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 www.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.

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 crisis.
An expert says the 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.

“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.

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.

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 lifesaving 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.
Focus on **YOUTH SUICIDE**

**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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The Key Assistance Report

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