the Clearinghouse

The Key ASSISTANCE REPORT

Focus on YOUTH SUICIDE

National Mental Health Consumers' Self-Help Clearinghouse

IN THIS ISSUE

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FOUR TOO MANY

Something had to be done. Immediately. And immediately *again*. And *again*.

Four students from Neshaminy High School's class of 2006 had killed themselves—three in the same year—and several more had attempted suicide and survived. The school, in Langhorne, Pa., a middle-class suburb of Philadelphia, has about 2,400 students. The national suicide rate for teens aged 15 to 19 is four a year per *50,000* people.

Yes, yes, something *had* to be done. But what?

Early on, the school's Student Assistance Program set in motion its standing crisis-response plan, offering support groups to help students deal with their grief. But, after four deaths, an unprecedented number of troubled, shaken kids were flocking to guidance counselors. Many of the kids exhibited symptoms of post-traumatic stress disorder, or PTSD, a disabling condition often marked by repeated flashbacks of traumatic events.

Student assistance workers reacted to the deluge by creating a "safe place" in the school's social work office, where they linked distressed kids to sources of support. Neshaminy plans to replace the makeshift drop-in center with a formal one where staff will provide services to kids in crisis on any given day.

Meanwhile, district officials, like an increasing number of others across the country, are researching additional suicide prevention programs to find the most promising—and appropriate—for its students.

A NATIONAL PRIORITY

Efforts like Neshaminy's have gained steam since the U.S. Surgeon General's 1999 Call to Action to Prevent Suicide made youth suicide prevention a national priority. President George W. Bush's New Freedom Commission on Mental Health also called for measures to address the issue, and Bush received bipartisan support in 2004 for the

Garrett Lee Smith Memorial Act, which earmarked $82 million for youth suicide prevention initiatives. The act was named for U.S. Sen. Gordon Smith's (R-Ore.) son, who took his life in 2003.

Suicide ranks third among causes of death for Americans aged 15 to 24 years, behind accidents and homicides. The most recent statistics from the U.S. Centers for Disease Control and Prevention (CDC) set the annual rate at 10 suicides per 100,000 youth, so suicide is relatively rare. But experts say it is highly preventable and that the fatalities are the tip of an iceberg. According to the American Association of Suicidology (AAS), an estimated 100 to 200 youth try to kill themselves for every one who dies of suicide; and many, many more think about suicide but don't attempt it.

TO PREVENT AND PROTECT

Most prevention strategies have not been studied enough to gauge effectiveness, and some approaches may have detrimental effects that are difficult to measure. The Suicide Prevention Resource Center (SPRC) offers a registry of evidence-based practices that can be accessed through its Web site at ww.sprc.org. Even with expert guidance, however, choosing an appropriate program is difficult. Zeroing in on suicidal youth is an imprecise science. Although many who fall into high-risk categories do not attempt suicide, danger generally increases with the number of risk factors involved.

Experts say more than 90 percent of youth who die of suicide have at least one diagnosable mental disorder. Mood disorders, alcohol or drug abuse (in males), and conduct disorders are most common, according to Madelyn S. Gould, a Columbia University professor and youth suicide expert. Risk is especially high for youth who have both mood and substance abuse disorders.

Other key factors include having already attempted suicide; having read, seen or heard about recent suicide attempts; and having access to firearms, which are involved in more than 60 percent of teen suicides. Most fatal attempts by youth are triggered by legal or disciplinary problems and/or the dissolution of a romantic relationship, Gould said.

Some factors have been found to protect youth against risk factors or buffer their effects. These include receiving treatment for mental disorders, having very limited access to firearms, family cohesion and practicing a religion.

Gender Discrepancy

Female youth in the United States attempt suicide more often than their male counterparts, but the males are five times more likely to die of suicide. Experts say the difference probably relates to choice of method. In the United States, males tend to use more lethal means, such as guns, than the medication overdoses favored by females.

Planning for Crisis and Recovery

Mary Ellen Copeland's Mental Health Recovery & WRAP Web site includes printable crisis- and post-crisis planning guides. Links to the worksheets appear near the bottom of the main page: www.mentalhealthrecovery.com.

AN OPEN WINDOW

Experts stress that suicidal people don't want to die but view killing themselves as the only way to end their pain. Youth may be especially susceptible to hopelessness because most have relatively little life experience and don't know that they can rebound from a cri-

CALLING FOR HELP

Native Youth Crisis Hotline
1-877-209-1266
Native Americans aged 15-24 years have the highest suicide rate in their age group—more than triple the national average. This toll-free, 24-hour hotline was established to help these youth cope with issues such as suicidality, violence, drug/alcohol abuse, and tobacco addiction. Accessible from the U.S. and Canada.

The Trevor Helpline for GLBTQ youth
1-866-4-U-TREVOR
(1-866-488-7386)
Studies indicate that gay and questioning youth attempt suicide more often than their heterosexual peers. Researchers have linked the higher rates to social factors such as verbal and physical abuse stemming from homophobia. This toll-free, 24-hour helpline offers support for these youth.

The KUTO (Kids Under Twenty-One) Crisis Helpline
1-888-644-KUTO (5886)
Hours of operation, in Central Standard Time:
Sunday - Thursday: 4 p.m. – 10 p.m.
Friday & Saturday: 4 p.m. – 12 a.m.

Toll-free helpline staffed entirely by youth crisis workers.

Covenant House Nineline
1-800-999-9999
For youth who want to talk about anything going on in their lives.

National Suicide Prevention Lifeline
English: 1-800-273-TALK (8255)
Spanish: 1-888-628-9454
TTY: 1-800-799-4TTY

Befrienders International/Samaritans
www.befrienders.org Offers e-mail support for people in crisis. To access this free service, write to jo@samaritans.org for replies in English or to samaritinosargentina@hotmail.com for support in Spanish. Trained volunteers answer most messages within 24 hours.

sis. This problem is compounded, experts say, by the fact that youth tend not to confide in adults who would intervene. Young people are much more likely to confide in peers, who either don't recognize suicide warning signs or feel bound to secrecy.

"Young people feel very strongly that they should handle problems by themselves," Gould explained.

Ty Smith, 22, of Colorado, had his first suicidal thoughts at 14, while in a mental health facility where he felt overwhelmed by feelings of powerlessness. He had been in the system for years by then, struggling with issues such as anxiety, depression, and intense anger.

"I believe the first couple of my suicide attempts were actually me trying to gain power over my life," he said. "I was in a fit of rage where I wasn't thinking… I was just so mad that I felt like I needed to do something."

Smith now leads activity groups for troubled youth at a drop-in center near his home. He still struggles with anger, and the depression that used to be episodic has held steady for six years. Still, he said he is much stronger now and has a deep connection with his mother that protects him from suicide. She also has depression and was hospitalized for long periods when he was growing up.

"My mom's the one thing that's really kept me alive," Smith said. "I know that if I would hurt myself that she might hurt herself."

Suicide Clusters: The Media's Role

Experts say detailed or dramatic coverage of suicides can lead to copycat attempts, especially among young people. Guidelines for safe reporting are available from the Suicide Prevention Resource Center at 1-877-GET-SPRC or www.SPRC.org, and from the National Institute of Mental Health at www.nimh.nih.gov/suicideresearch/mediasurvivors.cfm.

Confidentiality and Intervention

Calls to the helplines listed are confidential *unless operators believe a caller is in immediate danger.* They almost always can, but very rarely do, trace calls and send help. Youth may want to ask operators about local response procedures, but mental health experts stress that fear of intervention should not stop people from calling for support. Most people rescued from suicide attempts, experts say, are grateful to have survived once their crises have passed.

He meets many peers who are reluctant to talk about suicide because they have had traumatic encounters with the mental health system. When they are ready to open up, however, Smith is ready to listen. "A lot of the people that are very suicidal are also very lonely," he said. And Smith has observed another key fact about suicidality: "It fluctuates."

In many cases, preventing an attempt can save a person who will never again have the impulse to take his or her life.

"People aren't suicidal forever," explained Lanny Berman, executive director of AAS. "Things change, life changes. You have to get to someone before they act."

Still have questions about youth suicide? Contact the National Mental Health Consumers' Self-Help Clearinghouse at 1-800-553-4KEY or info@mhselfhelp.org.

THE ANTIDEPRESSANT DEBATE

The U.S. Food and Drug Administration (FDA) mandated in 2004 that antidepressants carry "black box" warnings after studies linked the drugs to increased suicidality in children and teens. Since then, studies have found increased risk in people up to 24 years old, and the FDA announced a proposal in 2006 to add this information to the warnings. Critics of the labels argue that the studies focused on suicidal thoughts and behaviors, not suicide deaths. Some experts fear the warnings may prevent very depressed youth from receiving life*saving* drugs. At least one recent study found lower suicide rates among children and adolescents in areas where certain antidepressants were most frequently prescribed. Research continues, and most experts agree that doctors who prescribe the drugs should monitor patients closely, especially in the first few months, when suicide risk is highest.

In a class of 25 high-school students, at least five are likely to have seriously considered suicide, and at least two are likely to have tried to kill themselves in the past year.

Suicide fatalities for people aged 15-24 years increased more than 200 percent from the 1950s to the late 1970s, stabilized from the late 1970s to the mid-1990s, and have slightly decreased since.

Latinas in Crisis

Female Hispanic adolescents attempt suicide at higher rates than their peers. According to the National Adolescent Health Information Center, roughly 15 percent of Latina high school students attempted suicide in 2005, compared to 9.8 percent of black female students and 9.3 percent of white female students.

RESOURCES

Suicide Prevention Action Network USA (SPAN USA)
www.spanusa.org
(202) 449-3600
Aims to prevent suicide through public education, community action, and grassroots advocacy. Web site lists national, state and local prevention organizations.

(continued on next page)

RESOURCES CONTINUED

American Association of Suicidology (AAS)
www.suicidology.org
(202) 237-2280
A national clearinghouse for information on suicide. Promotes research, public awareness and education.

National Strategy for Suicide Prevention (NSSP)
www.mentalhealth.samhsa.gov/suicide-prevention
The U.S. Department of Health and Human Services published the NSSP Goals and Objectives for Action in 2001. Its site features resources such as fact sheets; a directory of prevention activities; and a list of potential funding sources for programs and research. Some information is available in Spanish.

The Suicide Prevention Resource Center (SPRC)
www.sprc.org
1-877-GET-SPRC (438-7772)
Advances the National Strategy for Suicide Prevention by providing assistance in developing prevention and intervention programs and policies.

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