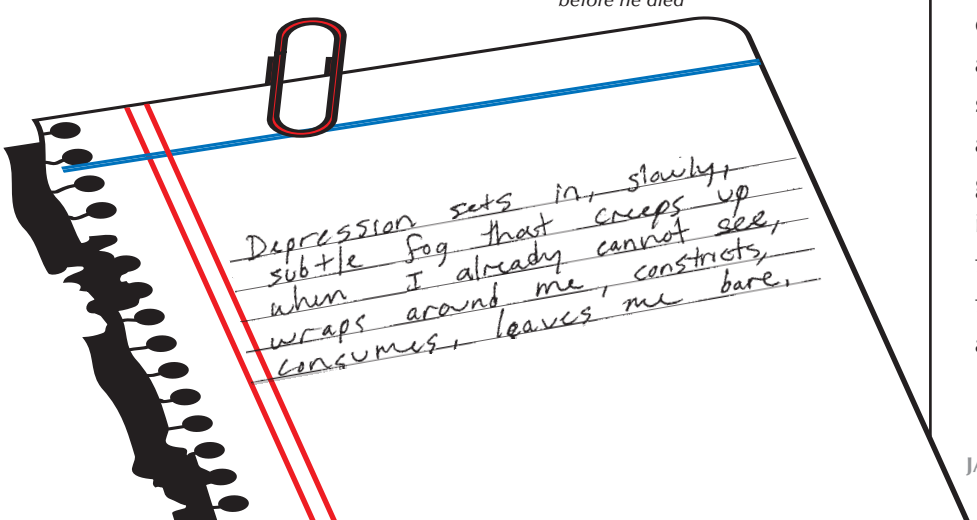
But saying the "s" word in school isn't the only fear schools have.

"And there's the contagion effect and the impact of celebrity suicide," continues CCSSO's Howley. "Quite frankly, schools try to include a lot. Prevention programs are important for schools to have. But how each state or district actualizes that varies. There are demands on school time. There's also liability—what happens if we train for something and then miss something? This is what schools are grappling with."

Susan Wooley, executive director of ASHA, the American School Health Association, agrees. →

AGE 18

Journal entry written a month before he died

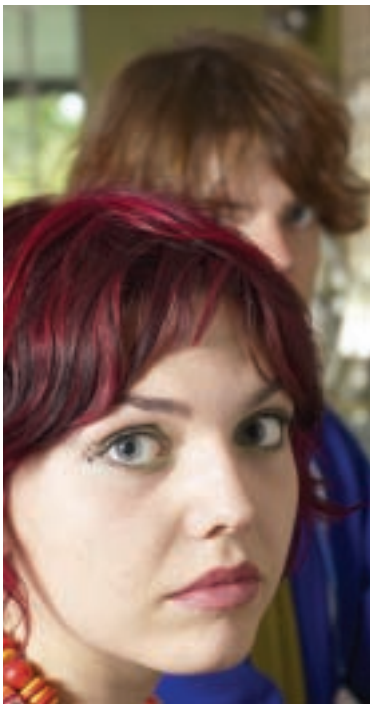


Suicide:
Not an isolated event

Emotional problems in children and adolescents can be both serious and long-lasting—and may frequently lead to consequences such as:

- ✔ **Poor academic achievement**
- ✔ **Social isolation**
- ✔ **Failure to complete high school**
- ✔ **Self-medication with drugs or alcohol**
- ✔ **Promiscuity**
- ✔ **Involvement in correctional system**
- ✔ **Lack of vocational success**
- ✔ **Inability to live independently**
- ✔ **Health problems**
- ✔ **Suicide**

The settings that affect children's emotional well-being run broad and deep, including their families, schools, communities, employers and our nation at large. So it makes good sense to address mental health issues in children at early stages, and for many reasons including ethical, familial, occupational, financial—and societal.



Girls attempt suicide four times as often as boys, but boys die more frequently by their own hand, in part because they are prone to use more lethal means.

"By the time someone is in the 11th or 12th grade, **it's a little late to start talking suicide prevention.** It's a little late to talk about coping skills, resiliency, competency. You're behind the curve."

—MORTON M. SILVERMAN, MD, University of Chicago

"Suicide prevention is a controversial topic. It's typically covered in school health in places that address it. But a lot of schools don't," says Wooley.

Last year her organization issued a resolution on suicide prevention and intervention in schools. But ultimately schools have autonomy in how—and if—they choose to treat suicide education in the classroom setting.

"There's not one curriculum out there, and not one thing all schools do," Wooley notes. "Schools just don't work that way."

Even for schools willing to address suicide prevention, the challenge is where to fit it into the curriculum. Some dovetail suicide into instruction on recognizing depression and how to get help. But very few elementary schools address mental illness or depression—much less suicide—in classroom instruction, according to Wooley.

"It's more likely when some event happens. It's unfortunate that it occurs after the event rather than before," she notes.

Yet psychiatrist-researcher Silverman sees appropriate elementary-level instruction as pivotal in addressing not only suicide but a host of other related and destructive behaviors.

"By the time someone is in the 11th or 12th grade, it's a little late to start talking suicide prevention," notes Silverman. "It's a little late to talk about coping skills, resiliency, competency. You're behind the curve."

Helping the whole child

Suicide typically doesn't occur in isolation. Other factors are usually present such as access to weapons, engaging in unprotected sex, clinical depression, bullying, tobacco use and drinking alcohol.

"Everybody won't have all of them. But if you have one, you're likely to have more," says David A. Brent, MD, academic chief of child and adolescent psychiatry at the University of Pittsburgh School of Medicine.

So when families, schools or clinicians see risk-taking behaviors in youths, behaviors that could lead to suicide, approaching the whole child is critical.

"That can be potentially life threatening," warns Brent of a singular or silo approach to treating a child with multiple risk factors. "The question is how to help the whole kid without overwhelming the clinician, school or family."

Brent sees school-based health clinics as a step in the right direction. These centers provide physical and mental health services to children in need of care—and at locations accessible to them. Their numbers have grown to nearly 1500 in the 2001/2002 school year, according to 2003 data released by the Robert Wood Johnson Foundation.

"School-based clinics, something between student counseling and intensive clinics, are good. A place where kids get help on campus and wouldn't have to go to another facility," notes Brent.

"They are a lot more beneficial because students can be referred internally, meaning low hassle and earlier intervention. For those at-risk kids who aren't in school but in correctional facilities, it's the same model: it's integrating mental health care in some place where the kids already are." →

Issues that impede treatment of children and teens

Barriers to treating suicidal youths are staggering, formidable and can have dire and deadly consequences. These barriers include:

Youths' reluctance to seek help

Harmful attitudes about help-seeking behaviors among vulnerable adolescents are real and life threatening. Research shows that youths at most serious risk for depression and suicidal ideation are the ones who often reject reaching out for help. Alarmingly, they are much more likely than their stable peers to feel that suicidal thoughts should be handled by oneself, and are unlikely to advise suicidal friends to seek out a mental health professional.

Access to guns

Suicide can be an impulsive act, particularly among youths. When a gun is used, the suicide attempt is likely to be fatal. So giving depressed or suicidal youths access to guns—no matter what the justification—can be deadly. This is supported by research showing that areas with higher household gun ownership rates have higher suicide rates, even when controlling for things also associated with suicide, like divorce rates and unemployment.

Severe shortage of child mental health practitioners

There are only about 7400 child and adolescent psychiatrists in the United States, with most practicing in highly populated areas. Yet, conservatively about 12 percent of U.S. children and adolescents suffer from functionally impairing mental disorders, according to cautious estimates from the Institute of Medicine and National Institute of Mental Health. This dearth of child psychiatrists places a burden on pediatricians, family physicians and others to identify at-risk children—and make referral and treatment decisions for which they may be inadequately trained.

Fragmented services

Identifying youngsters at risk for suicide is only a first step; getting them help is critical to saving lives. That can be a challenge for schools, parents and others who must identify fragmented community services and integrate those services to best serve vulnerable children.

Stigma and parental resistance

Facing the fact that their child could be suicidal is more than many parents can emotionally bear. In defense they may contend their child's problems aren't that serious. Or their parenting skills may be impaired by mental illnesses or addictive disorders of their own. Other reasons for parental resistance in getting help for suicidal children can include societal stigma toward suicide and mental illness, an assumption that the parent is always going to be blamed, insensitivity or lack of understanding about actual risk for suicide in their child, or privacy issues and having family matters opened to public scrutiny.

Financial limits

Over 43 million Americans lack health insurance, and those who have coverage often face discriminatory and strict limits imposed on mental health services. Yet suicidal youths may require intensive treatment that is not covered by health insurance, or can wipe out coverage in a brief period of time.

Antidepressant medication safety warnings

The number of antidepressant prescriptions dispensed to youths 18 and under dropped significantly after the FDA issued a strong warning regarding their safety in 2004. While use of antidepressants in children and adolescents has been controversial, some fear backlash from this warning may put emotionally disturbed youngsters at risk. Those who might benefit from medication may no longer have access to it because of fears of parents or prescribing physicians.

Threat of litigation

Recent lawsuits brought against school districts and universities whose students have completed suicide have made many educators take notice. They've also brought attention to evidence-based school interventions that address youth suicide. Yet some schools remain reticent to implement effective, comprehensive programs and policies, even though *absence* of these may place students, staff and school districts at risk.

"The competent community is where **everybody tries to support and take care of one another**—and where they have the competence to do that." —JOHN KALAFAT, PhD, Rutgers University

The competent community

A key in deterring a child from engaging in risky behaviors—including suicidal thoughts and acts—is how engaged the youngster feels to both family and school. This is according to research, including findings from the 1997 National Longitudinal Study on Adolescent Health. In fact, a feeling of connectedness was the number-one protective factor for students against suicidal behavior according to the study, which surveyed more than 90,000 students in grades 7–12.

"Drifting, not being engaged in family or school has a very strong association with suicide in young men," the University of Pittsburgh's Brent adds. "So increasing the connection to school, family and others is good."

A caring, competent and connected community is critical to suicide prevention, say experts. This "competent community" offers a climate where students feel respected, supported and comfortable with approaching an adult when facing problems. It's where prevention programs are not short-term or delivered in isolation, but well-integrated. And it has strong community links with parents, health providers, social services, juvenile justice, treatment facilities and other institutions.

Being engaged in family, school and community is a key to preventing suicide. It's important for youths to feel comfortable, connected, respected and supported by peers and adults.

"The Air Force took up this theme. That's the model: Leaders dedicated to protecting members of the community," says school suicide prevention expert Kalafat. He is referring to the U.S. Air Force suicide prevention initiative which uses a system-wide community approach and has been shown to markedly reduce rates of suicide among enlisted personnel.

Yet building a competent community that can address youth suicide is challenging. Priorities vary for school administrators, parents, staff, children and community agencies. And critical issues may be neglected because different community stakeholders have limited time, scopes of responsibility and views regarding suicide.

"The stigma associated with suicide is huge," notes the University of Chicago's Silverman. "So it's not simple to convince principals and school administrators that this is a needed, important, valuable part of their curriculum."

Kalafat agrees and notes that inundated school administrators think twice about adding another element to their curricula or campus services, especially when it has to do with suicide.

"Schools are dealing with so many things. And they think, 'How often does suicide occur, and how often on school grounds?'" Kalafat notes. "An administrator will tell me, 'Look, I'm having to deal with violence, drugs, pregnant teens, an increasingly heterogeneous student population—some of which are totally unprepared to learn. Tell me why I have to deal with this.'"

But that's exactly the point. Sound suicide prevention programs can have many spin-off benefits, according to research, sort of a "halo effect" in curbing other youth risk behaviors.

"We have to convince school administrators that a competent community is what they'd support. That it dovetails with a good school climate where we support and respect each other," adds Kalafat. And that means not just focusing on suicide prevention, but on reduction of substance abuse, violence, bullying and other benefits that can accompany it. It's about building help-seeking behaviors in general among youngsters—and having people trained to respond appropriately to these children when they reach out."

SUICIDE PREVENTION PROGRAMS FOR SCHOOL SETTINGS

School-based suicide prevention programs can include suicide-awareness curricula, screening, gatekeeper training, peer helper programs, postvention/crisis intervention or skills training. Care should be taken when selecting a program because some have not been shown effective. Below are programs worthy of consideration from SPRC, the Suicide Prevention Resource Center (sprc.org). Also see The Youth Suicide Prevention School-Based Guide, a valuable and comprehensive tool for schools at theguide.fmhi.usf.edu/.

EFFECTIVE

C-Care/CAST
(Coping and Support Training)
Combines one-on-one counseling with small-group training sessions
Target ages: 14–18
Info: elainet@u.washington.edu

PROMISING

Lifelines
Curriculum on warning signs of suicide, how to respond to a suicidal peer, help-seeking and school resources
Target ages: 12–17
Info: kalafat@rci.rutgers.edu

Reconnecting Youth
Semester-long class for youths with at-risk behaviors; teacher and peer group support is core hypothesis
Target ages: 14–18
Info: beth.mcnamara@comcast.net

Zuni Life Skills Development
Culturally tailored intervention to improve communication, increase goal setting, manage anger and depression, respond appropriately to a suicidal peer
Target ages: 14–18
Info: lafrom@stanford.edu

Columbia TeenScreen®
Screens teens (with parental permission) to identify those at greatest risk so that appropriate intervention can occur
Target ages: 11–18
Info: teenscreen@childpsych.columbia.edu

SOS Signs of Suicide®
Combines two prominent strategies into single program: curriculum and screening
Target ages: 14–18
Info: highschool@mentalhealthscreening.org

UNRATED

ASIST
Knowledge of warning signs, how to help
Info: info@livingworks.net

Yellow Ribbon®
Promotes help-seeking behavior
Info: Ask4help@yellowribbon.org

EFFECTIVE: Utilized superior evaluation methods. PROMISING: Evaluated with less rigorous methods or showed moderate causal link between program and outcomes. UNRATED: Theoretically sound but not sufficiently evaluated to place them in other categories.

IOM issues landmark report

Carter Center Mental Health Task Force founder Rosalynn Carter discussed the new IOM report's policy implications with experts who gathered in Atlanta last November.

On November 1 the Institute of Medicine of the National Academies released a landmark report relevant to suicide prevention. *Improving the Quality of Health Care for Mental and Substance-Use Conditions* addresses a critical chasm between major medical research advances and applying these to treatment of people with these disorders. Each year millions of Americans receive health care for these conditions, which can, if unchecked, lead to thoughts of suicide. They are the leading causes of disability and death of women and the second highest of men. Effective treatments exist and continually improve. Yet deficiencies in care delivery prevent many from receiving appropriate and potentially lifesaving treatments. That situation has serious consequences—for people with these conditions, their loved ones, workplaces, education, welfare and justice systems and our nation overall. To purchase a copy of this newly released IOM report, visit iom.edu/report.asp?id=30836.

CORRECTION

On page 23 in Volume I Issue 2, we called out six U.S. counties with the highest rates of suicide from 1999–2002. Our data interpretation was incorrect. Here are the top six U.S. counties: Alaska – Nome – 84.1/100,000; Alaska – Yukon-Koyukuk – 72.0/100,000; Alaska – Northwest Arctic – 69.2/100,000; New Mexico – Sierra – 43.8/100,000; Tennessee – DeKalb – 42.8/100,000; Oregon – Curry – 37.7/100,000.

CALENDAR

National Health Policy Conference
AcademyHealth

Insights on critical health care issues confronting policymakers.

February 6–7
academyhealth.org

2006 Military Suicide Prevention Conference
United States Department of Defense

Annual event on prevention initiatives.

February 6–9
Hollywood, Florida
www.ha.osd.mil/2006mspc

4th Aeschi Conference
Aeschi Working Group

Biennial international forum on new developments to treat suicidal patients.

March 1–4
Aeschi, Switzerland
www.aeschiconference.unibe.ch

Depression on College Campuses
University of Michigan Depression Center

4th annual conference will consider the university's role in responding to crisis, disaster and loss.

March 21–22
Ann Arbor, Michigan
med.umich.edu/depression

100 Years of School Social Work
School Social Work Association of America (SSWAA)

March 29–April 1
Boston
sswaa.org

Prevention is an Intervention
National Association of School Psychologists (NASP)

March 28–April 1
Anaheim, California
nasponline.org

GAINS Center National Conference
Substance Abuse and Mental Health Services Administration, U.S. DHHS

System transformation at the interface of the criminal justice and mental health systems

April 5–7
Boston
gainscenter.samhsa.gov

Science and Practice in Suicidology: Promoting Collaboration, Integration and Understanding
American Association of Suicidology (AAS)

39th annual conference gathering professionals from across the globe representing many disciplines and many voices. These include health policymakers, physicians, mental health attorneys, academic researchers, clinicians, crisis interventionists and survivors of suicide loss and attempt.

April 28–May 1
Seattle
suicidology.org

THE FACE OF DEPRESSION.

He was the youngest of seven children in a close-knit family. He had supportive parents and 17 nieces and nephews. He earned a college degree and held a meaningful job in the financial industry. He had lots of good friends who would do anything for him.

Yet he still died by suicide.

Charlie Kubly took his life in 2003 after a long struggle with depression. He was just 28 years old. And he was one of more than 30,000 American who die by suicide each year. As a society, we talk openly about other diseases, yet we don't talk openly about depression and mental illness. That has to change. So that people like Charlie, with so much to give and so much to live for, can find the hope and help they need to recover, carry on—and live life to the fullest.

charlie's Fund

THE CHARLES E. KUBLY FOUNDATION

A PUBLIC CHARITY DEVOTED TO IMPROVING
THE LIVES OF THOSE AFFECTED BY DEPRESSION.

Attend our annual **Beyond the Blues** music festival, Saturday, September 16, 2006, at the Milwaukee County Zoo. Funds raised support important mental health projects in Wisconsin. Visit www.charlesekublyfoundation.org or call 414.962.0918.


"No one talks about depression. No one has depression in a Latino community."
—Rodolfo Palma-Lulión, College Student
Real Men. Real Depression.
"I was really trying to get out of depression alone. It was really pushing people away. I couldn't sit through classes at all. When I involved other people, it became easier. The more I told professors, 'Look, I'm going through depression ...I'm having a hard time dealing with this,' the easier it got to deal with." Depression is a real disease that can be successfully treated. For information, call 1-866-227-6464, visit www.nimh.nih.gov, or contact your health care provider.
It takes courage to ask for help. Rodolfo did.
NIMH
National Institute of Mental Health
National Institutes of Health

Overview

Advancing Suicide Prevention™ (ISSN 1554-4508) is a strategic health policy magazine for professionals in all arenas impacting suicide prevention or whose work places them in contact with suicidal individuals. These include professionals in health care, social and human services, policy development, advocacy, education, research, legal and law enforcement, corrections, crisis intervention, pastoral and bereavement counseling. The magazine is owned by PDV Communications Inc.

Circulation

20,000 core base, controlled

Advertising

Closing date is approximately 60 days before the month of publication. Please call for exact deadline. For rate card and other information visit advancingsp.com or call 920-457-4033.

Sponsorships

Sponsorships of special supplements, inserts and more are available. Call 920-457-4033 for more information.

Subscription Services

Subscribe online
advancingsp.com

Orders, inquiries and address changes
Advancing Suicide Prevention
Phone: 866-457-4077
Fax: 800-869-0040
Email: ASPcs@magserv.com
Address: *Advancing Suicide Prevention*
P.O. Box 16495
North Hollywood, CA 91615-6495

Annual rates
US $47.00
Canada $67.00
International $75.00

Payments accepted
VISA, MasterCard
Checks in U.S. dollars payable to PDV Communications Inc.

Article Reprints and Permissions

Contact Customer Service Department at PDV Communications to order reprints or to obtain permissions to copy, quote or translate *Advancing Suicide Prevention* articles. Reprints are available in hard copy, as electronic downloads with permission to print, and in customized versions.

For information or to order
Customer Service Department
PDV Communications Inc.
629 North 8th Street, Suite 203
Sheboygan, WI 53081-4502
Phone: 920-457-4033
(8 a.m.–5 p.m. CST weekdays)
Fax: 920-457-4011
Email: clandgraf@advancingsp.com

Reprint Prices

1–9 copies	$7.00 each
10–49	$6.50
50–79	$6.00
80–99	$5.50
100–499	$5.00

(Minimum order $50. Discounts apply to multiple copies of the same article.)

Custom and Quantity Orders
For quantity estimates or quotes on customized reprints, call 920-457-4033, fax 920-457-4011 or email clandgraf@advancingsp.com

Privacy Statement

Advancing Suicide Prevention makes reasonable efforts to ensure that privacy issues are handled responsibly.

Disclaimer

Opinions, when presented in the pages of *Advancing Suicide Prevention,* are those of the person being quoted and do not necessarily reflect the views of sponsors, advertisers, editorial advisory board or publisher. Although great care has been taken in compiling and checking the information in this publication to ensure accuracy, PDV Communications Inc. and its servants or agents shall not be responsible or in any way liable for the continued currency of the information or for any errors, omissions or inaccuracies in this magazine, whether arising from negligence or otherwise or for any consequences arising therefrom. Also PDV Communications Inc. and its servants or agents shall not be responsible or in any way liable for advertiser-generated inaccuracies, nor should advertiser presence be construed as endorsement by PDV Communications Inc. and its servants or agents. Individuals should consult with their own health care providers on issues related to their specific situations. This magazine is not a substitute for such consultation. The *Advancing Suicide Prevention* editorial advisory board provides insight and other editorial support. In no way are they responsible for the views presented in *Advancing Suicide Prevention.*

Coming Soon

POPULATION AT RISK

SUICIDE AMONG THE AGED

Highest rates for suicide in the U.S. are among the elderly. Yet depression and thoughts of suicide do not have to be part of aging. Don't miss this key issue that considers the mental health and well-being of our aging population.

also in this issue:

- **Treatment Options**
  Better access, better treatment as Baby Boomers age
- **Stigma and Shame**
  Conspiracy of silence and its toll
- **Parity for Mental Health**
  An update

Postmaster

Send domestic address changes, orders and inquiries to *Advancing Suicide Prevention*, Subscription Services, P.O. Box 16495, North Hollywood, CA 91615-6495. Standard postage paid at Random Lake, Wis. and additional mailing offices. Printed in the U.S.A. *Advancing Suicide Prevention* (ISSN 1554-4508) is published by PDV Communications Inc., 629 North 8th St., Suite 203, Sheboygan, WI 53081-4502.

Incarcerated teens in a holding cell in Cobb County Jail, Marietta, Georgia, February 2, 2005

On any given night in juvenile detention facilities across the United States, more than 1900 vulnerable youths are warehoused as a last resort while awaiting mental health treatment that is not available. In two-thirds of these units, youths either attempt suicide or attack others. Yet resources to treat them—or the estimated 65 to 75 percent of youth offenders with psychiatric disorders—are sorely lacking. The fallout? Suicide rates in juvenile detention and correctional facilities that are *more than four times higher* than youth suicide in the general population. Advocates for juvenile justice say society needs to do more to treat mental illness in youths rather than sending them to jail.

Adolescent Maltreatment - Alcohol and Teens Athlete Alcohol and Drug Use - Community-based Prevention Models - Dating Violence - Depression Domestic Violence and Youth - Drunk Driving Countermeasures - Eating Disorders - Gambling Grief and Bereavement - Harm Reduction - Help Seeking Behaviors - Homeless Youth - Inhalant Abuse - Involving and Engaging Youth in After-School Programs - Juvenile Bullying - Juvenile Delinquency - Juvenile Sex Offenders - Lesbian, Gay, and Bisexual Students - Mentoring - Outreach to Hispanic Students & Their Families - Positive Youth Development - Post-Traumatic Stress Disorder Pregnancy Prevention - Resiliency - School Based Alcohol and Drug Use Prevention Models - School and Gun Violence - School Dropout Prevention Self-Injury - Suicide Prevention - Tattooing and Body Piercing - Teen Fathers - Teen Mothers Teenage Tobacco Use - Youth Gang Violence

Let's just say that we know prevention.

The Prevention Researcher

www.TPRonline.org

460 COMMUNITIES IN 42 STATES ARE WORKING TO PREVENT SUICIDE WITH TEENSCREEN

Can we help you start or expand your program?

The Columbia University TeenScreen Program is an evidence-based youth suicide prevention program that partners with government agencies, mental health organizations and school districts to establish voluntary mental health screening programs for teens.

The program uses questionnaires developed and tested for more than a decade that screen for the leading risk factors of suicide—including depression, substance abuse and previous suicide attempts.

Parents of students identified as at possible risk are notified and offered assistance in connecting with local mental health services.

Screening takes place in schools, community centers, homeless shelters, foster care, doctors' offices, and other youth-focused organizations and settings.

Through the generosity of private donors, TeenScreen provides free consultation, materials, training and support to select program partners. TeenScreen does not receive funding from the pharmaceutical industry.

If we can help you offer families in your community the chance for confidential youth mental health screenings, please call us at **866-TEENSCREEN** or visit us at **www.TeenScreen.org.**

Columbia University
TeenScreen® Program
Mental Health Check-ups for Youth