REPORT
of the
NATIONAL CONFERENCE ON

Youth Suicide

ity Response To A National Tragedy

Washington, D.C.
June 19–20, 1985

Co-Sponsors:
- The Department of Health and Human Services; Administration for Children, Youth and Families
- The Youth Suicide National Center

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Department of Health and Human Services,
Administration for Children, Youth and Families

and the

Youth Suicide National Center

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NATIONAL CONFERENCE ON YOUTH SUICIDE

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

TO THE PARTICIPANTS IN THE NATIONAL CONFERENCE ON YOUTH SUICIDE

This Conference addresses that most bedrock human fundamental: life or death.

Too many young Americans --- thousands of them every year --- are choosing death.

Why?

As we grapple with that question in the next two days -- as we look at and beyond the statistics -- we are surely going to touch some raw national nerves.

Alcohol and drugs are, almost certainly, jagged and gigantic pieces in the suicide puzzle. But there are no single or simple answers to this authentic and on-going national tragedy.

Yet we convene this Conference in the spirit of hope. It presents a valuable opportunity for leaders in the field and concerned citizens to collaborate on ways to understand, reach out, and turn the suicide tide.

When American youngsters look downward and choose the abyss, all of us are diminished.

This Conference will explore the ways and means of shifting their sights and vision --- upward. That cause is good.

Margaret M. Heckler
Secretary

United States Senate

COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510

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January 1986

Dear Colleague:

We applaud the Youth Suicide National Center and the Office of Human Development Services, Administration of Children, Youth and Families of the Department of Health and Human Services for producing such an outstanding report on the tragedy of youth suicide. We commend this important material to you for consideration and use in resolving the phenomenon of children taking their own lives.

As Chairman and senior majority member of the Judiciary Subcommittee on Juvenile Justice, we have taken the lead in exploring youth suicide and have held hearings during the 98th Congress and during the 99th Congress on April 30, 1985 revealing that American children, adolescents, and young adults are killing themselves in ever-increasing numbers. According to the American Psychiatric Association, the incidence of suicide among young people aged 15 to 24 has risen by three hundred percent during the last thirty years. Specifically, the rate climbed from 4.1 per 100,000 in the 1950s to 12.5 per 100,000 in 1980.

This year, more than 5,000 young Americans can be expected to take their own lives. As the National Institute of Mental Health recently reported, an American teenager will commit suicide every 90 minutes.

Suicide now trails only accidents and homicides as the leading cause of death for people between the ages of 15 and 24. Even younger children experience problems that lead them to attempt suicide. According to a report prepared by the National Center for Health Statistics, during a 13-year period ending in 1978 there were almost 2,000 documented cases of suicide among children under the age of 14. Recent studies indicate that more than two million high school students attempted suicide,

Unfortunately, researchers state, the statistics represent only the "tip of the iceberg." Some experts estimate that the actual number of suicides among young people is at least four times greater than is reported.

Youth suicide is a phenomenon that is so perplexing, contradictory, frightening, and troubling that our society avoids addressing it. As individuals and as a Nation, we refuse to believe that young people emerging from childhood can feel the degree of sadness, hopelessness, and despair that leads to suicide.

Many teenagers experience strong feelings of stress, confusion, and self-doubt associated with growing up, and the pressures to succeed combined with economic uncertainties can intensify these feelings. For some teenagers, divorce and the break-up of the family, the formation of a new family with step-parents and step-siblings, the death of a loved one or moving to a new community and school, can be very unsettling and intensify their self-doubts. In some cases, suicide appears to be the only "solution."

It is clear that youth suicide is a problem of epidemic proportions, but it is equally clear that there is no single answer or program to solve the problem. It is not exclusively a Federal problem, or a State problem, or a public problem. It is a problem for all of us, and a problem that calls for the involvement of all segments of our society.

As a caring Nation concerned about the future of our young people, we must help. The children that we have already lost to suicide include some of the best and brightest of their generation.

Youth suicide is a problem of nationwide scope. It can only be solved through the combined efforts of individuals, families, communities, organizations, and Federal, state, and local governments to educate our society about what can be done.

As part of that effort, the Federal government has taken the lead in raising public awareness, disseminating information, and undertaking research and demonstration of services that may help to resolve the tragedy. The Federal effort has seen President Reagan sign into law a resolution, introduced by Congressman Joseph J. DioGuardi (R-NY) and Senator Denton, and cosponsored by Senator Specter, designating June 1985 as "Youth Suicide Prevention Month."

The effort has also seen the Reagan Administration spearhead the National Conference on Youth Suicide, held in June 1985, with the stated objectives of increasing national awareness of the problem of youth suicides and encouraging expanded, community-based strategies for addressing the problem. The Conference called upon experts in the mental health profession to explain the problem and inform the Nation of the latest research and treatment advances.

Youngsters and parents whose lives have been directly affected by the tragedy of suicide also were called upon to provide insight into what might be done in the family and in the community to prevent the further senseless waste of young lives. By all accounts, the Conference was a tremendous success. In fact, many participants returned to their communities and, with the knowledge obtained from the Conference, established suicide prevention programs.

To assist other communities, the Youth Suicide National Center, in conjunction with the Office of Human Services, Administration for Children, Youth and Families of the Department of Health and Human Services, has compiled for dissemination the findings and recommendations of the Conference. We note that the findings and recommendations were developed within seven months of the Conference, thereby recognizing the urgency associated with the problem. The Administration has been involved in an effort to address the tragedy of youth suicide in an expedited, cost-efficient and effective manner.

The effort takes into consideration the fact that the first line of prevention, identification and intervention, must come from parents and local institutions with which youngsters come into every day contact: schools, churches, volunteer and youth service groups, recreational clubs, PTAs, etc. The efforts of the Reagan Administration currently are strengthening that first line of defense against youth suicide.

With the knowledge discovered from the report and with the support of individuals, families, communities, organizations, and Federal, state, and local governments, children and teenagers who are suicidal can be restored to a more healthful path of development. If those efforts can save one child's life and prevent the agony suffered by the family of a child suicide, then we will have accomplished a great deal.

We hope this report will contribute significantly to your understanding of this critical issue.

Sincerely,

Jeremiah Denton
United States Senator

Arlen Specter
United States Senator

FOREWORD

Dodie Truman Livingston
Commissioner
Administration for Children, Youth and Families
Department of Health and Human Services

Whether we speak from personal experiences or from the perspective of youth-serving individuals, it is no exaggeration to say youth suicide is a national tragedy as well as a personal tragedy for those whom it touches.

The problem is widespread and touches every segment of society.

Over the past 30 years the suicide rate for people 15 to 24 years of age has increased dramatically from 4.0 per 100,000 in the mid-1950's to 12.0 per 100,000 in 1982. As a consequence, suicide moved from the fifth leading cause of death in this age group in 1960 to the second leading cause of death in 1984.

Approximately two million young people in this country, between the ages of 15 and 19, have attempted suicide. Every 90 minutes a young suicide is completed. For each young person who completes a suicide, many, many others try and fail.

The first National Conference on Youth Suicide, which is documented in this volume, was held in June, 1985. Co-sponsored by the Administration for Children, Youth and Families and the Youth Suicide National Center, it was intended to raise awareness of the problem at the national level and to generate community-level responses across the country. More than 500 people from all over the United States and from abroad attended. Former Health and Human Services Secretary Margaret Heckler, whose close friend lost a young son to suicide, keynoted the conference and chose that time to announce that she had appointed a department-wide task force which, through three additional national conferences,

would study the phenomenon of youth suicide and produce a recommended plan of action.

This volume contains the proceedings of the Conference. It represents the most concentrated work and the best thinking of the leading national experts in the fields of suicidology, mental health, medicine, education and social work, and we are proud of the contribution that it makes to our collective knowledge.

The purpose of our conference was to share what we knew and what we didn't; to tell one another what has worked and what hasn't; and to forge new partnerships that we hope will make our efforts ever more effective. As President Reagan likes to say, it was "a new beginning."

Now, let us work together as "friends for life" to combat this problem.

FOREWORD

Charlotte P. Ross
President/Executive Director
Youth Suicide National Center

The National Conference on Youth Suicide, a cooperative effort of private and public sectors of our country, was a significant step forward in dealing with a problem of epidemic proportions. It signaled the determination of our nation's leaders and citizens to do something about the needless waste of young American lives.

More than 5,000 young people kill themselves each year in the United States, leaving that many surviving families in a lingering misery of guilt and loss and anguish; these feelings do not pass with time, but last for years. How many more youthful deaths are suicides, we cannot say for sure, but even with the accepted figure, we know that suicide is the third leading cause of death among high-school-age youngsters, the second greatest killer among college students. We know, for whatever hopeful signs of leveling off we sometimes see, that suicide is a personal tragedy that continues to be an immense social burden.

For the first time, the National Conference brought together a broad-based, but special, group of people who have struggled with the problem of youth suicide in their professional lives or their personal lives. Too often they have struggled alone or with little support. For those who have studied youth suicide, for those who have worked to prevent it, for those who have suffered from it, the National Conference offered a unique opportunity to exchange ideas, experiences, plans, strategies and aspirations, both in the formal conference setting itself and informally outside it.

In many ways, it was a historic occasion, one that confirmed that we were prepared as a nation to face a large problem whose solution was not easy. No society, including ours, likes to take on a condition that is not only complicated, but traditionally considered shameful, sinful, and embarrassing, or even criminal. This conference said clearly that avoidance and denial were no longer acceptable alternatives.

The conference did not bring forth simple, or even complicated solutions. It was never expected or intended to do so since there is much yet to be learned about the social, familial, biological, physiological and psychological factors which underlie suicide.

What we do know without question is that youth suicide is now a major health problem in the United States. It is estimated that there are approximately half a million suicide attempts by 15- to 24-year-olds each year, all of them fervent cries for help, even when they are retrospectively deemed not serious.

The need to make the general public aware of that fact, and of the numbers who were lost to suicide was, while not a central reason for the Conference, a significant aspect of it. It simply was not enough any longer for the problem to remain so largely the domain of concerned professionals and grieving families. Thus the Conference was an important step in reaching out to the public, educating and sensitizing them to the pervasive spread of youth suicide.

Barely a decade ago, the World Health Organization declared, in effect, that youth suicide was an epidemic that recognized no national boundaries. International statistics gathered by the World Health Organization provided a base of knowledge that was previously lacking and focused attention on youth as a population at risk. It brought together leading health professionals from nations around the world in order to encourage efforts to consider theories of causes that might lead ultimately to strategies for the future.

Following that meeting, local efforts focused on reducing the incidence of suicide among our youth began in the United States. In California, the traditional public health approach of training caretakers, in this case usually school personnel, was initiated and led to developing methods for student education programs. Young people were taught ways to help their schoolmates who confided their thoughts of suicide as well as ways to overcome their own difficulties.

These efforts, and several notable programs developed elsewhere (Colorado, Texas, New Jersey, New York) were reported in both the professional and popular literature. However, there was a long way to go, in part because while these early programs offered promise in the search for effective responses to the problem, comprehensive evaluation studies were essentially nonexistent. Research efforts were

focused primarily on causes and risk factors rather than evaluation of programs. However, the need to respond was considered important enough, and the early experimental programs encouraging enough, to become a compelling motive for action in a number of communities.

Thus, in 1983, California became the first state in the nation to introduce legislation designed to respond to the problem of suicide among its youth, calling for the development and evaluation of a statewide program of suicide prevention for the public schools. Soon after, Florida and then New Jersey passed similar legislation, and other states began following suit.

In 1984 youth suicide was addressed in the halls of Congress and the first of several federal bills was introduced to provide support for youth suicide prevention activities.

That year youth suicide also found its place on the national media agenda. CBS presented the first made-for-television movie on the subject, followed by prime-time or after school programs on youth suicide by NBC and ABC. With increasing frequency, newspapers, magazines and the electronic media focused on the problem and efforts to deal with it.

Also during that year, the concern of several other people with personal as well as professional interest in the subject, led to the initiation of a series of significant steps to address the problem. Dodie Livingston, Commissioner of the Department of Health and Human Services' Administration for Children, Youth and Families (ACYF), developed a grant program designed to produce suicide prevention training materials for runaway youth shelters. Seeking to do more, she met with Barbara Wyatt, Director of Young Volunteers in ACTION, in the winter of 1984 to discuss further steps which could be taken to address the issue.

Calling on representatives from other interested groups, including the American Association of Suicidology, the American Psychological Association, the American Psychiatric Association, and the National Institute of Mental Health, a series of meetings were held during the next several months to develop a plan of action. From these discussions came consensus on several issues.

First, the number of recently developed prevention, intervention, and postvention programs being offered and adopted by schools, churches, and social service agencies offered promise of models for community action across the

country. For the most part, however, they had not been vigorously evaluated. There was a need to bring together the people who had developed the programs, those who were using them, and those who would be studying them, to explore the potential and effectiveness of individual and specific programs.

Second, research was being conducted in several disparate areas and disciplines. The findings of these studies, the answers they provided as well as the further questions they prompted, were of urgent interest and concern. There was a pressing need to bring them together.

Third, because there was much to be learned from the families of suicides and from young people themselves, they, like the researchers, needed a vehicle for sharing what they had learned.

Fourth, because many Americans, despite increasing local activity and more extensive media coverage, remained unaware, indifferent, or misinformed about youth suicide, there was a compelling need for a nationally coordinated public awareness effort.

From that basic agreement came the obvious catalytic agent. A national conference on youth suicide would provide the opportunity for an interdisciplinary exchange of information and expertise among professionals and laymen as it melded public and private experience.

That, in turn, could lead to a more precise definition of key issues and their relationship to health, education, community organization and public-private partnership questions, including the role of the public sector.

The partnership of public and private resources was reflected not only in the concept and design of the program, but also in its implementation. The Administration for Children, Youth and Families invited the Youth Suicide National Center, a newly formed Washington-based, nonprofit organization, to co-sponsor the Conference.

To be most effective, it was determined that the Conference should be held in June so that communities seeking to initiate student programs could plan for the new school year. The time frame was short, but commitment and enthusiasm were strong.

Within two months the program was developed, the Conference was planned, and the announcements were issued. The response

reflected both the interest in and urgency of the issue. More than five hundred individuals and representatives from a broad range of community and government agencies gathered in the nation's capital for two days of intensive discussion, presentations, and explorations of ways the concerned citizens of our country could work individually and collaboratively to combat the problem of youth suicide.

An added boost for the Conference, and youth suicide prevention, came when President Ronald Reagan, with the unanimous concurrence of Congress, proclaimed June as National Youth Suicide Prevention Month. (See Appendix for Senate Joint Resolutions 53, 1985, and 266, 1986.) Stating in part that "suicide is no longer a silent subject but a recognized public health problem that can and must be addressed," the President invited citizens to act, saying "all of us have the opportunity and responsibility to help deal with this growing problem."

Leading the agenda was a specially produced public service announcement on youth suicide, featuring First Lady Nancy Reagan. Secretary of the Department of Health and Human Services, Margaret Heckler, delivered the keynote address and announced the establishment on June 3, 1985, of the HHS Department-wide Secretary's Task Force on Youth Suicide.

During the next 48 hours, leaders of federal, state and local agencies and national authorities shared the podium with youth, parents and involved citizens. Popular entertainer Debby Boone spoke of why she recorded a song urging youth to "Choose Life," and why she came to the Conference. Ms. Boone said that she did not want her children growing up in schools where depression is so common as to seem almost normal and where they could face the prospect of a classmate's suicide. She and other parents wanted to find out what they could do in their communities to reverse the statistics and to surround their children with an atmosphere of life and hope.

Each afternoon was devoted to workshops addressing specific key issues, offering participants the opportunity to discuss, in greater depth, local projects, approaches and experiences. Speakers provided details of model programs, state legislation, the needs of special high risk populations and survivors, methods of assessment, treatment techniques, and current research. The use of music and humor in working with students, the views of Phyllis Schlafly on the school and youth suicide, responsible use of the media, issues surrounding juveniles in shelters and detention facilities, and deciphering the complex and often-times confusing

statistics of youth suicide were among the subjects which elicited lively discussion.

All sessions, including workshops, were audio taped and made available to those who were unable to attend. Audio tapes are still available through the Youth Suicide National Center.

News reports in the media described the Conference sessions and the unprecedented opportunity for leading psychiatrists, psychologists and other professionals in the field to discuss the scope and the future of the youth suicide issue. Their coverage helped to increase national awareness of youth suicide.

While the formal evaluation reports of the Conference participants indicated a high degree of satisfaction, the measure of its success could be felt clearly and immediately in the enthusiastic participation and spirited discussions in the halls and the hallways. A continuing measure of its effect has been the more than seven thousand calls and letters following the meeting. These include reports of local and regional activities, requests for further information and pledges to continue networking and collaborating on efforts to reduce the toll of young lives lost to suicide. One such letter concludes with the comment, "Thank you for your intense efforts in the last three months. You've helped people who don't yet feel this problem by building resources for them when they do." Another seems to sum it up by saying, "ACYF and the Youth Suicide National Center have demonstrated that a conference need not be 'just another conference' ...it can be a prompt, direct and effective response to an urgent need."

Many people contributed to the success of the Conference. The omission of some names is inevitable and unfortunate; however special note should be taken of the invaluable contributions of Dodie Livingston, Barbara Wyatt, Seymour Perlin and Ursula Meese.

But everybody who helped plan the conference and everybody who attended must share in the accolades of peers and press that flowed from the meeting. Many people, in government and out, have long struggled with the problem of youth suicide, groping for some insights, seeking for some solutions. They have been the pathfinders, the innovators, the lonely searchers.

The Conference drew on their work, helping to focus on a continuing process. That was, we think, immensely valuable, and yet it is not enough. Ultimate success can be measured only by the momentum gained to move forward in a life-saving way. With this kind of continuing effort, we may yet see the

day when our nation's teenagers learn about suicide from a textbook rather than through the death of a friend.

That, we think, also represents the objectives of the authors whose papers follow.

Introductory Statements

MARGARET M. HECKLER

The Secretary of Health and Human Services
Washington, DC

In the short time we have together, we are not going to eliminate youth suicide. We are not going to come up with a simple, "magic bullet" of a solution to the problem. We can listen, we can learn, and we can understand. If understanding is the beginning of wisdom, then we can all leave here a little wiser than when we arrived.

Mark Twain once said, "We are living in stressful times, at least I am." Today, all of us are. There is no way to prove that the world has become a more complicated and a more stressful place than it once was, but I believe that it has. I think most people have a sense that most things aren't as certain, as stable, and in a peculiar sense, as comforting as they once were. All too often, people feel that time and events are in control of them rather than the other way around.

I'm not going to play amateur sociologist and try to explain why all this is so, but I am going to make this simple observation: if we adults are sometimes torn and beaten down by the complications of modern life, then surely our children feel the same, but on a more intense level.

Youth has always been a time of special stress. Young people want to feel safe and protected. They want life to be predictable. The passage from childhood to young adulthood has always been at war against that desire for stability. It is a time of ambivalence, shyness, and uncertainty, a time when your relationship to friends, the opposite sex and your family are undergoing a profound redefinition.

All of us went through it. We remember it, imperfectly, but we remember it. The awkwardness, the painful embarrassments, and sometimes the sheer puzzlement or anger at what was going on.

Young people are going through the same thing today, but with added handicaps. Modern communication has made that inevitable. The fact is that youngsters are forced to grow up a lot faster than we did. It is an influence from outside the

family that surrounds our youth with information that is often profoundly disturbing. For all the beneficial aspects of information, modern American society suffers from its share of failures.

Since 1960, the rate of suicide among 15 to 24 year-olds has tripled. A young person commits suicide every 90 minutes. Last year, more than 5,000 adolescents and young adults ended their own lives, making suicide the third leading cause of death in this age group. The problem of youth suicide is all-permeating; the self-induced fatalities among youth know no economic bounds. For every one person that commits suicide, at least 120 others try but fail, and thousands of others struggle each day with the thought of self-inflicted death. These statements are not "ifs," they are truths, cold, hard facts.

We want to know the reasons for the mysterious increase in this mysterious phenomenon we call youth suicide. The reasons, the causes, the risk factors, as well as the proposed solutions for youth suicide are as varied as are the experts examining them.

Many argue that the declining influence of religion in our society may well be a major cause of escalating youth suicide rates. Researchers have provided data which suggest that Catholics have the lowest rates of suicide. We need to examine differences between youths from families where religion is important and those in whose lives religion plays no part.

Other scientists have reported that 44-46% of teenagers who attempt suicide come from one-parent families. This means that over 50% come from homes in which both parents are present. Some say homeless and runaway youth are among the group most vulnerable to suicidal tendencies.

Law enforcement personnel relate that youth suicide is a significant problem among delinquent children and those who have been in legal trouble. Alcohol and drug abuse are jagged and gigantic pieces in this suicide puzzle. Substance abuse may reflect an underlying emotional problem or may add to the stress felt by, or influence the judgment of, the individual.

More and more of our young people are growing up in a world where drugs and alcohol are more easily available to them than ever before. Amid these stresses and temptations, it is perhaps a tribute to them that they cope as well as they do.

Our challenge is to help expert and layman alike better understand the causes of youth suicide and help prevent it. We cannot make the world over again in an image more to our liking. Television isn't going to disappear. No simple law will banish drugs. Our divorce rate isn't going to drop by

half in the next six months. All those problems will remain. But, despite them, we rely on those who have studied and worked with this problem to provide the information and ideas that will lead us toward a solution.

You can help save the lives of young people. In another sense, you will also help save the lives of parents. Studies show there is no greater emotional blow than the loss of a child. Few parents ever recover fully from that trauma. How much worse it must be to have those feelings of grief compounded by the guilt any parent of a young suicide will feel.

When we lose a young person, we lose not only his or her future, but a part of our own. As a nation and as individuals, we have a responsibility to help our children when they most need it. I am pleased and reassured that so many of you in government at all levels, led by Ursula Meese who has formed the Youth Suicide National Center, as well as those of you in industry, in education, and in other community-based and private endeavors, share with me this keen sense of personal and social responsibility.

To deal effectively with youth suicide, it is essential to unite the active, caring energy of all those who touch the lives of young Americans. As a first step in this direction, on June 3, 1985 I established a high-level Health and Human Services Task Force on Youth Suicide. This working group, chaired by Dr. Shervert Frazier, Director of the National Institute of Mental Health, is made up of senior officials of the National Institute on Drug Abuse; National Institute on Alcohol Abuse and Alcoholism; Centers for Disease Control; Office of Human Development Services; and the Administration for Children, Youth and Families. Working with other agencies of the federal government, as well as with Congress and state and local governments, the Task Force will assess and consolidate information and recommend and initiate activities which will address the youth suicide dilemma. Also, we will try to promote regional forums to encourage communication among health and mental health professionals, educators, parents and families.

The Centers for Disease Control will concentrate on the need for better data on the frequency and trends in youth suicide. As you know, reporting problems are a special problem because of the social stigma attached to youth suicide. The information is needed not only to measure progress, but to provide essential information to local communities.

Moreover, targeted research generated by the Task Force should help answer some crucial questions about the social and psychological factors that place youngsters at risk for suicide. These answers will help communities respond to, and hopefully lessen, this terrible problem.

Despite the combined efforts of the members of the Task Force, however, we need the assistance of every caring American. With information in hand, cooperative national action can become a reality. In short order, our social institutions and individuals whose missions and activities daily touch the lives of our young people: educators, law enforcement personnel, health care providers, religious leaders and countless others, will band together in a true "fight for life."

Ironically, however, the most far reaching thing we can do is also the most simple. It is what we can do at the family level. We can listen and we can care. As a parent, I know that listening and caring are critical.

Although being there for a struggling youth is a simple task, it's not always easy. Being there takes time, and more than just an ounce of understanding. It takes a willingness to seek help on behalf of the child and to recognize that a problem does exist.

Once we make a commitment to keep the family strong and active in our childrens' behalf, half the battle is won. From that solid foundation, we can examine with care and a new perspective the other factors that color the harsh realities of youth suicide.

It is with these goals in mind, and in the spirit of hope, that we convene this Conference during the month designated by President Reagan as "Youth Suicide Prevention Month."

Adults all too often dismiss the stresses of youth with the easy remark that "Kids just aren't what they used to be." Perhaps they aren't, but neither are adults, and neither is the world we live in. The world has changed, and all of us have changed with it. What hasn't changed is our duty to our children and to each other. John Donne once wrote, "Each of us is involved in mankind." His words express a noble goal. Each of you has taken a step toward achieving it.

DODIE TRUMAN LIVINGSTON

Commissioner
Administration for Children, Youth and Families
Department of Health and Human Resources
Washington, DC

Welcome to the first National Conference on Youth Suicide. We know you share our concern about this very serious problem facing America's young people. The conference is co-sponsored by the Department of Health and Human Services and the Youth Suicide National Center.

As many of you probably know, 1985 is International Youth Year, proclaimed by the United Nations around the world. The whole idea of IYY is to focus on the accomplishments and problems of our young people here and around the world. We have dedicated this program to all young people. It is our hope that these proceedings will help them, through the work that you are doing and the work we are doing here in Washington.

The idea for this conference originally came from Barbara Wyatt at the ACTION Agency. Barbara has initiated a number of projects for children, and she came to us in ACYF with the idea of collaborating on some written materials, posters, and curriculum guides for people who are working in youth suicide. We liked the idea and we thought this was such an important issue that it would be a very worthwhile project. We have been on a very fast track. If we could save one life by going ahead with our conference now, then it was well worth all the extra effort.

DORCAS R. HARDY

Assistant Secretary for Human Development Services
Department of Health and Human Services
Washington, DC

This is the first National Conference on Youth Suicide and we are pleased to be hosting it. The Conference provides us an opportunity to articulate our personal and community concern, to expose a serious issue, and then to collaborate our ideas to see what we, as concerned individuals and communities, can do to help.

As this Conference proceeds, you will hear some horrifying statistics. It's easy to think of them solely as numbers, but we are talking about human lives, and deaths. We must never lose sight of the human element as we talk in mathematical terms.

Suicide is the third leading cause of death among teenagers. During 1984, some 6,000 teenagers, aged 15 to 19, committed suicide.

Many researchers have stated that drug overdoses, fatal car accidents, and other self-destructive patterns of behavior, such as eating disorders and alcohol abuse are, in fact, teen suicides masquerading under other names. In 1982 there were 42,000 youth aged 15-24 who died from various causes in the United States. Over three-quarters died from causes that may be attributed to a self-destructive lifestyle.

The statistics point out that the tragedy is not confined to one segment of our youth. The number of suicides among young Whites and most minority groups appears to be nearly equal. In the Northern part of the United States, more Black youths commit suicide; in the South, more White youths commit suicide. We know that suicide is the number one killer of Native American youth. We also know that young women account for 90% of the suicide attempts, while young men account for 70% of the "successful" suicides.

Extensive research reveals many more facts and figures, but who is really at risk? How are we to recognize which young people are in imminent danger of becoming victims of this tragedy? Most important of all, how can we prevent the tragedy of youth suicide?

Although it is difficult to pinpoint exact causes, it is possible to identify risk factors and behaviors that mark the potential youth suicide victim. Youth who commit suicide often display the symptoms of clinical depression: experiencing feelings of loss, rejection, failure, unimportance, loneliness, separateness, and lack of confidence in the future. They are very likely to have been abused or neglected.

A breakdown of the traditional family unit, through disharmony, divorce or frequent relocation, can deprive youngsters of the sense of safety, support and unconditional love they need to flourish. Other factors, such as unrealistically high expectations set by parents, or perfectionistic tendencies of the child, may also contribute.

All of the risk factors associated with suicidal youth are notably more prevalent among runaway and homeless youth. Our runaway and homeless youth program is actively involved in this because we fund over 265 shelters across the nation. An above average incidence of family problems, low self-esteem, physical and sexual abuse and neglect are all reported among this population.

According to the U.S. General Accounting Office, in 1983 the percentage of shelter clients who had been physically abused ranged in some cases as high as 40%; estimates of neglect were also high.

In that same year, the major reasons cited by these youngsters for seeking services included "such family-specific problems as poor communication, parental strictness, and emotional neglect; and to a lesser extent, problems associated with school and the juvenile justice system."

How do we translate these facts, figures and research into action? One positive approach is to address the problem of suicidal runaways, a population to which we have access through our nationwide community-oriented shelter network. Until now, the policy and practice of delivering services to suicidal runaway youth has been based largely on workers' intuition and on the informal application of crisis intervention techniques in a shelter setting. We believe this ad hoc approach needs to be improved. Recently we awarded grants to selected state, local, public or non-profit organizations for the development of effective techniques for intervention and provision of emergency services to depressed and suicidal youth who use shelters. I believe the strategies these grantees develop will assist all of us.

Another positive approach is this Conference, which gives us an opportunity to hear from a wide variety of experts who will expand our knowledge and awareness. It gives us an opportunity not only to listen, but also to participate and

set goals for prevention and public awareness for our own communities.

All of you, your networks and institutions are vital to the prevention of youth suicide. Schools, churches, recreational clubs, PTA's, parents, and mental health professionals together have the ability to prevent this tragedy. Together we have the ability to create public awareness and together we can develop effective community-based responses.

I believe we have our work and partnership cut out for us. We can translate the research into action, and we can make a difference. I will do my share, and I expect you to do yours.

You received a brochure which we're going to distribute nationwide. Let me share with you some of the sad stories included in this leaflet.

Nineteen-year-old Gerald hanged himself. He was a straight "A" student in high school He killed himself after the first semester of college when he received his first "B" and was no longer at the top of his class.

Sixteen-year-old Craig put a hose to his car's exhaust pipe. He left a note expressing his love for his family and asking their forgiveness because he "could never live up to their expectations."

Fifteen-year-old Perry ran away from home often, got into trouble with the police, drank too much alcohol, and started skipping classes. He was angry, and everyone seemed to be angry with him. He shot himself soon after having been confronted with stealing money from his parents.

Eleven-year-old Becky swallowed an entire bottle of aspirin. She said she did it because she didn't have anything to live for since her best friend moved away. After several months of not eating or sleeping, Becky tried again. This time she died.

These are not isolated instances. These are stories of America's youngsters at the edge, and beyond. There is hope, though. We need to get a message out to the communities that the signs these youngsters are exhibiting are desperate signs. Many suicide attempts can be avoided if the workers in our youth shelters just knew the signals. There are thousands of individuals who deal with hundreds of thousands of youngsters on a daily basis. Sometimes they hold a life in the palm of their hands. They can mean the difference between life and death. It is a tremendous responsibility and challenge. There are many who have accepted the challenge and stand ready to help. Charlotte Ross and the board members of the Youth Suicide National Center are meeting the challenge. The privately supported National Center, located here in

Washington, is at the forefront and on the front line in the battle against youth suicide. It is a community-based organization that understands it is on that front that the battle will be waged and won.

You had the opportunity to witness the public service announcement that First Lady Nancy Reagan did for us. When we approached the First Lady about doing the announcement, she did not hesitate for one second. She has been working actively on behalf of America's and the world's troubled youngsters. She gladly accepted the challenge to do this for the prevention of youth suicide. I am pleased to announce that starting tomorrow, these public service announcements will be distributed to over 500 television stations, nationwide. We estimate that well over 75 million Americans will be hearing Mrs. Reagan's message of hope. I know that Mrs. Reagan and the President are committed to this challenge.

Perhaps there is a design to this challenge. You, who have chosen to either work with troubled youngsters, families in crisis or community self-help groups understand all that is at stake, and you perform above and beyond the call of duty. We must look at these youngsters and remember that "there but for the grace of God go I." May you find the strength and courage to continue on in your good work; and may you always remember that when you work with one child, you are working for all humanity.

URSULA MEESE

Vice Chairperson
Youth Suicide National Center
Washington, DC

Several weeks ago, someone asked me, "Why are you taking on this crusade with all the other responsibilities you have?" I told them that I have been in the trenches of suicide prevention for six years and have hundreds of hours of counseling at the end of a life-line or a hot-line, or, as we called it in Sacramento, California, "Good Morning, Suicide Prevention." I know what one person, one organization, and one community can do towards solving this problem of youth suicide.

In training for phone counseling, you are told that just about one in 100 people are really on the edge of killing themselves. I liked those odds, but I was shocked. The first call I got was from an elderly woman who announced, very matter of factly, that at 3:00, within an hour-and-a-half of her phone call, she was going to take a handful of pills so she would be dead at 3:30, the first anniversary of her husband's death. Her husband's doctor had told her, one year previously, that it was going to be difficult, but that within a year, she would feel better and would be able to cope with the pain, and that the loneliness would not be there. The reason she called Suicide Prevention was that it was the doctor's day off. She wanted him to know that it didn't work, and that I was to call him tomorrow to say, "It didn't work." I was scared. I was desperate. I was going to lose my very first caller. Fortunately, I didn't panic. Within an hour, I located the doctor at El Paso Country Club on the golf course, hole number 14. He did not remember the woman. The woman would not give me her last name, only her first name, her husband's first name, and the name of the doctor. Fifteen minutes before she took that handful of pills, the doctor arrived at her house. That lady lived for seven more years and died a natural death. From that moment on, I was committed to suicide prevention. I was a convert, and I will be a friend of suicide prevention all my life.

Two years later I was on the phone with a young man. It was not a particularly serious conversation, and in the middle of the conversation, he shot himself. My body went into shock, but my mind went into automatic pilot and I was able to locate

where he was and send help. After that, I went through a terrific, unbelievable guilt trip. What had I said, what hadn't I said, why me? I thought if I felt this way about a stranger that I had talked to for only five minutes, what must other people feel, survivors of those loved ones who died by their own hand, the guilt of a parent when a teenager dies, the guilt of a six-year-old when a mother dies.

We established, in Sacramento, a working relationship with the coroner's office, where, in the case of a suicide, the coroner called one of the counselors on the 24-hour line, and we went out and started working with the family, making arrangements if that was necessary and trying to alleviate any guilt. That program was extremely successful. It is something that is desperately needed, as survivors will tell you. It shows what one concerned individual, one organization, one community, one county can do. We're very fortunate to have with us on this panel, the experts, the professionals who will give you guidance on what you can do.

SEYMOUR PERLIN, M.D.
Chairman

Youth Suicide National Center
Washington, DC

As Chairman of the Youth Suicide National Center, I would like to comment on the observation or the assessment of suicidality and depression in young people. Instead of saying, "Look at them," I urge you to look into yourselves. If we can see our own vulnerability, our own potential for suicidality among us as parents, and as friends and colleagues, then I think that we can hear, think and tune in to the signs, symptoms, and feelings of our young people.

This Conference is conducted in an extraordinary spirit of collaboration. The cooperation between the government agencies and officials, Charlotte Ross, President and Executive Director of the Youth Suicide National Center, and me will continue after the Conference. We are presenting an example that is necessary to create a network of caring and research.

I publicly thank Charlotte Ross for doing an extraordinary job and making a unique contribution toward addressing the problem of youth suicide.

PROCEEDINGS OF THE NATIONAL CONFERENCE ON YOUTH SUICIDE

CHOOSE LIFE

Debby Boone
Entertainer
Beverly Hills, CA

I'm here because I believe people across America need to have a heart for the youth of today who feel so hopeless that they are taking their lives. Magazines, TV news reports and TV programs indicate that youth suicide is not on the decline, but very much on the rise. None of us can turn our heads and say it doesn't affect me, it's not up to me. It affects all of us. I don't think there's anyone in this room who hasn't been affected by a suicide. It changes your life. It takes a piece of your life.

I've been affected in many ways. No one in my immediate family, but people I love have taken their lives or made attempts on their lives. Recently my music put me in contact with several young people who feel hopeless and despondent, who feel there is no reason to live, and that ending their lives is the only alternative. This is shocking and painful for me to conceive of, because I believe we have so much to live for, and I want to pass that feeling on to someone else.

I sat in a room for about 10 minutes with Edith Shaeffer and she was speaking of when her late husband was ill and near death. He asked her to take a home near the hospital where he was being treated. This required her selling their home in Switzerland and moving in a very short period of time. The doctors counseled against the move. She told me, "I believe that God gives you certain opportunities in your life to express your love to somebody that you might never have again. He'll give you one chance, or maybe a couple of chances. When you take that chance, you'll express your love in a deeper way that will mean more to that person than any other time in your life, and if you pass it up, you may have passed it up forever. That was my chance to let him know how much I loved him, and I did it, and I'll never regret it."

I believe this is my chance to get involved and have a platform to speak to kids, to reach out to youth and to share my own feelings of pain in my adolescence, my own times of dealing with depression and struggles. I want to share and relate on that level, encourage and give some kind of hope.

Recently I was on a concert tour having just completed an album. It was all brand new music and it was a younger audience. While on this six-week tour, I came in contact with three young suicidal girls. They were desperate young girls who told me, "You're my last chance. Can you help me? Will I ever get through this pain? Is there any hope for my life?"

You don't expect these kinds of things to happen on a concert tour. You're hoping you'll do a good job. I take my music very seriously because I believe those of us who have a platform to speak influence lives, influence people and the choices they make. When I choose the songs and the lyrics that are in those songs, they are messages of hope, messages of life. I was so directly confronted by young people trying to find out if there was any hope because my music is so full of that hope.

I spent time with these young girls, and then I corresponded with them. These were serious, troubled girls who related to me not just because I'm somebody in the public eye and a singer who has achieved some sort of success, but because I'm someone's daughter. They all had problems with their parents. One particular girl felt very alone. The problem was she was the good child, and the others were kind of problem children. The parents were consumed with dealing with those problems, and she felt that no one understood her and no one was there for her.

In our correspondence I was able to encourage her, to be her friend. I was able to find local help for her. I plugged her into a church group where she was able to get one-on-one help in her home town. She has made friends now. That's all she needed. She didn't want to die; she just didn't want to be alone anymore. This is a girl who has hopes and dreams now, and she's pursuing a future instead of cutting off her potential.

I won't relate the other stories, but my life changed because I was able to help these young girls. I realized I affected these three lives, and I could make a difference.

My record company started to check into organizations involved in youth suicide prevention. They got in touch with Charlotte Ross, and that relationship has enabled me to become a part of what all of us are doing here. I want very much to do everything that I can do. I'm not an expert. I don't have any training in psychology. I do have a heart. I do care about people and I know that a lot of the issue involves people knowing they are cared about.

Together we can break down barriers and break down divisions so that people will come together to choose life for each other. We can break the trends that are destructive, choose together to move on and deal with these problems collectively. This is something that can have a tremendous impact, a

national impact, an international impact, and a hope for the future.

What can I do to make a change? How can I help? I am a mother of three children growing up in an age that's kind of frightening for me as a parent. I'm sure you feel those same fears, feel those same pressures. Am I going to be everything my children need me to be to get through the pressures of this world?

My parents weren't perfect, but I am very grateful to have had parents who loved me deeply and who instilled in me morals, standards and strong convictions which were things that I had to hold onto. It made me feel that I had a purpose and a calling in my life. I wasn't floundering around in a sea of people asking if there was any reason for my existence. I knew I could have an effect on other lives.

I want to learn through my involvement here. I'm looking to learn ways to build confidence and a sense of identity in my own children. When they get to school, where the peer pressure is so heavy, I want them to feel confident in themselves. They will have chosen standards for their lives and be proud of them. They won't feel so compelled to be like everyone else, or how everyone tells them they should be. They won't be afraid to be different or take a stand. I want to learn how to instill those concepts now.

We can make a huge difference. One of the things that I want to get involved in is training kids in how to reach out to each other. I want to teach my children how to be friends for life to their friends; not the kind of friends that keep dangerous secrets; not the kind of friends who encourage destructive choices.

When I was 15 years old, I experienced times of deep pain and confusion. Where am I going? Who am I? Does anyone really understand what I feel at this moment? There was conflict with my parents. I had a confrontation with my father one evening. I had been smoking and I got caught.

There had been a press conference and there were ashtrays full of cigarette butts. I took a half-smoked cigarette and smoked it. How my father recognized the one less cigarette in the ashtray is beyond me. He has some kind of connection that is unbelievable. He came storming in, and somehow knew it was me rather than any of my four sisters. He accused me and warned me that in the morning I was going to receive punishment.

I had done it, but I was angry because I felt I had been treated unfairly and accused without any real proof. There had been several conflicts between my father and myself. This incident set me off the edge. As he left the room, I was crying. I was enraged. I was angry about the restrictions and I was having problems dealing with my conflict against

authority figures. I talked to my older sister, Cherry, and I was spewing out words of hatred.

This was a lot of drama over one cigarette butt, but at that age in your life, these kinds of things trigger the deep emotions. I remember saying awful things against my parents; they didn't understand me; why are they so tough on me; they're killing me; and I can't wait to get away from them. I was contemplating running away, somehow getting away from this tension.

My sister, Cherry, looked at me with tears running down her cheeks and she said, "Debby, I'm not even supposed to know this, and probably not supposed to share it with you, but I feel I have to, just to give you some insight about Mommy and Daddy. Mommy told me she found Daddy on his knees crying out to God asking to show him some way of communicating his love to you because he felt he had not been able to communicate in a way that you could receive. He felt he had to discipline you. He had to give you boundaries, but in so doing, he felt he had shut himself off from you, and would God please give him a way to communicate his love to you so that you would know."

When my sister told me this, I felt a sense of love and acceptance even through the restrictions, even through the hard times. I saw my father as someone who was trying to do his best, and he was willing to admit he wasn't perfect. He wasn't a perfect parent; none of us are. I'm finding that out now, in a real way. I saw us then as friends.

Cherry changed the pattern I was setting for myself and became my friend for life. My father became a friend who was working with me, not arbitrarily inflicting his own standards on me, because he loved me so much. My whole perspective changed because Cherry reached out to me. At other times in my life, a friend spoke to me and gave me a different perspective, reached out to me and changed my thinking, causing me to make choices that would be good for my future.

That brings me to the song that I'm going to sing, "Choose Life." I am honored it has been chosen as a theme song for youth suicide prevention. It is appropriate because it is a song about choices, choices leading to life as opposed to those that bring death and destruction. I am hoping it will encourage young people not only to take their choices seriously, but also to encourage each other in the kinds of choices they will be making.

International Trends

YOUTH SUICIDE: AN INTERNATIONAL PROBLEM

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Heightened youth suicide rates is not a phenomenon limited only to the United States. This is readily apparent from a survey of the changes of rates for youth ages 15 to 24 in countries scattered throughout the world. The changes in rates from ten countries are discussed below: two from North America (United States and Canada), six from Europe (England, France, Austria, West Germany, Finland and Sweden), and two from the Far East (Japan and Australia). While this obviously does not represent the entire world, countries from other continents, such as South America, Africa, Asia, etc., are not included for a variety of reasons: inadequate certification procedures, unreliable statistics, political, religious or cultural resistance to reporting suicide, and others.

Graphs for each country depict the suicide rates by sex and total over the last 20 to 25 years for both the youth group between the ages of 15 to 24 and for the total population. This omits the younger adolescent below 15, but it has been the age group between 15 to 24 that has shown the greatest amount of increase and change over the past two and a half decades. Also, the data are grouped in such categories in the World Health Statistics Annuals (1960-1982) and the National Center for Health Statistics of the U.S. (1960-1982), the sources for the rates presented below.

The information is presented in terms of rates, following the standard epidemiological custom of reporting the number of deaths per 100,000 of the living population. The rate for the total population is based on the total number of suicides reported by that country divided by its population expressed as per 100,000; the rate for the 15 to 24 age group is the total number of suicides in that age group divided by the number of persons age 15 to 24 alive in that age group in that year.

Finally, the data are for suicide deaths only. They do not include non-lethal suicidal behavior such as suicide attempts or threats, or ideation, or severe depression. These non-lethal forms of suicidal behavior are, of course, much more common than suicide deaths -- anywhere from 10 to 100 times more frequent depending on which researcher is reporting and what criteria were used to define the non-lethal suicidal behavior. Thus, in viewing the data on suicide commits, only a small portion of the total picture is displayed, albeit a much more tragic and deeply affecting portion.

NORTH AMERICA

UNITED STATES

Total Population (See Figure 1)

The suicide rate for the total population shows a practically steady increase from 1960 to 1977, starting with a rate of 10.6 per 100,000 and increasing to a rate of 13.3, an increase of 25%. Since then it has dropped slightly to around 12.4 in 1983, a decrease of 9%.

The rate for all males was roughly parallel; it went up in the same period from 16.5 to 20.1, about 22%, then dropped to 19.2 in 1982, a slight decrease of 5%.

All women showed a larger percentage of change (because of the smaller numbers), an increase from 4.9 in 1960 to 6.8 in 1977, 39%, then back down to 5.6 in 1982, a drop of 21%.

Youth Group

In the 15 to 24 age group, the rate for the total group rises from 6.2 in 1965 to a peak rate of 13.6 in 1977, an increase of 119%. It then falls back to 11.7 in 1983, a decrease of 16%, leaving it still at least doubled.

The greatest amount of increase in this age group is contributed by the young males, where the rate more than doubles from 9.4 in 1965 to 21.8 in 1977, an increase of 132%. It then drops slightly to 20.2 in 1980, the last year data for separate age groups were available, about an 8% drop.

The young women also show a sizable increase but not quite so much as the males, from 3.0 in 1965 to 5.3 in 1977, a rise of 77%, after which they drop 23% to 4.3 in 1980.

In general, the peak rise in suicide rate over about two decades in the young age group of 119% is almost 5 times as great as the rise for the total population, 25%. It is also apparent that it was the young males, with their rise of 132%, that contributed to that disparity.

CANADA (See Figure 2)

Total Population

The suicide rates for Canada's total population and its young have shown the same trends as the U.S., except that its swings have been more extreme. The total population suicide rate reached its peak in 1978, a year after the U.S., increasing from 7.6 in 1960 to 14.8, or a 95% rise. Since then it has decreased only slightly to 14.0 in 1981, a drop of 6%.

The males increased 86% from 12.0 in 1960 to 22.3 in 1978, and then dropped a slight 5% to 21.3 in 1981.

The females, again because of the smaller rates, showed the largest increase of 143%, from 3.0 in 1960 to 7.3 in 1978. They also decreased only a slight 7% to 6.8 in 1981.

Youth Group

Again, it was the younger age group who showed the largest increases with rates that just about tripled. The rate for the total young jumped from a low of 5.7 in 1965 to its highest point of 17.4 in 1977, an increase of 205%. A slight decrease to 16.2 occurred in 1981, about 7%.

The young males made up most of this increase, from 9.0 in 1965 to 28.7 in 1977, a jump of 219%. The rate then remained practically the same through 1981, 27.2, a drop of only 6%.

The young females also contributed greatly with an increase from 2.3 to 6.6 ((1965 to 1979), a rise of 187%. Their rate dropped to 4.9 in 1981, a decrease of 35%.

Thus, as in the United States, the young age group increases about twice as much as the total population, 205% vs. 95%. In general, in North America, the changes in rates for the young in the United States and Canada are remarkably similar, doubling or tripling their rates over a period of two decades, with most of this contribution coming from the young males.

EUROPE

ENGLAND (See Figure 3)

Total Population

The suicide rates both for the total population and for the youth in England show a very different pattern from that seen in the United States and Canada. Their rates not only have not increased, but for the total population have even fallen. The rate for the total population falls from 11.2 in

1960 to a low of 7.5 in 1975, a drop of 49%. The rate rises again after that to 8.9 in 1981, an increase of 19%.

The males in the total population drop from a rate of 13.9 in 1960 to a low point of 9.1 in 1975, a decrease of 53%. The rate then increases to 11.5 in 1982, a rise of 26%, regaining half of the original drop.

The total women's rate has shown the least amount of change, from 8.7 in 1980 to 6.0 in 1975, a drop of 45%. After rising to a rate of 6.5, it drops to 5.9 in 1982, approximately the same level it had in 1975.

Youth Group

In the younger age group there has been practically no change for the total young over the period from 1965 when the rate was 4.5 to 1982 when it is recorded as 4.3, a slight 5% drop. The highest rate of 5.0 is reached in 1977, a rise of 11%.

The rate for the males in the younger age group changes practically not at all, starting with 6.3 in 1965 and ending with 6.4 in 1982. Their lowest rate is 5.2 in 1971, a drop of 21%, after which it goes back up to its original level and a little better, a rate of 7.0 in 1978 and 1981, a jump of 35%.

The young women started with a rate of 2.6 in 1965 and end with a rate of 2.0 in 1982. Their rate stayed between 2.6 and 2.9 over the years until 1976, then jumped to 3.7 in 1977, a 28% rise. By 1981 and 1982 their rates had again dropped sharply to 2.0, an 85% drop.

FRANCE (See Figure 4)

Total Population

The rate for France's total population has fluctuated little, rising slightly from 1965 through 1978, the last year data were available. However, like the U.S. and Canada, the rates for the young have risen from 1965 to 1978.

The total population rate rises from a low of 15.0 in 1965 to its highest point of 17.2 in 1978, an increase of 15%. The males start with a rate of 23.0 in 1965 and go up to 24.7 in 1978, a slight increase of 7%. The females start with a rate of 7.5 in 1965 and end with a rate of 10.0 in 1978, a rise of 33%.

Youth Group

The total youth group almost doubles from a rate of 5.0 in 1965 to a rate of 9.7 in 1978, a jump of 94%.

The young males start with a rate of 6.2 in 1965 and rise consistently to a rate of 14.0 in 1978, more than doubling their rate by 126%.

The young females' rate of 3.6 in 1965 increases to 5.2 in 1978, an increase of 44%.

AUSTRIA (See Figure 5)

Total Population

One of the countries on the continent with a high rate is Austria, which is interesting in the light of its high proportion of Catholics (about 95%). In general, Austria has seen the same rise of suicide rates for its young, although the increase started later than the U.S. and Canada, in the early '70's.

The rate for the total population starts with 23.1 in 1960, and then lowers slightly after some fluctuations, to its lowest point in 1973 of 22.1. It then rises to its highest point in 1982 of 27.6, an increase of 25%.

The rate for the males, fluctuating in the same manner, starts at 32.4 in 1960, falls to its lowest point in 1973, 31.6, and then rises to 42.1 in 1982, an increase of 33%.

The rate for the females generally remains the same over the two decades, starting with a rate of 14.8 in 1960, hitting its lowest point of 13.4 in 1976, and rising to 15.1, its highest point, in 1981, an increase of only 13%.

Youth Group

The younger age group shows much more variation. With a number of fluctuations, the total younger age group rate rises from 11.9 in 1965 to its highest rate in 1981 and 1982 of 20.5, an increase of 72%.

The rate for the males in this age group increases with even wider variability, from a rate of 18.7 in 1965 (and again in 1973) to its highest rate of 33.6 in 1981, a jump of 80%.

The rate for the females rises from a rate of 4.9 in 1965 to its highest point of 10.5 in 1981, an increase of 114%. However, the rate drops again to a rate of 6.8 in 1982, ending up with only a 39% increase between 1965 and 1982.

WEST GERMANY (See Figure 6)

In general, the rates for the German Federal Republic total population and even more for the young have been like those in the U.S., increasing from 1960 and reaching their highest points in the late 1970's. Since then the rate for the young has rather consistently dropped, while the rate for

the total population has tended to level off.

Total Population

In 1960 the suicide rate for the total population was 18.8. It then fluctuates around 20 until 1977, when it jumps to its peak of 22.7, for a total increase of 21%. It then drops slightly but consistently until 1982, when it hits 21.3, a drop of 7%.

The rate for the males in the total population increases from a rate of 25.6 in 1960 to a peak of 30.2 in 1977, an increase of 18%. The rate has stayed almost at that same level since then, decreasing only to 29.8 in 1982, a drop of 1%.

The females record a rate of 12.7 in 1960, which rises to around 15 for a number of years following, until it reaches its peak of 15.8 in 1977, an increase of 24%. Since then it has dropped steadily to a rate of 13.6 in 1982, a decrease of 16%.

Youth Group

In the younger age group, the low point rate of 12.6 in 1965 for the total young increases consistently until 1977 when it reaches its highest point of 17.1, an increase of 36%. Since then it has decreased with minor fluctuations to 13.8 in 1982, a drop of 24%.

The younger males start with a rate of 18.1 in 1965 and rise almost continually until 1977 when they reach 25.1, an increase of 39%. After that the rate drops with only one fluctuation to 20.9 in 1982, a decrease of 20%.

The rate for younger females rises from 6.7 in 1965 to 9.6 in 1978, a jump of 43%. Since then, with some variability, it has decreased to 6.2 in 1982, a decrease of 55%.

FINLAND (See Figure 7)

In Scandinavia the two countries that record the highest rates are Finland and Sweden. Finland, for example, has experienced extreme increases in its youth group, especially among the males. Sweden, on the other hand, has shown wide variability over the two decades, with increases until the mid-70's, followed by marked decreases, although still higher than the original starting rate.

Total Population

For Finland, the suicide rate in the total population goes from a low of 19.8 in 1965 to its highest point of 25.8 in 1976 and 1977, an increase of 30%. Since then it has stayed at the relatively high rate, with a rate of 25.7 in 1980.

The rate for the males in the total population starts high with 32.2 in 1965 and goes up to its highest point of 42.3 in 1976, a rise of 31%. Since 1976 it has stayed at relatively the same level with a rate of 41.6 in 1980, a drop of only 2%.

The rate for the females rises with very little variability from 8.1 in 1965 to 10.7 in 1980, an increase of 32%.

Youth Group

The younger age group shows much wider swings. The rate for the total younger age group starts at 9.4 in 1965 and then almost triples, reaching a rate of 26.1 in 1975, an increase of 178%. In 1978 the rate drops to 20.7 (26%) and then goes back up in 1980 to 23.6, a rise of 14%.

The younger males' rate starts with 14.7 in 1965 and within one decade more than triples to 45.8 in 1975, an increase of 211%. Since 1975 the rate has decreased with some fluctuation to 37.5, a drop of 22%.

The rate for the females in the younger age group rises with many fluctuations from 3.9 in 1965 to 9.1 in 1980, again almost doubling in size (82%).

SWEDEN (See Figure 8)

Total Population

The Swedish rate for the total population was 17.4 in 1960. It rose to 22.3 in 1970, an increase of 28% and then stayed between 19 and 20 through 1982, ending with a rate of 19.4, a slight drop of only 15%.

The rate for the males in the population goes from 26.3 in 1960 to a high of 31.3 in 1970, a rise of 19%. The rate then fluctuates between 27 and 29 through 1982, dropping as low as 24.6 in 1981, and ending with a rate of 27.8 in 1982, a drop of only 13% since 1970.

The rate for the females in the total population rises from 8.6 in 1960 to 13.2 in 1970, after which it fluctuates relatively little, staying between 10.6 in 1981 and 12.9 in 1979, and ending at 11.2 in 1982, a drop of 18%.

Youth Group

In the younger age group the rate for the total young group ranges from 8.1 in 1965 to its highest point of 15.9 in 1975, an increase of 96%. It then drops to 9.3 in 1981, a decrease of 71%, and goes back up to 10.3 in 1982.
The rate for the males in the younger age group starts at 10.9 in 1965, hits a high of 22.0 in 1975, an increase of 102%. Since 1975 the male rate has fluctuated considerably,

but has tended to decrease, with the last reported rate of 14.0 in 1982 representing a drop of 57%.

The female suicide rate has been very variable, going from 5.2 in 1965 to a high of 11.8 in 1976, an increase of 127%. It then goes down to a low rate of 4.1 in 1981, a drop of 171%, after which it jumps in the following year to 6.4, an increase of 56%.

EUROPEAN SUMMARY

In summary, Europe, except for England and Wales, has experienced the same phenomenon as the U.S. and Canada. England's youth rate has remained relatively stable over the last two decades, despite the total population rate decline by the mid 1970's, when it seems to begin a slow climb up again. France's total population rate has remained relatively level (up through 1978), but its youth suicide rates, especially males, have climbed steadily since 1965. Austria's and West Germany's young both report increasing suicide rates, beginning in the early 1970's and peaking around 1978 and 1979. Since then, West Germany's youth rate has shown a downward trend, while Austria's youth rate, especially its young males, continues to stay high through the early 1980's. Finland and Sweden, two neighboring Scandinavian countries with traditionally high rates, show varying trends. Finland's young males have shown the most extreme rise and their young females have recorded (proportionally) almost as high an increase. Sweden, on the other hand, experienced its rise in youth suicide in the mid 1970's and since then the young males have shown a trend down, while the young females have seemed to average out to their original level.

FAR EAST AND OCEANIA

JAPAN (See Figure 9)

Generally, Japan's youth suicide rate, especially the young males, climbs to its high point and stays there throughout most of the 1970's. The late '70's and early '80's, however, have seen a marked drop in the rates to about their original level.

Total Population

In the general population, Japan's lowest rates occur in 1965 when the rate for the total population is 14.7. That rate increases slightly but consistently until 1979 when it reaches 18.0, an increase of 28%. From 1979 to 1982 it has remained almost the same, decreasingly only slightly to 17.4 in 1982, a decrease of only 3%.

The lowest rate for the males is 17.2 in 1970. It increases to a high point of 22.6 in 1979, a jump of 40%, and stays at this level through 1982.

The rate for females is 12.2 in 1965 and rises to a high point of 15.0 in 1974, an increase of 24%. Since 1974 the rate has decreased slowly but consistently until it reaches 12.4 in 1982, a decrease of 21%, and almost the place from which it started.

Youth Group

In the younger age group the rate for the total youth group starts at 13.5 in 1965; this decreases to 13.0 in 1970, then increases to 16.5 in 1973, a jump of 33%. A slow decrease in the rate for this age group appears through 1979, with the rate of 14.9 indicating an 11% decrease. Since then the rate has dropped more rapidly to 10.6 in 1982, a drop of 41%.

The young males have a rate of 15.3 in 1965, which decreases to 14.0 in 1970. This rate increases to 19.9 in 1973 and then stays relatively the same until 1979 when it, too, drops rapidly from 19.8 to 14.5 in 1982, a decrease of 37%.

The young females have a low rate of 11.7 in 1965 which increases gradually to 13.3 in 1974, an increase of 25%. Thereafter, the rate drops gradually until 1979 when it reaches 9.8, a 24% drop, followed by a more precipitous drop of 51% to a rate of 6.5 in 1982.

AUSTRALIA (See Figure 10)

Australia's male youth suicide rate has, with fluctuations since the early '70's, tended upward, while the female youth rate has stayed pretty much the same. This contrasts with the total male population rate which has remained the same, and the total female population rate, which has decreased.

Total Population

In general, the rate for the total population reaches its peak in the late 60's, and except for a small rise in 1971, shows a fairly level or slightly decreasing suicide rate over the decade. The suicide rate for the general population is lowest in 1960 at 10.4. It then rises to 14.9 in 1965, an increase of 43%. The following decade and a half shows a gradual decrease with slight variations, the rate reaching 11.0 in 1980.

The rate for all males starts from a low of 15.0 in 1960 and reaches 18.8 in 1965, an increase of 26%. The rate then levels off around 16 for the decade of the 1970's (except for a slight peak in 1971 of 17.9) ending at 16.4 in 1980, a drop of 15%.

The total female population rate rises from 6.2 in 1960 to 10.8 in 1965, an increase of 74%. The rate then generally decreases over the 1970's decade (again except for a slight

peak in 1971 when it reaches 9.3) ending at 5.6 in 1980, a drop of 93%.

Youth Group

The young group total rate generally levels off after its peak of 9.3 in 1971, and then increases in the last 5 years of the 1970's to a peak of 12.1 in 1979, a rise of 36%. The rate then drops a slight 8% to 11.2 in 1980.

The rate for the younger males starts at 12.4 in 1970, peaks the next year at 15.9, a jump of 28%. After dropping in the early 1970's to 13.7, the rate climbs in the last half of the decade until it reaches 18.1 in 1979, an increase of 32%, before dropping slightly to 17.6 in 1980.

The rate for the younger females starts at 4.7 in 1970, increases to 6.4 in 1973, a rise of 36%, after which it drops in 1975 to a low of 3.9. Like the male rate, the rate climbs again in the last 5 years of the '70's to reach 5.7 in 1979, a rise of 46%, before dropping again to 4.5 in 1980.

FAR EAST SUMMARY

To summarize for the Far Eastern part of the world, it appears that while the suicide rate for Japan's general population has remained relatively the same over the past two decades, the rate for the younger age group, especially the males, rises to a high rate throughout the '70's, before showing a considerable drop.

In contrast to the rate for the general population in Australia which rises considerably in the late '60's but then maintains a fairly level course throughout the '70's, the younger age males and females both show a marked rise over the last half of the '70's, before dropping in the early '80's.

WHY THE YOUNG ARE KILLING THEMSELVES

There is no single answer to the question of why the young are killing themselves so much more frequently now than two decades ago. In a recent review of over 100 separate references on suicide among the young, a number were reviewed for motivations for suicide. The countries represented in the review were the United States, England, Japan, Australia, Finland, France, Germany, Sweden, Poland and Canada. The articles were studies of adolescents and youth who had appeared in coroners' offices, hospitals, clinics and schools as a result of having committed, attempted or threatened suicide.

The most frequently mentioned state was a mental disorder and the most frequently mentioned feelings were depression and hopelessness. The descriptions of the emotional and physical symptoms included the familiar signs of depression such as sleep disturbances, changes in eating habits, trouble con-

centrating, apathy, agitation, fatigability and anxiety. A previous history of suicide attempt or threat was considered especially significant as an indication of high suicide risk.

The most frequently mentioned social behaviors were withdrawal and isolation, reflecting poor interpersonal relationships. Poor school performance was noted. A number of the reports indicated drug abuse and/or heavy alcohol use.

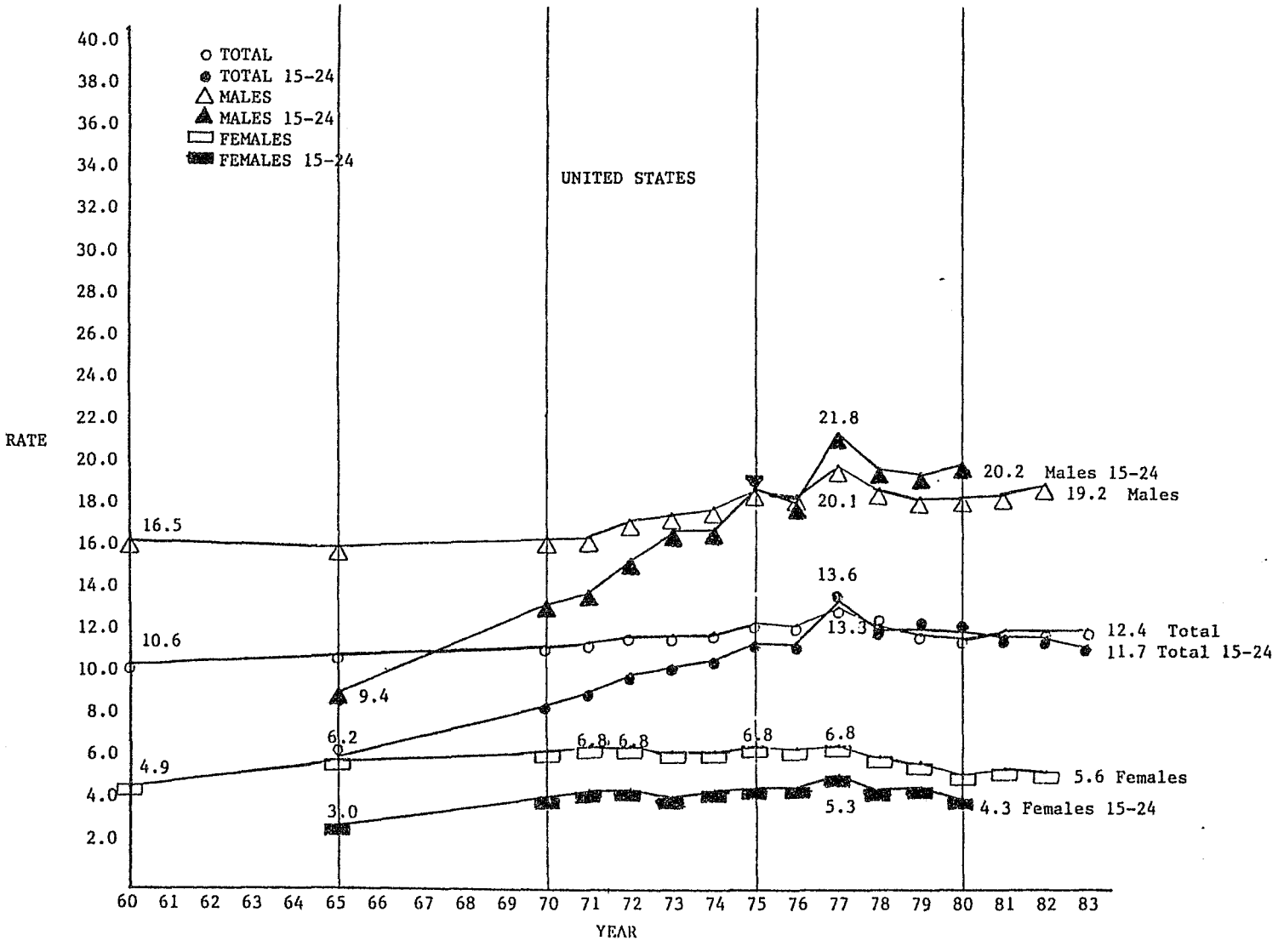
In terms of personality development and psychodynamics, the area of parental and family interaction seemed to be the most highly significant (Etzioni, 1977; Shorter, 1977). Loss or threatened loss of a parent, poor relationships between the parents, with alcoholism, assaultive and disturbed behavior among the family members were noted almost as often. The family has changed its roles in significant ways over the last two decades. In many ways the family seemed to have abrogated its role and responsibility for preparing the child for appropriate functioning in adult society. This vacuum was filled only in part by the school, or more often by peers, who were equally confused about the values and objectives of society. For a long time the shift was an emphasis on the self rather than on society, with little concern for responsibilities and obligations to others. A focus on the self, with self expression, self fulfillment and self awareness became not only acceptable but approved. Unfortunately, what has been lost for the adolescent has been the secure feeling that comes from a sense of belonging to a nurturing family environment within which supportive learning could take place. An affluent society also contributed to this state by providing financial and social independence long before youth was ready and could handle them.

Some experts believe that excessive sexual license has increased alienation among the young (Repschitz, 1976). The high level of unselective hyperactivity has resulted in a loss of a sense of warmth and tenderness in sexual intimacy that has turned the experience into a mechanical bore. Support for this conclusion is found in the increased number of separations and divorces, especially among teenagers. Along with the loss of meaningfulness in life has been the feeling that life itself is uncertain and tenuous, especially as the young have grown up within the nuclear age and its potential for instant termination. Life has become cheap and readily expendable, as witnessed by the marked increase in violence on T.V. and in real life. All of this has undoubtedly led to a feeling of living on the brink of disaster.

The extremely important social-psychological problem of suicide prevention, especially among the young, requires both immediate and long range processes for prevention. The problem seems not to lie so much in case finding, recognition and identification as it does in developing new and more effective treatment modes. Basic, however, are attitudes and motivations of the professional and the general public. Once

the problem is recognized and resources are focused, creative and resourceful procedures can follow. The problem is worldwide. It is up to us to make sure that the young are motivated to inherit this world.

FIGURE 1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MALES 15-24
FEMALES
FEMALES 15-24
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14.0
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8.0
6.0
4.0
2.0
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16.5
10.6
4.9
9.4
6.2
3.0
21.8
20.1
13.6
13.3
6.8 6.8
6.8
6.8
5.3
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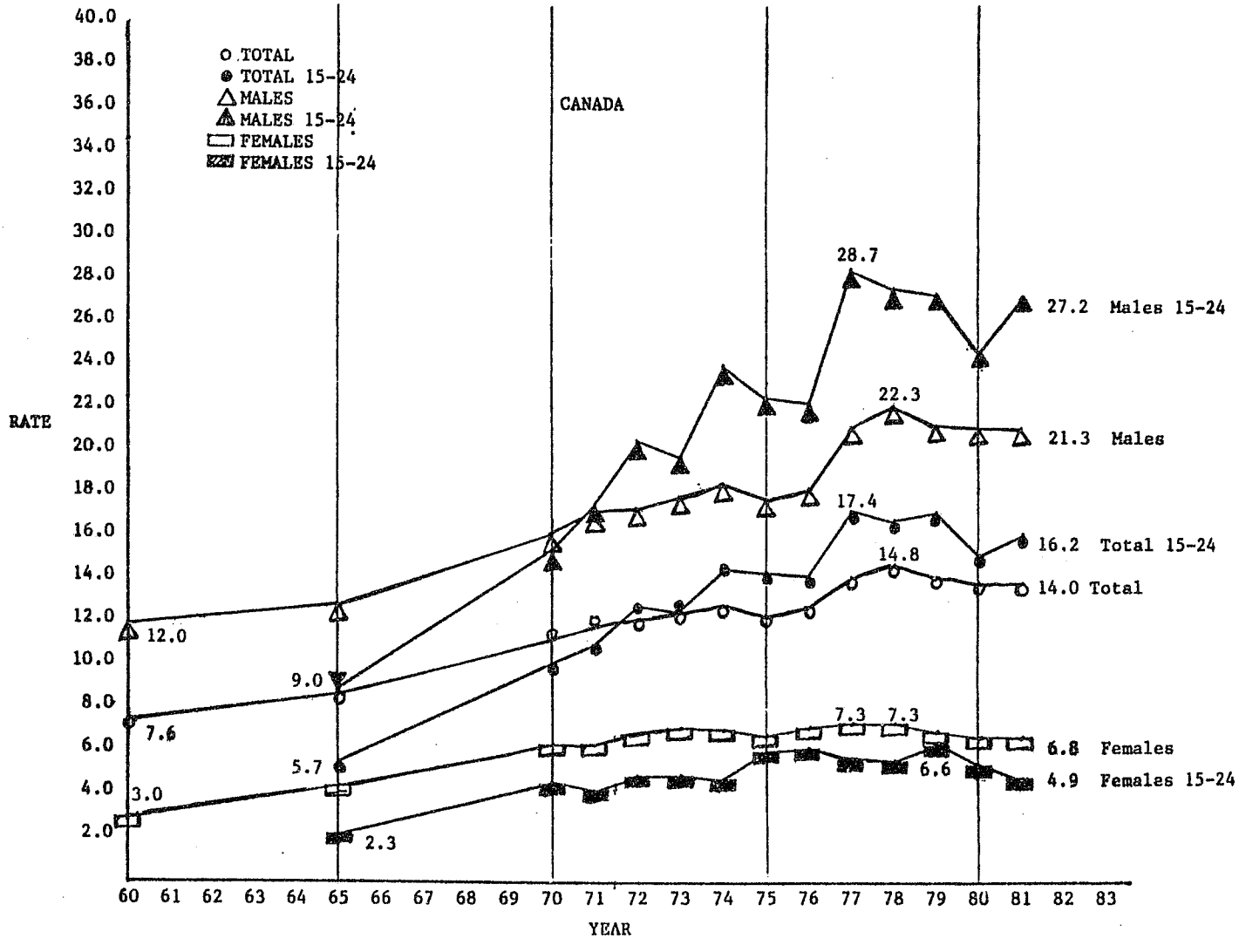
19.2 Males
12.4 Total
11.7 Total 15-24
5.6 Females
4.3 Females 15-24

FIGURE 2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MALES
MALES 15-24
FEMALES
FEMALES 15-24
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RATE
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20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
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12.0
9.0
7.6
5.7
3.0
2.3
28.7
22.3
17.4
14.8
7.3
7.3
6.6
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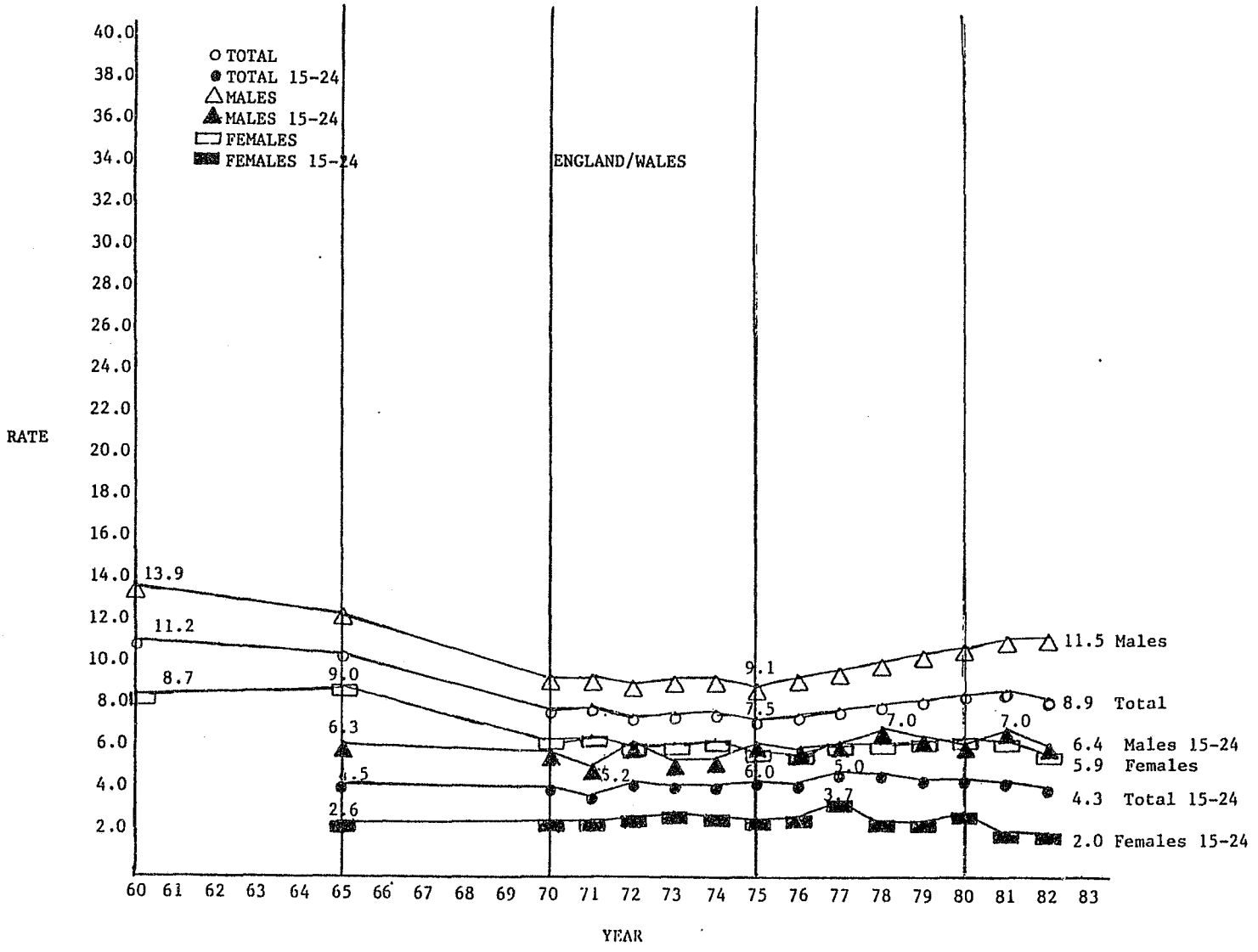
21.3 Males
16.2 Total 15-24
14.0 Total
6.8 Females
4.9 Females 15-24

FIGURE 3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MALES
MALES 15-24
FEMALES
FEMALES 15-24
ENGLAND/WALES
RATE
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14.0
12.0
10.0
8.0
6.0
4.0
2.0
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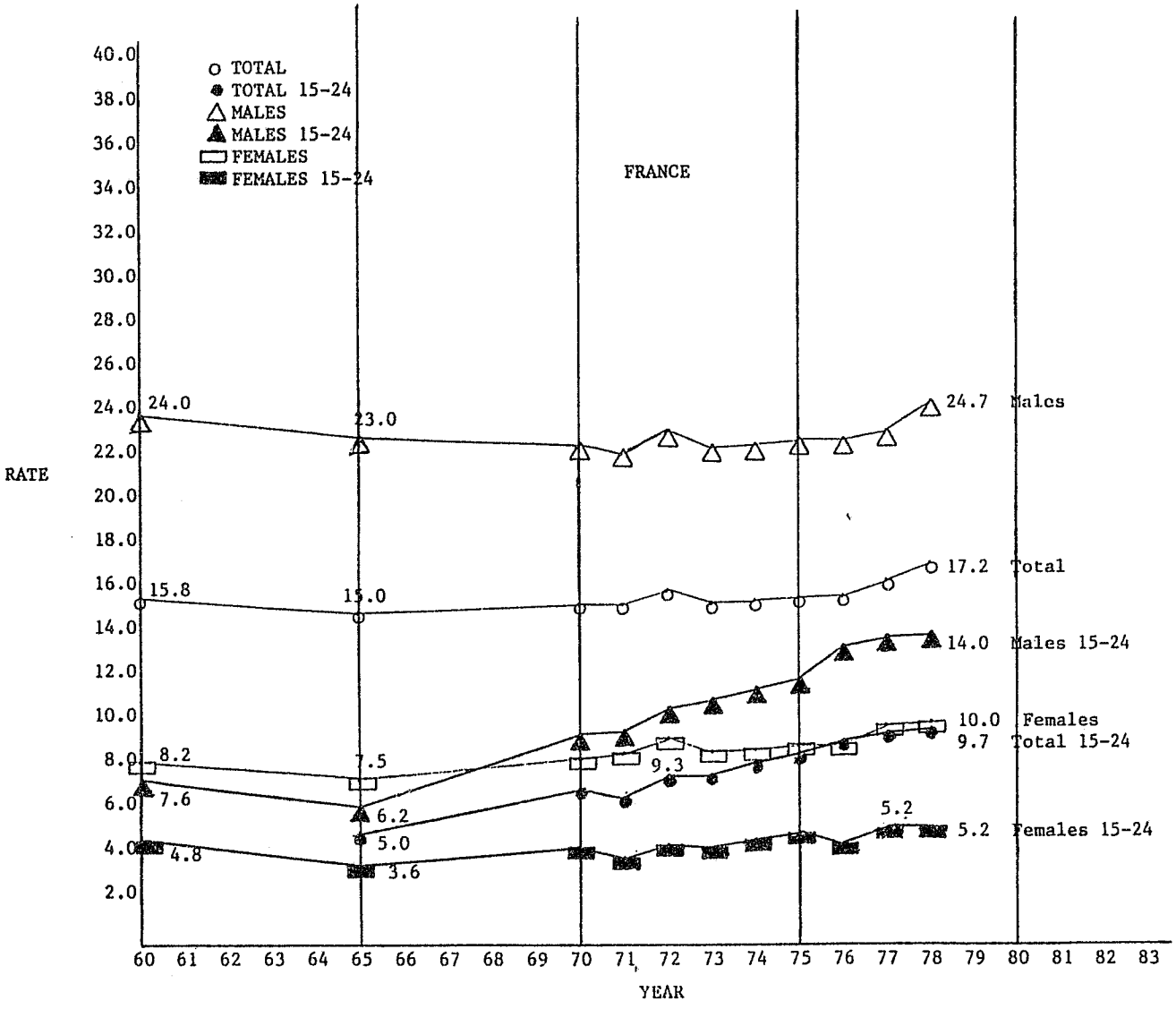
13.9
11.2
8.7
9.0
6.3
4.5
2.6
9.1
7.5
6.0
5.2
7.0
5.0
3.7
7.0
11.5 Males
8.9 Total
6.4 Males 15-24
5.9 Females
4.3 Total 15-24
2.0 Females 15-24

FIGURE 4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MALES
MALES 15-24
FEMALES
FEMALES 15-24
FRANCE
RATE
YEAR
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14.0
12.0
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8.0
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4.0
2.0
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23.0
24.7 Males
17.2 Total
15.8
15.0
14.0 Males 15-24
10.0 Females
9.7 Total 15-24
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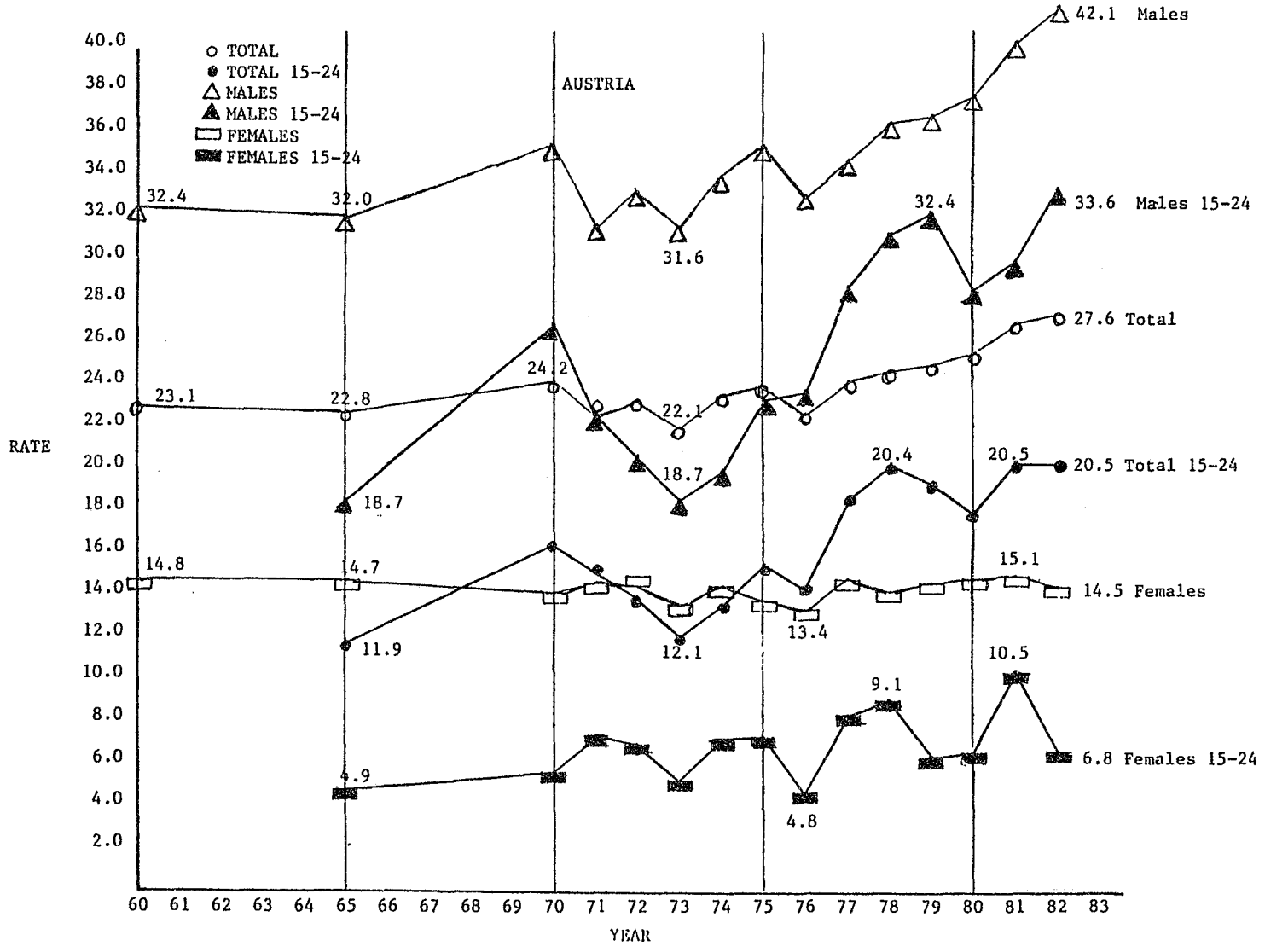
5.2
5.2 Females 15-24
4.8
3.6

FIGURE 5


AUSTRIA
TOTAL
TOTAL 15-24
MALES
MALES 15-24
FEMALES
FEMALES 15-24
RATE
YEAR
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33.6 Males 15-24
27.6 Total
20.5 Total 15-24
14.5 Females
6.8 Females 15-24
32.4
32.0
31.6
32.4
23.1
22.8
24.2
22.1
18.7
18.7
20.4
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11.9
12.1
13.4
15.1
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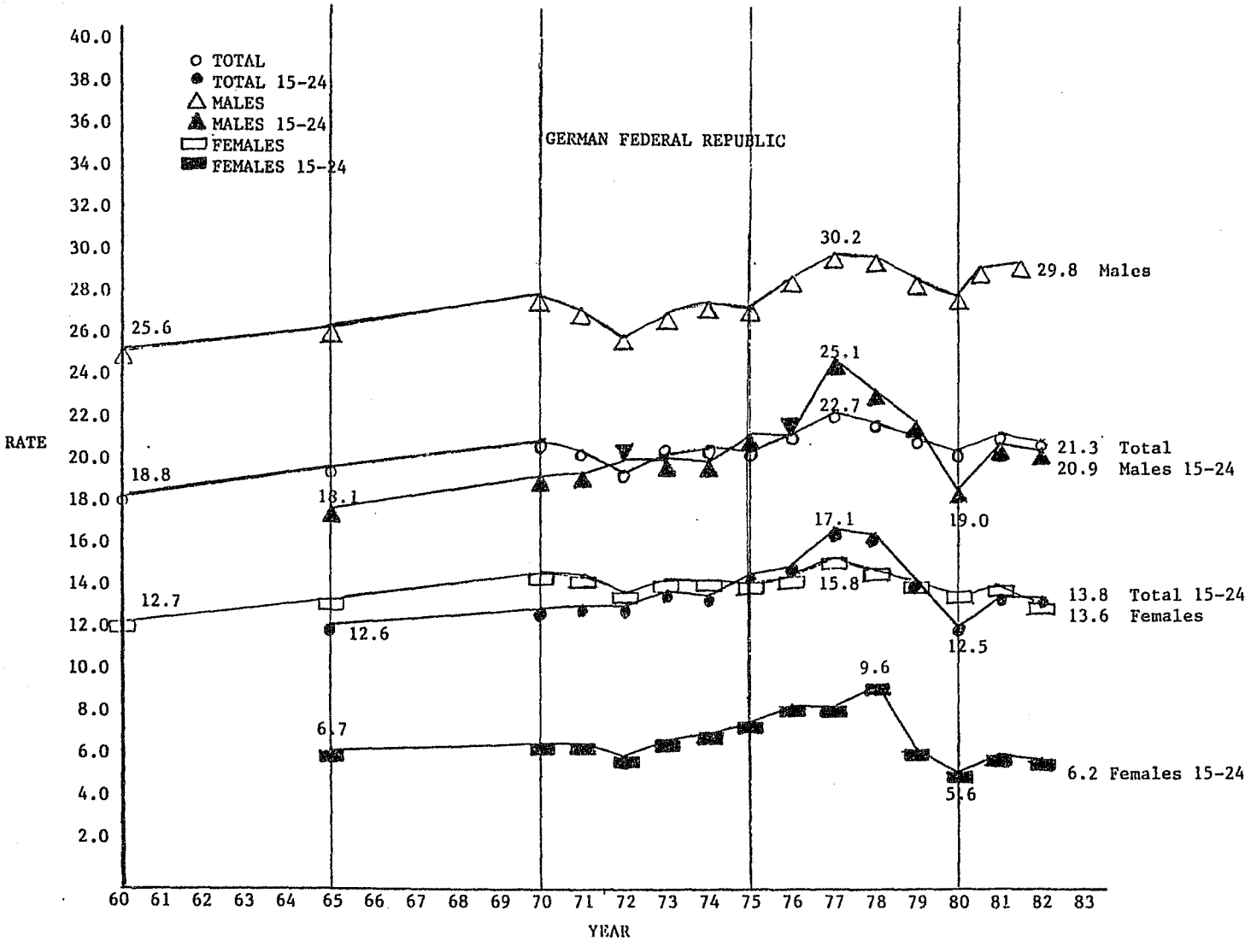
9.1
4.9
4.8

FIGURE 6


GERMAN FEDERAL REPUBLIC
TOTAL
TOTAL 15-24
MALES
MALES 15-24
FEMALES
FEMALES 15-24
RATE
YEAR
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30.2
29.8 Males
18.8
18.1
25.1
22.7
19.0
21.3 Total
20.9 Males 15-24
12.7
12.6
17.1
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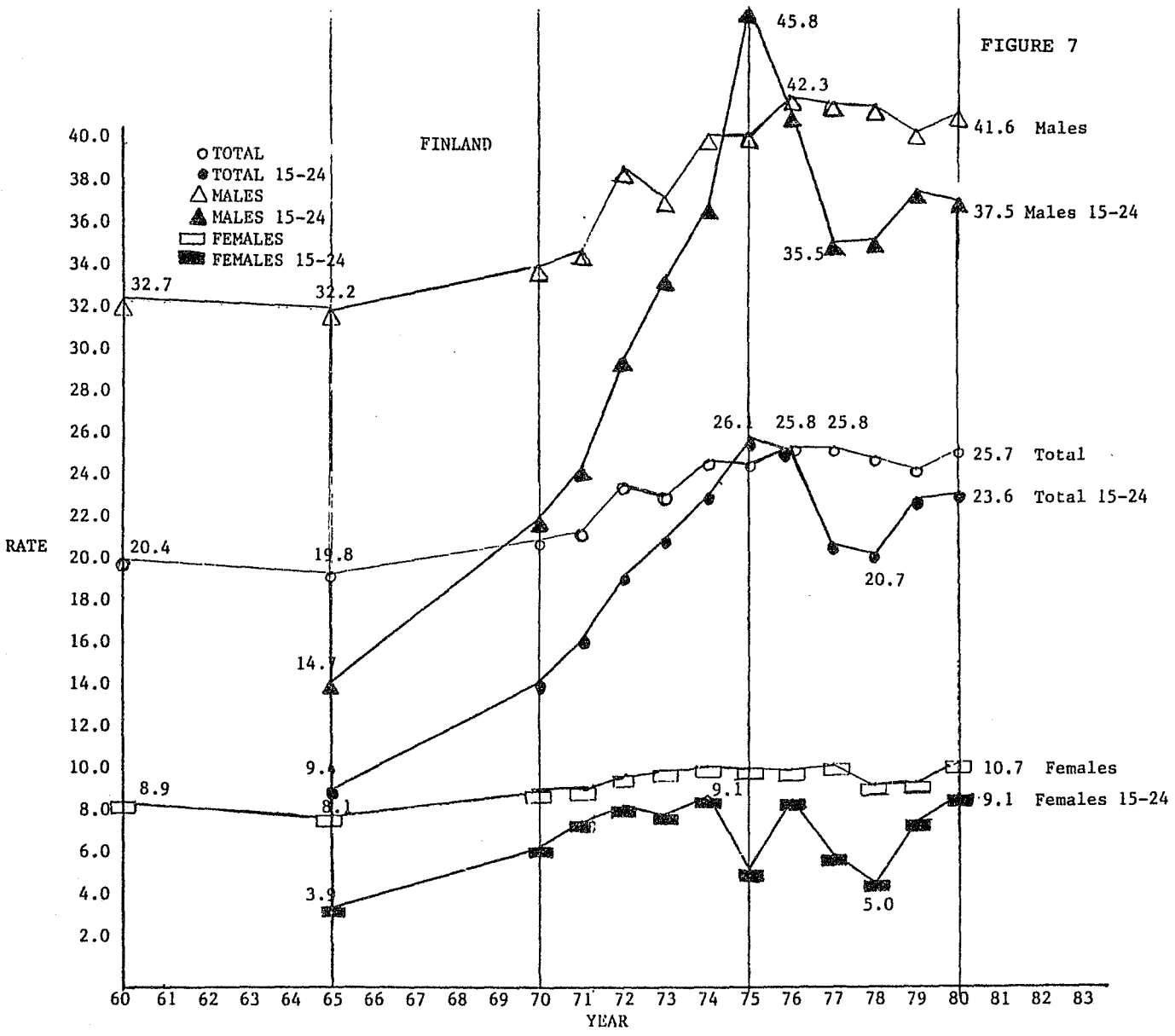
12.5
13.8 Total 15-24
13.6 Females
6.7
9.6
5.6
6.2 Females 15-24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TOTAL
TOTAL 15-24
MALES
MALES 15-24
FEMALES
FEMALES 15-24
RATE
YEAR
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41.6 Males
37.5 Males 15-24
35.5
32.7
32.2
26.1
25.8 25.8
25.7 Total
23.6 Total 15-24
20.7
20.4
19.8
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9.4
10.7 Females
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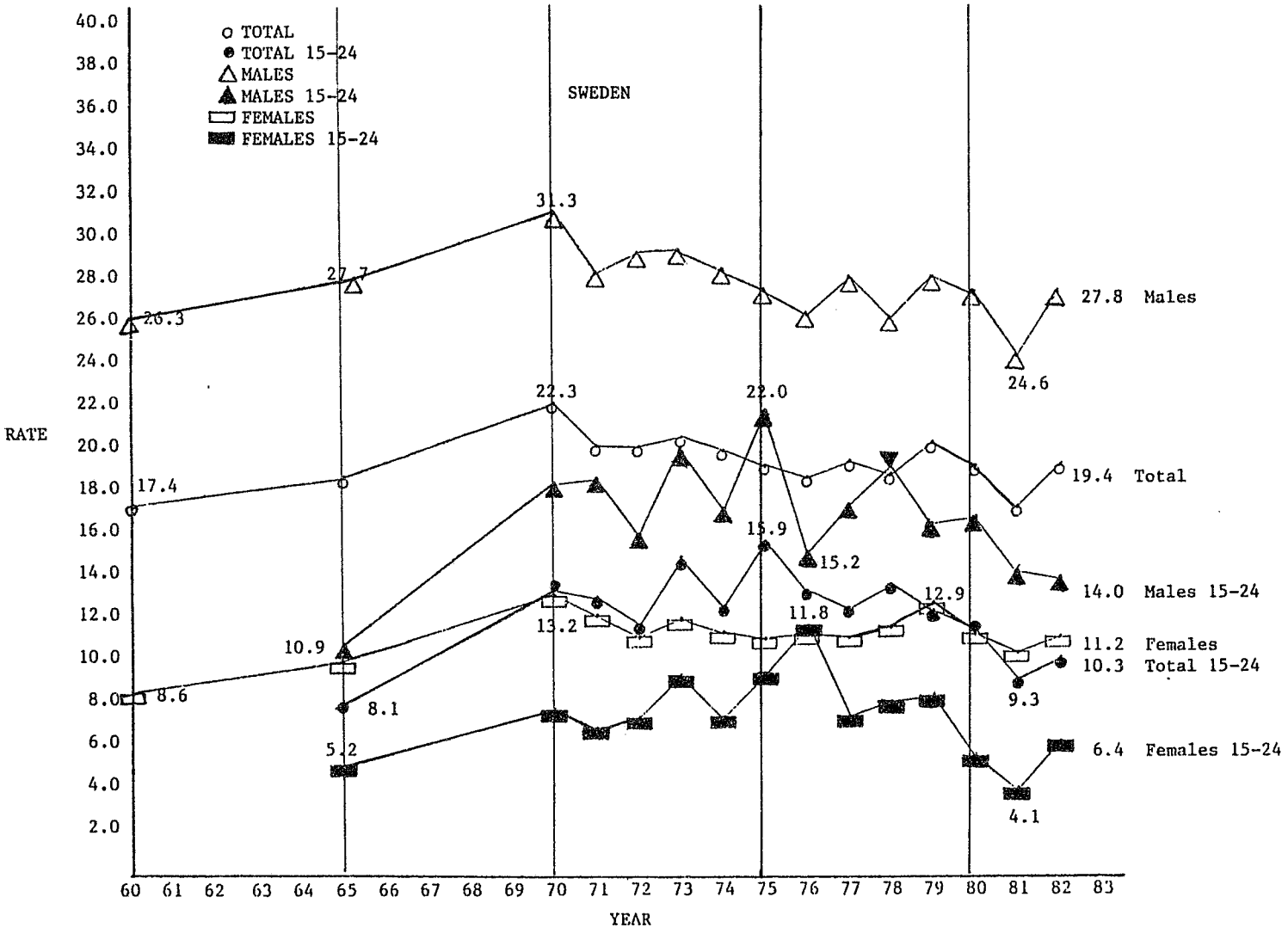
8.1
9.1
5.0
3.9

FIGURE 7

FIGURE 8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MALES
MALES 15-24
FEMALES
FEMALES 15-24
SWEDEN
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18.0
16.0
14.0
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8.0
6.0
4.0
2.0
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26.3
27.7
31.3
24.6
27.8 Males
17.4
22.3
22.0
19.4 Total
15.9
15.2
14.0 Males 15-24
10.9
13.2
11.8
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11.2 Females
10.3 Total 15-24
8.6
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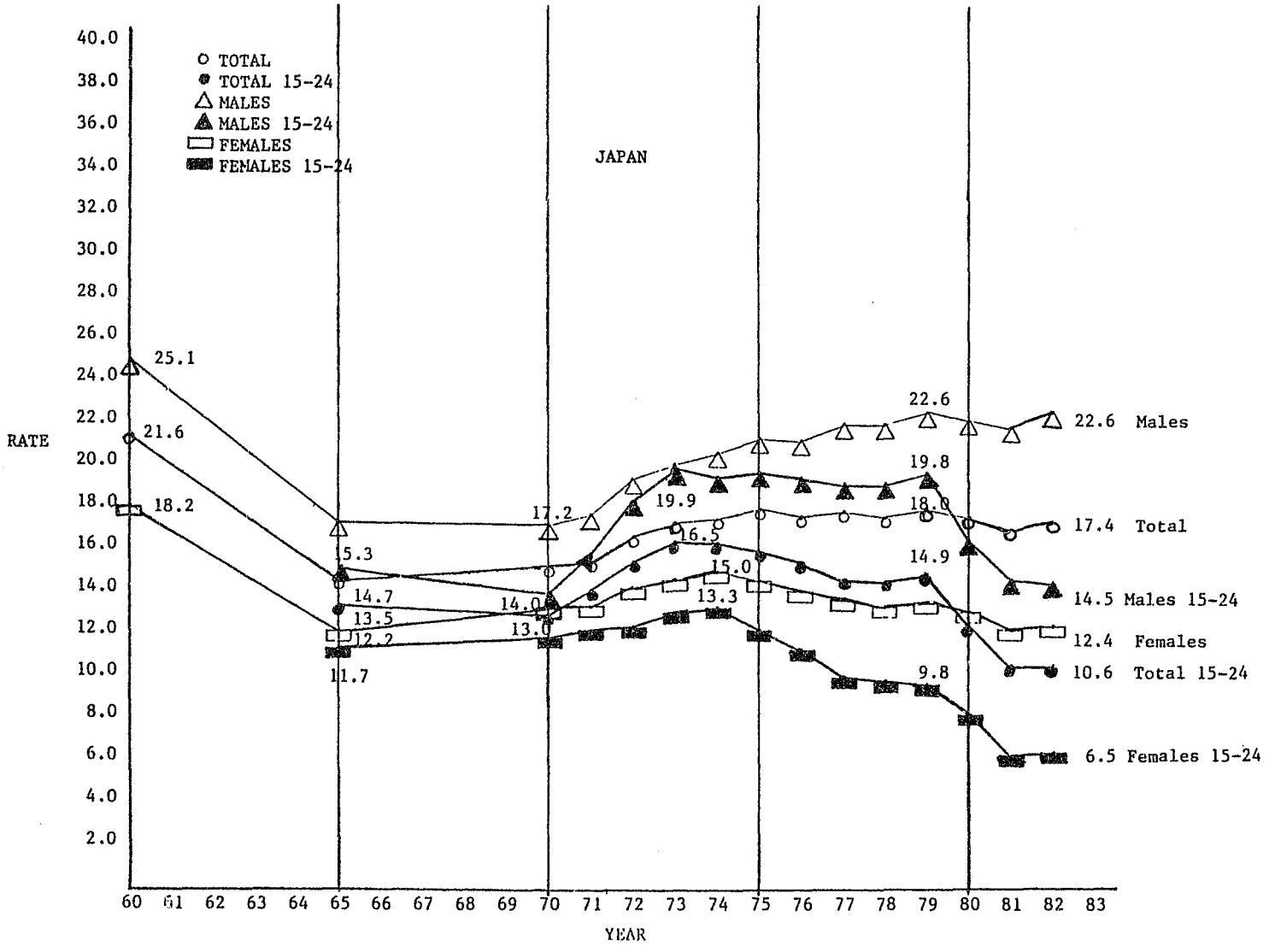
9.3
5.2
6.4 Females 15-24
4.1

FIGURE 9


JAPAN
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TOTAL 15-24
MALES
MALES 15-24
FEMALES
FEMALES 15-24
RATE
YEAR
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26.0
24.0
22.0
20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83
25.1
21.6
18.2
15.3
14.7
13.5
12.2
11.7
17.2
14.0
13.0
19.9
16.5
15.0
13.3
22.6
19.8
18.0
14.9
9.8
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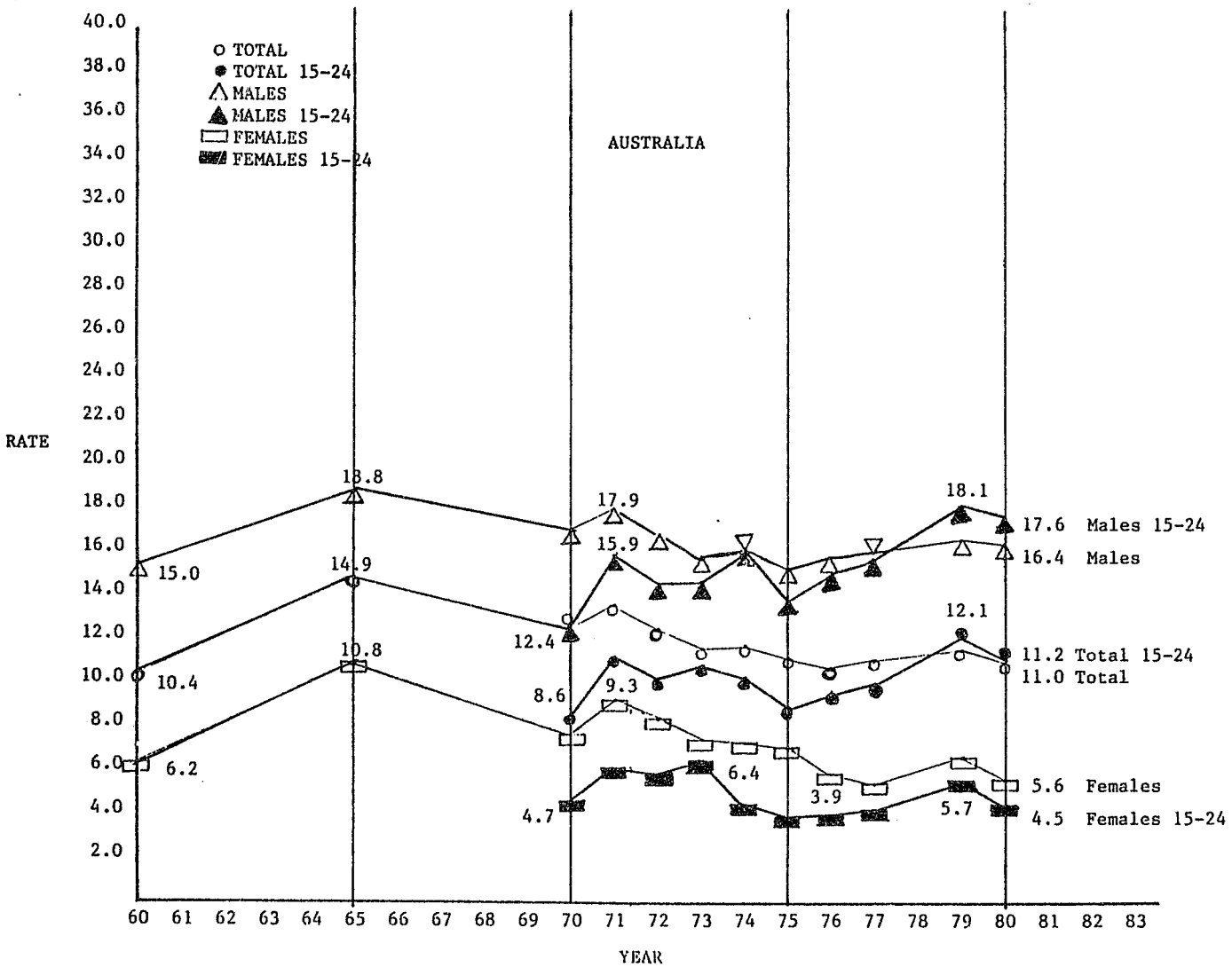
17.4 Total
14.5 Males 15-24
12.4 Females
10.6 Total 15-24
6.5 Females 15-24

FIGURE 10


TOTAL
TOTAL 15-24
MALES
MALES 15-24
FEMALES
FEMALES 15-24
AUSTRALIA
RATE
YEAR
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34.0
32.0
30.0
28.0
26.0
24.0
22.0
20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83
15.0
18.8
17.9
15.9
18.1
17.6 Males 15-24
16.4 Males
10.4
14.9
12.4
12.1
11.2 Total 15-24
11.0 Total
8.6
9.3
10.8
6.2
6.4
3.9
5.6 Females
4.7
5.7
4.5 Females 15-24

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Special Groups

SUICIDE AMONG NATIVE AMERICAN YOUTH

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Director
Native American Programs
Denver, CO

Suicide among Native American youth appears, at first glance, to be similar to that in the rest of society except for the fact that the rate is several times the national average. The tendency, therefore, would be to provide the same preventative measures, such as hotlines, counseling, alcohol prevention and rehabilitation. In the case of Native Americans, this would definitely be treating the symptoms and ignoring the problem, although, in the interim, treatment of the symptoms is very important.

The basic problem is the lack of an active, viable economy on the Reservations, plus the stifling, motivation-robbing presence of the Federal Government. For over 150 years, the Federal Government has determined the present and future of American Indians. Although this presence has diminished in recent years, particularly with the implementation of P.L. 93-638, the Self Determination Act, the result is still the same. This patron-client relationship has resulted in a loss of personal identity, of motivation and of enthusiasm about life in general.

In recent years Tribes have begun to break away from this imposed dependency situation by exercising their Self Determination rights and by beginning to develop Reservation economies. It has been the lack of an economy with the opportunity for meaningful employment that has created many of the symptoms among Indian youth and adults. Without the prospect or the perceived certainty of meaningful employment after completion of school, a high percentage of Indian youth drop out of school and turn to various means of escape with far too many ending in suicide.

The reduction of the involvement of the Federal Government in the lives of Tribes and individual Indian people is most desirable and is beginning to take place. However, it is of great concern that this not in any way affect the Trust Relationship or the Status of Reservations as guaranteed by treaties, acts of Congress and Presidential orders.

The problem of the lack of Reservation economies needs to be addressed by tribes, Federal agencies and the private sector. This problem and the attendant aspects, such as the lack of access to the capital market, has been the subject of numerous studies and papers. It is now time to get on with implementing the many valid known solutions.

This is not to suggest that by reducing the involvement of the Federal Government and by the creation of Reservation economies that suicide among Indian youth will disappear, but it certainly will be reduced.

NATIVE AMERICAN SUICIDE IN NEW MEXICO, 1957-1979: A COMPARATIVE STUDY

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Albuquerque, NM

INTRODUCTION

Suicide among Native Americans has been a topic of interest to social scientists for the past four decades and numerous studies have been conducted to examine this phenomenon among various Indian groups. This study examines completed suicides among the Apache, Navajo and Pueblo Indians of New Mexico from 1957 through 1979. It is a descriptive, demographic and epidemiological study which is both longitudinal, spanning 23 years, and comparative in nature. A number of demographic and situational variables are examined for the three cultural groups. In addition, the social integration and acculturation explanations for suicide in Native American groups will be discussed to see if either explanation is supported by the findings of this study. Past studies of Native American suicide have had two general shortcomings. First, most studies have encompassed a relatively short time span, often from one to ten years. Since Native American populations are generally small and suicide rates fluctuate greatly from year to year, results of studies with short time spans can be very misleading. Second, few studies have attempted a comparison between different cultural groups or tribal groups. Usually one tribal group has been studied and the results have been reported in a vacuum. This study has been designed to overcome these shortcomings.

RELATED RESEARCH

Although sociological research on suicide dates back to the 19th century, social scientists did not begin to study suicide

among Native Americans until the 1940's (Devereux, 1942; Fenton, 1941; Wyman and Thorne, 1945). It was not until the 1960's and 1970's that this research began to flourish. Most of the research was conducted among tribal groups thought to be experiencing a problem with suicide in their community. As a result, some of the more highly publicized studies indicated that Native Americans had suicide rates 10 and 12 times higher than that of the total United States population (Berman, 1979; Dizmang et al., 1974; Shore et al., 1972). Suicide appeared to be running rampant among the Indian population.

As social scientists began to look over the results of numerous Native American suicide studies, some realized that each cultural and tribal group had a unique pattern of suicide (Bynum, 1972; Havighurst, 1971; May and Dizmang, 1973; McIntosh and Santos, 1981; Santora and Starkey, 1982; Webb and Willard, 1975; and Willard, 1979). While some groups had a reported rate as high as 150 per 100,000, other groups had reported rates as low as zero per 100,000. Therefore, it made little sense to talk about Native American suicide patterns and rates only in an aggregate sense and the stereotype of the "suicidal Indian" lost its credence (May and Dizmang, 1974; Shore, 1975; Webb and Willard, 1975). More social scientists realized the importance of viewing each cultural group or tribal group as a unique and separate entity.

Beginning in the 1940's, studies have been conducted examining the phenomenon of suicide among the Apache, Navajo and Pueblo groups in New Mexico. Most of these studies looked at a single cultural group and little comparative research was conducted. A brief review of these studies will show their contribution to an understanding of the uniqueness of the suicide phenomenon among each cultural group and the questions remaining to be answered.

Apache

Studies of New Mexico Jicarilla and Mescalero Apache suicide are virtually nonexistent although Levy (1965) provides limited comparisons with his more complete data on Navajo suicides. Levy found a rate of 20.8 per 100,000 for completed suicides among the Apache from 1953 to 1962. There are several studies of suicide among the White Mountain Apache of Arizona (Everett, 1970; Levy and Kunitz, 1969), but the New Mexico Apache have been ignored.

Navajo

Of the three cultural groups in New Mexico, the Navajo have received the most attention from social scientists in regard to the phenomenon of suicide. Wyman and Thorne (1945) made the first survey of suicide and suicide attempts on the Navajo reservation for the period 1890 through 1944. They inter-

viewed eight informants in the Chaco Canyon, New Mexico area to elicit an estimate of the frequency, pattern, causes and beliefs regarding Navajo suicide. They combined this information with notes and data from other field researchers and informants, and came up with a total of 28 suicides and five suicide attempts among the Navajo during that time period. This, therefore, described a low historical rate of suicide among the Navajo.

Two decades later, Levy (1965) conducted a study of Navajo suicide from 1954 through 1963 using Navajo police records for his primary data. His was a quite comprehensive study that included suicides occurring both on the reservation and in communities close to the reservation. Included were suicides from New Mexico, Arizona and Utah. Levy found that the Navajo rate of suicide (8.28 per 100,000) was lower than the national and state averages. Contemporary patterns of Navajo suicide were described and interpreted. This is one of the few comparative studies of Native American suicide in that it included references to New Mexico Pueblo and New Mexico Apache patterns of suicide and showed that Navajo rates were lower than rates for either of these tribes.

Levy has incorporated the findings of his 10 year study in several other articles about the Navajo. For example, Levy et al., (1969) described the relationship between Navajo suicide and Navajo homicide. There was evidence of convergence in that both suicide and homicide were performed predominantly by males between the ages of 35 and 39 years, with domestic quarrels and sexual jealousy being the most frequently cited motives. They also discovered that the proportion of Navajo homicides followed by suicide was higher than that for the U.S. population as a whole. In another article, Levy and Kunitz (1971) explored the idea of whether Navajo suicide was a result of acculturation or a continuation of traditional beliefs. Traditional beliefs received more support from the data presented.

Another study of Navajo suicide looked at completed suicides and suicide attempts over a seven and one-half month period in late 1968 and early 1969 (Miller and Schoenfeld, 1973). The data were obtained from suicide reporting forms completed by the physicians of the Indian Health Services network and three mission hospitals on the Navajo reservation. Miller and Schoenfeld found the rate for completed suicides to be 12.8 per 100,000 which was slightly higher than the national average and comparable to the rates for New Mexico and Arizona. The suicide attempt pattern was not significantly different from other populations.

Two recent demographic studies including all major causes of mortality among the Navajo found an increase in suicide. In one, the crude suicide rate for all Navajo in Arizona, New Mexico and Utah for 1975-1977 was 20.3 per 100,000 and the age-adjusted rate was 2.3 times higher than the U.S. rate.

These authors indicatd that the Navajo rate of suicide had increased in the 1970's (Broudy and May, 1983; May and Broudy, 1980). In the second study, Kunitz (1983) also noted an increase in Navajo suicide rates from 1972-1978 and linked this to a parallel trend in overall U.S. rates which have risen in the past years.

Pueblo

Pueblo suicide has received more attention than Apache suicide but not quite as much as Navajo suicide. Here again Levy (1965) incorporated available statistics into his study of Navajo suicide. He found a rate of 10.2 per 100,000 for completed suicides among the Peublo from 1953-1962. Biernoff studied completed suicides of all New Mexico Pueblo Indians with the exception of Zuni from 1959 through 1969, and attempted suicides from 1966 through 1969. Data on complete suicides were obtained from the New Mexico State Department of Vital Statistics and the Bureau of Indian Affairs Division of Law and Order. Suicide attempt data were obtained from various Indian Health Service installations. Biernoff found that the overall Pueblo suicide rate was 18 per 100,000 for 1960 through 1969. Furthermore, there was a substantial increase in the suicide rate for 1967 through 1969, 45 per 100,000, and marked differences in rates for various tribal groups.

Andre and Ghachu (1974) studied completed suicides and attempted suicides at Zuni Pueblo from 1965 through 1974. Data for 1965 through 1970 were gathered from clinic records and the records of the police, probation and parole, and social service agencies, while data from 1971 through 1974 were obtained from a suicide register in the Zuni community. The suicide rate at Zuni Pueblo was found to be 40 per 100,000 which is over three times the national rate. The manuscript discussed the suicide pattern over this nine and one-half year period and suggested some explanations for the findings.

Finally, Blanchard et al. (1976) conducted a psychological autopsy on a Pueblo Indian adolescent who had committed suicide. They suggested anomie, alienation, racial discrimination and the self-fulfilling prophecy of Anglo teachers as reasons for this suicide.

From this brief review of studies of Native American suicide among the cultural groups in New Mexico, it can be seen that more research is needed to adequately describe the phenomenon of suicide among these groups, much less to explain it. The present study attempts to provide just such a detailed description of the phenomenon.

METHODS

The primary data for this study were obtained from death certificates registered with the New Mexico State Department of Vital Statistics from 1957 through 1979. To be certain that all of the New Mexico Native American suicides were identified, the following sources were consulted: 1) summaries of suicides in New Mexico from 1958 through 1974 which were provided by the New Mexico State Department of Vital Statistics to the Indian Health Service Mental Health Program in Albuquerque; 2) computer printouts of suicides from 1969 through 1978 from the Vital Statistics Department; and 3) a mortality tape of all deaths in New Mexico from 1957 through 1979 generated by Vital Statistics, but obtainable through the New Mexico Tumor Registry. Using these three sources of identification insured the most complete list of cases. Because there was no information readily available to identify cases prior to 1957, the study was restricted to the years 1957 through 1979. Death certificates were obtained for all of the Native American suicides which had been identified. To be as consistent as possible, the suicides included in the following analysis are limited to those Apache, Navajo and Pueblo Indians who were residents of New Mexico at the time of death and who died in New Mexico.

The validity of using death certificates to determine suicide rates, test hypotheses, and construct theories has been challenged by many and it is generally acknowledged that suicide is an underreported phenomenon (Lester and Lester, 1971; Massey, 1967; Nelson et al., 1978). Despite the problems associated with using death certificates, they remain one of the few official sources of data on suicide available to researchers.

Population estimates used to calculate rates for 1957 through 1979 for all tribes and reservations in the study came from the Indian Health Service. During the period 1957-1979 the population estimates increased from 2,400 to 3,705 for the Apache, 32,309 to 60,841 for the Navajo, and 19,550 to 27,824 for the Pueblo. These figures are based on resident population on and adjacent to the reservation rather than enrolled population. They are estimates calculated from the Census of the United States which is widely believed to undercount the actual Indian population. Therefore the rates in this study may be slightly exaggerated due to the low population estimates, but the margin of error would probably not be greater than 7-10% for most tribes (Passel, 1976). The Indian Health Service data were used because they represent the most consistent, detailed and complete estimates of local resident population available. This consistency allows the most accurate measurement of trends over time and the most accurate inter-tribal comparisons because the direction of error should be similar for all tribes. In addition, rates may be slightly exaggerated due to the use of a resident population base while including suicides by New Mexico Indians who may have lived

outside of the IHS defined service area for the particular tribe.

Since tribal affiliation was not recorded on most death certificates, tribal affiliation was determined from the information on birthplace, burial place, surname and place of residence at the time of death. In the rare cases when these indicators showed little agreement, outside referees from appropriate tribes were consulted to make a positive identification of the particular individual's tribal affiliation.

RESULTS

From 1957 through 1979, 328 Native American suicides were on file at the New Mexico State Department of Vital Statistics. Of these, 317, or 96.6%, actually occurred in New Mexico, while 11, or 3.4%, took place in other states. In addition, 303, or 92.5%, were residents of New Mexico and 23, or 6.9%, were residents of Arizona at the time of death. All but two of the deaths, or 99.4%, were listed as suicides; the other two, or 9.6%, were listed as apparent suicides.

Almost all of the recorded Indian suicides in New Mexico were committed by Apache, 9.4%; Navajo, 45.1%, or Pueblo, 42.4%, Indians. The other three percent represented miscellaneous other Native American tribes. Because the data for out-of-state deaths were available only for seven of the 23 years included in this study and the population estimates used to calculate death rates are based on resident population in New Mexico, all of the following results were determined by using the 284 suicides committed by the Apache, Navajo and Pueblo Indians who died in New Mexico and who were residents of New Mexico at the time of death. Of the 30 Apache suicides, 63.3% were Jicarilla and 36.7% were Mescalero. The 117 Navajo suicides included 0.9% from Alamo, 4.3% from Canoncito, 2.6% from Ramah, 74.4% from the Main Reservation in New Mexico, 15.4% from the Main Reservation in Arizona, 0.9% from the Main Reservation in Utah, and 1.7% from other tribal groups. Tribal affiliations for the 137 Pueblo suicides were the following: Nambe - 1.5%; Picuris - 0.7%; Pojoaque - 0.0%; San Ildefonso - 0.7%; San Juan - 3.6%; Santa Clara - 1.5%; Taos - 7.3%; Tesuque - 0.0%; Cochiti - 3.6%; Isleta - 14.6%; Jemez - 2.9%; Sandia - 0.0%; San Felipe - 4.4%; Santa Ana - 2.2%; Santo Domingo - 0.7%; Zia - 2.2%; Acoma - 5.8%; Laguna - 22.6%; and Zuni - 25.5%.

A pattern begins to emerge from the calculation of crude suicide rates. Tables 1 and 2 present crude and three-year-average rates for the years 1957-1979. Figure 1 presents the three-year average rates graphically. When one is interpreting rates for small populations, caution is advised since one or two deaths can result in enormously large rates. In trying to deal with this real problem of analysis using small populations, this study describes the suicide problem over a

long period of time, in larger cultural groups which have larger population bases, and by calculating three-year-averages as well as standard crude death rates. Three-year-averages are used to smooth out the extreme annual fluctuations resulting from the small numbers involved in the study groups. For example, there were only three years prior to 1966 in which the Apache had any suicides at all. Yet because of the small population, the two suicides in 1957, two in 1959 and one in 1960 translate into the extremely high rates for these respective years of 83.3, 79.3 and 38.7 per 100,000. Using three-year-averages drops the rates for these years considerably although they are still well above national and state rates. The U.S. rate of suicide varied between 9.8 and 13.3 during the years 1957-1979 while the New Mexico rate showed a much greater variability and increase from 9.9 to 19.3 (U.S. DHEW, 1957-1977; Monthly Vital Statistics Reports, 1979, 1980, 1982)[1].

From the three-year-averages one can see that the Apache rate has risen since 1965, reaching peaks in 1968 and again in 1974, and another upward trend was apparent in 1978. The crude suicide rate for the New Mexico Apache for the entire period 1957-1979 was 43.3, or more than double the rate of 20.8 reported by Levy (1965) for the Jicarilla and Mescalero Apache in the time period 1953-1962. Statistics gathered for the present study show the New Mexico Apache committing suicide at a rate of 32.7 per 100,000 in the years 1957-1962 which is still considerably higher than the rate cited by Levy. An extremely low suicide rate from 1953 through 1957 could perhaps account for such a discrepancy, but it is impossible to tell whether that was in fact the case.

The lowest rates of all were found among the Navajo where the three-year averages indicate that suicide declined from 1958 through 1962, then remained fairly constant through 1971, and rose considerably through the rest of the 1970's. Before 1972 Navajo rates were usually lower than rates for the United States or New Mexico. Since then, however, Navajo rates have generally been as high as or higher than the national and the New Mexico averages. For the entire period 1957-1979, the crude suicide rate for the Navajo was 12.0 per 100,000.

Going back to the earlier period of 1890-1944, Wyman and Thorne (1945) found the frequency of suicide among the Navajo not very different from that of the national population. They documented only two suicides in the late 1800's and two more between then and 1910. The 14 suicides they listed from approxiately 1930 to 1944 may suggest an increase in Navajo suicide at that time. Levy (1965) also reported an increasing incidence of suicide from 1954 through 1963 with an average suicide rate for that period of 8.28 per 100,000 or slightly lower than the national average. In general, Levy's figures conincide with the findings of the present study. The data of May and Broudy (1980) are similar also, for their rate of 20.3 for 1975-1977 is similar to the 21.9 of this study. By con-

trast Miller and Schoenfeld (1973) calculated a rate of 12.8 for part of 1968 and 1969 which is considerably higher than the actual calculations of 2.5 and 9.9 shown on Table 1 or the three-year averages of 7.6 and 5.8 shown in Table 2 for those years. Like Levy and others, Miller and Schoenfeld included the entire Navajo population rather than just the Navajo living in New Mexico. This may account for at least some of the difference.

The suicide rates for the Pueblo in this study were generally higher than those for the New Mexico Navajo, especially since 1967, and were generally lower than the Apache rates. On the other hand, when both Apache and Navajo rates were dropping between 1958 and 1964, Pueblo rates were rising with peaks of 18.7 in 1962 and 1964. Figure 1 shows a dramatic rise in Pueblo suicides from 1965 through 1968, followed by a decline from 1969 through 1973, with a peak of 43.8 in 1976. The overall crude suicide rate for 1957-1979 was 27.8 per 100,000.

Levy's (1965) figure of 10.2 suicides per 100,000 Pueblo Indians living in New Mexico from 1953 through 1962 is comparable to the 1957-1962 rate of 11.1 in the present study. By contrast, a comparison of the present study with Biernoff's shows a marked discrepancy. Excluding Zuni Pueblo, Biernoff documented 36 New Mexico Pueblo suicides from 1960 through 1969 and calculated the rate as 18 per 100,000. Using the 35

Pueblo suicides, excluding Zuni Pueblo, included in this study during that time period, the calculated rate would be 22.7 where the population base is that provided by the Indian Health Service rather than the tribal rolls used by Biernoff.

Clearly, suicide rates among the New Mexico Apache, Navajo and Pueblo Indians have fluctuated greatly in recent decades. When the three groups are combined as in the final column of Table 2, three-year-averaging reveals a decline in suicide rates from 1958 through 1965, followed by a fairly precipitous rise thereafter. The relative positions of the groups have remained quite stable, with the Apache rates consistently being the highest and the Navajo the lowest, with the Pueblo in between. Since the mid-1960's, however, both the Apache and the Pueblo rates have risen and, since 1972, the Navajo rates also have climbed. The Indian suicide pattern in New Mexico does, to some extent, parallel the increase shown in the U.S. and the state, but the magnitude of increase seems to be greater.

A final note on the trends of suicide is appropriate here. As indicated previously, the crude suicide rates of both the U.S. population and New Mexico have increased in recent decades. The crude rates of the Apache, Navajo and Pueblo have all risen in the same manner as the nation and state, but at a faster rate. By the late 1970's, the Apache and Pueblo had crude rates which were considerably higher than the nation or state and the Navajo rate was higher than the U.S. rate and

similar to the New Mexico rate. Age-adjusted rates, found in Tables 4 and 5, provide the most accurate comparisons of these differences. The combined, age-adjusted rate of Apache, Navajo and Pueblo went from 1.3 times the U.S. rate in the early years of this study to 1.9 in the middle to 2.3 in 1973-1979, from 14.7 to 21.9 to 28.2 per 100,000. Looking at tribal specific age-adjusted rates and standardized mortality ratios, the Navajo age-adjusted rate has gone from 0.8 of the U.S. rate to 1.7 times the U.S. rate; the Pueblo from 1.7 to 3.2 times the U.S. rate; and the Apache from 3.4 to 4.9 times the U.S. rate. Therefore, the increase in suicide registered among these tribes by the crude rates is real even when age is controlled and the increase is considerably greater than the increase in the U.S. population.

Levy (1984) has suggested that all rural areas in Arizona have experienced increases in suicide. Both non-Indian and Indian communities alike have experienced a significant rise in suicide rates in the last decade. This may also be true in New Mexico and non-Indian data should be examined for a similar trend.

The discussion will now turn to the characteristics of the individuals committing suicide. Seven demographic variables, sex, age, marital status, veteran status, occupation, birthstate and residence, will be discussed for the study groups and some comparisons will be made to trends in the United States population as a whole and to other Indian groups when appropriate. Again, caution is advised with some of the comparisons of Native American and U.S. suicide patterns since the populations are very different with regard to size, age, culture, socioeconomic status, rurality and other living conditions.

Sex: This study found Native American suicide in New Mexico to be predominantly a male phenomenon with 89.8% of the suicides being male, Apache, 90%; Navajo, 88%; Pueblo, 91.2%; and only 10.2% of the suicides being female. The three groups combined show a male to female ratio of 8.8:1 with an Apache ratio of 9:1, a Navajo ratio of 7.4:1, and a Pueblo ratio of 10.4:1. It appears that more females are committing suicide now than in the past for at least the Navajo and Pueblo groups. For the Navajo, Wyman and Thorne (1945) found a 13:1 ratio for 1890-1944 and Levy (1965) calculated a 13.4:1 ratio during 1954-1963. The change seems even greater for the Pueblo when one compares the ratio of 20:1 found by Levy (1965) for all New Mexico Pueblo groups from 1954-1963; 15.7:1 reported by Biernoff for Pueblos excluding Zuni from 1959-1969; and 18.1 calculated by Andre and Ghachu (1974) for the Zuni during 1965-1974. The ratios of 3:1 and 2:1 to 7:1 reported by Massey (1967) and Frederick (1978) respectively for the general U.S. population indicate that suicide is even more of a male phenomenon among New Mexico Indians than in the overall U.S. population.

Age: The age range for the Native American suicides in this study is 12 to 69 years with a median age of 25.9 years. Table 3 shows the highest frequency occurring in the 20-24 year age range, 24.6%, followed by the 15-19 year, 18.3%, and 25-29 year, 18%, age ranges. A full 81.1% of the Indian suicides occurred between 10 and 39 years of age and all of the female suicides were between 10 and 44 years of age.

Apache suicides occurred at a very young age with a range of 12-48 years and a median of 21.5 years. The 15-19 year age group exhibited the highest percentage of suicides, 40%, while 93.4% of the suicides were committed by individuals between 10 and 39 years. These data are different than Levy's (1965) finding of a 14-55 year age range for the New Mexico Apache and his observation that Apache suicides appear to be more middle-aged than Navajo suicides. Apache suicides were the youngest of the three tribal groups.

The Navajo data show a more dispersed age pattern than the Apache data with an age range of 12-69 years and a median of 27.4 years. The highest percentage of suicides was in the 20-24 year age group, 24.8%, while 75.4% of the suicides were between 10 and 39 years of age. Contrary to the findings of this study, Wyman and Thorne (1945) reported no cases of Navajo suicide by children and most were middle-aged or older. In addition, this study indicates that Navajo suicides are clustering in younger years than the 25-29 year age range reported by Levy (1965).

The age range for the Pueblo is similar to that for the Navajo with a range of 12-67 years and a median of 25.1 years. Again, the highest percentage of suicides was in the 20-24 year age group, 26.3%, with 83.3% between the ages of 10-39 years. Biernoff's finding of a 29.6 mean for the Pueblo Indians, excluding Zuni, is comparable to the 28.4 year mean found in this study. Howver, the age range of 14-55 years for the New Mexico Pueblo reported by Levy (1965) is much smaller than that found in this study.

Looking now at age-specific rates one can gain a better understanding of the age differences in suicides between the U.S. and Native Americans in New Mexico. In Table 4, the age-specific rates for the three tribes combined are presented for three time periods. In each time period the Native American rates are considerably higher than U.S. rates for almost all age categories, ranging from two to eight times higher than U.S. rates for ages 5-14, four to five times higher for ages 15-24, and two to three times higher in ages 25-34. In addition, the rates of suicide in most of the younger age categories have not only increased, they have increased faster than the U.S. rates. Native American suicide rates increased 49% and 29% in later years compared to four percent for the U.S. Therefore, both the youthful nature of suicide and a faster rate of increase are apparent in this comparison.

Tribal differences in age-specific rates are described in Table 5. In both the early and late time periods depicted, the Apaches had the highest rates in virtually all of the age categories under 55 years. The mortality ratios indicate that the three groups had higher rates than U.S. rates for most age categories under 35 years from 1957-1968 and for all categories under 45 years for 1969-1979. In general, Table 5 shows that the rates of suicide increased in virtually every age category in every cultural group over the two periods analyzed. The percent increases reflected in the age-adjusted rates for each cultural group during these periods are: Apache, 47%; Navajo, 105%; Pueblo, 87%. Although the Apache had the highest rates of suicide, they had the lowest percent increase while the Navajo with the lowest rates had the highest percent increase. The rates of all three groups were increasing faster than the U.S. rate.

One final point needs to be made from Tables 4 and 5. There appears to be an increase in suicide rates among the older age groups of New Mexico Indians. In Table Four suicides first appeared in the 65-74 age category in the years 1966-1972 and continued into 1973-1979. In addition, rates of suicide among Indians 55-64 years increased over the time of this study. Table 5 indicates that this trend has been occurring among the Navajo and Pueblo and not the Apache. This could be a significant trend to watch in the future. As the Indian population characteristics change toward an older population and mortality experience changes in general (Broudy and May, 1983; Kunitz, 1983), suicide in the older ages may become more common among various tribes.

The age pattern found in this study of New Mexico Native American suicides, then, is similar to the pattern reported for other Native American groups (Conrad and Kahn, 1974; May and Dizmang, 1974; Shore, 1975). Indian suicides are disproportionately young which is a pattern quite different from that of the general U.S. population, but somewhat similar to that of other nonwhites (Lester and Lester, 1971; Massey, 1967). In addition, although Frederick (1978) and Hendin (1982) among many others have noted an incrase in young adult suicides in the U.S. in recent years, they still found the highest rates among older persons.

Among New Mexico Indians there has also been an increase in suicide among some of the younger age groups. Suicide among Indians under 45 years of age has increased greatly from 1957-1979. The mortality ratios of the rates for the three groups compared to the U.S. rates show that the Indian suicide rates in all of the age groups below 45 years were 1.4 to 7.8 times higher than the U.S. rates during that time period and 2.5 to 7.8 times higher in the most recent time period. Therefore, the rate of suicide among Native Americans in most of these age groups is not only higher than U.S. rates, but has increased as rapidly if not more rapidly than U.S. rates. Indians may be affected by the larger natural trend of more

youthful suicide as noted for the Navajo by Kunitz (1983), but th rates of these three groups continue to be much higher than national rates in the age categories under 45 years.

Marital Status: The pattern of marital status differs somewhat for each tribal group in this study. Three-fourths of the Apache suicides were single while 21.4% were married and 3.6% were divorced. Over half of the Pueblo suicides were single, 53%, while 38.1% were married, 5.9% were separated or divorced, and 3% were widowed. The Navajo show a different pattern with 50.4% of the suicides being married, 33.3% being single, 6.9% being separated or divorced, and 3.4% being widowed. When looking at marital status by sex, all subgroups were more likely to be single with the exception of the Navajo males who were more likely to be married, 53.9%, than single, 36.3%. Levy (1965) found the same marital pattern for Navajo suicides but Andre and Ghachu (1974) reported a higher percentage of married, 68.4%, than single, 26.3%, Zuni Pueblo Indians. The young age of the suicide population in this study may account for the large percentage of single individuals.

Veteran Status: Of those death certificates reporting veteran status, the majority of Indians of each cultural group were non-veterans: Apache, 83.3%; Navajo, 81.2%; Pueblo, 66.7%. Veteran status was not reported for 21.1% of the cases. However, even if all of the missing cases were veterans, the percentage of non-veterans would still greatly exceed the percentage of veterans for the Apache and Navajo while the distribution of Pueblo cases would be approximately half-and-half. These findings are contrary to the popular notion that many Indians who commit suicide are veterans who have been exposed to the White world and have experienced difficulty when returning to reservation life. This finding does not address the issue of whether or not veterans have higher rates of suicide than non-veterans. While this would be an interesting area to explore, denominator data on veterans in the general populace of these tribes would be very difficult to obtain.

Occupation: Since the listing of occupation on New Mexico death certificates is generally unreliable and occupation was not listed for 12% of the cases, detailed findings will not be reported. However, the finding that 20.4% of the suicides were students should be mentioned since this finding suggests a specific area which could be explored further for prevention purposes.

Birthstate and Residence: The majority of Native American suicides in this study were born in New Mexico, 90.7%, with an additional 7.5% born in the adjacent state of Arizona. Most of those born out-of-state were Navajo who were born in Arizona. The data further indicated that many of the Native Americans who committed suicide were living on the reservation at the time of their death. All of the Apache and 86.8% of

the Pueblo Indians lived on the reservation. Among the Navajo, 32.8% were residing on the reservation proper, 47.4% lived in the Navajo checkerboard area or in Indian communities immediately adjacent to the reservation. Thus 80.2% of the Navajo were living in areas characterized by reservation conditions. Only 19.8% of the Navajo and 12.5% of the Pueblo suicides were living in other areas off the reservation and away from their tribal culture. Therefore, findings for each of the three groups tend to contradict the off-reservation susceptibility speculation to varying degrees. In other words, the idea that it is the displaced Indian living off the reservation in an alien community who would be most likely to kill himself, is not supported by the data for any of the cultural groups. While acquiring denominator data for these areas is currently difficult if not impossible, calculating rates for on-reservation and off-reservation areas would clarify the issue. Levy (1965) attempted such an on and off reservation analysis in his study of the Navajo, and the analysis did not support the anomie hypothesis. Residence patterns of New Mexico Indians are generally quite fluid. It is common for young adults to move frequently from reservation to town and back again. For this study, we can only compare on and off reservation occurrence using the distribution of tribes in the 1970 census. A careful examination of the 1970 census data from reports (U.S. Census, 1973) and county data (Stanley, n.d.) indicates that 90% of all Pueblos in New Mexico live on reservations, an 87.3% to 90.6% range for Zuni, Tanoan and Keresan. Similar data for the Navajo are impossible to accurately reconstruct but an estimate for Navajo residence in reservation communities has also been placed at 90% for 1970 (Levy, 1984). There are no data or estimates for the Apache. The estimates indicating that 90% of the Pueblo and Navajo population live on the reservation and 10% live in non-Indian communities seems quite consistent with the fact that 100% of the Apaches, 87% of the Pueblo and 80% of the Navajo who committed suicide were living on reservations at the time of their death. Therefore, the findings of this study do not lead to the conclusion that off reservation situations are more conducive to suicide.

In addition to demographic variables, situational variables surrounding the act were also included in this study. Method of death, place of injury, place of death, and calendar and time variables will now be discussed.

Method: A high percentage of extremely lethal methods were used by New Mexico Indians to commit suicide. Table 6 shows that males and females in all three cultural groups had the same pattern of method: suicide by firearms and explosives occurring most frequently followed by hanging, strangulation or suffocation and then poisoning with analgesic and soporific substances, or drug overdose. The only exception to this pattern was for Pueblo females among whom 50% died by firearms, 41.7% by drug overdose, and 8.3% by hanging. These findings indicate the serious intent of those committing the

act and confirm prior research. Levy (1965), Wyman and Thorne (1945) and Andre and Ghachu (1974) found firearms and hanging to be the methods most requently used by the Apache, Navajo and Pueblo, and Navajo and Zuni, respectively. There were no cases of self-immolation with kerosene for the Apache in this study as had been reported for other Apache tribes by Burlison (1983) and Levy and Kunitz (1969). For the U.S. population as a whole, the order of method is the same and the percentages correspond somewhat to the percentages for the female Indians of the three groups combined. In 1976 the percentages for various methods of suicide in the U.S. population were 54.9% for firearms, 13.7% for hanging, and 13.7% for poisoning by solid or liquid substances (U.S. DHEW, 1976). The pattern of suicide method for Native American males is similar to that of Black males and all Native Americans in the U.S. However, the pattern for Native American females in this study is quite different from the pattern for White, Black and all Native American females in the U.S. due to their greater proportion of suicides by hanging and firearms and lower proportion due to drug overdose or other poisoning (McIntosh and Santos, 1982).

Place of Injury: Because a high percentage, 21.8%, of the death certificates did not list place of injury, findings regarding this variable are tentative. The available data indicate that most of the suicides among the Apache, 66.7%, Navajo, 56.3%, and Pueblo, 81%, occurred in and around a home or residence. Levy's (1965) finding that the Navajo commit suicide in and around the home for purposes of revenge and to instill guilt in a significant other, may apply to some of the Apache as well as Navajo suicides since the fear of the dead and the belief in ghosts is held by both groups. The high percentage of Pueblo suicides around the home may be a reflection of the sedentary, village orientation; but certainly these findings await explanation through more detailed research.

Place of Death: In a pattern somewhat similar to the one for place of residence, many of the New Mexico Native Americans who committed suicide died on the reservation or in Indian communities: Apache, 82.8%; Navajo, 60.2%; Pueblo, 67.5%. Off-reservation deaths accounted for 17.2% of the Apache suicides, 39.8% of the Navajo suicides, and 32.6% of the Pueblo suicides. This is further evidence that many Indians in this study killed themselves on their reservation and not in a city or other alien place. The higher percentage of off-reservation deaths than off-reservation residence can be attributed to those suicide victims who were transported to hospitals off the reservations in Gallup, Albuquerque or Santa Fe and whose place of death was then recorded as the county and community in which the hospital was located.

Calendar and Time Variables: No real patterns emerged when looking at the month, day of the month, or day of the week of death for the Native Americans in this study. The only

interesting observation is that Apache suicides occurred at least twice as frequently in May and December than during any other month of the year. No meaningful discussion of time of injury can be made because 28.9% of the death certificates were either missing this information or the time of injury was listed as "unknown."

Thus far this paper has discussed suicide among the three Native American cultural groups in New Mexico and has not addressed the individual reservations, tribes and villages which compose each cultural group. Since each reservation, tribe or village has its own distinct character, generalizations about the cultural groups may not apply equally well to all of the subgroups. For example, generalizations about Pueblo Indians may not accurately describe Zuni, Santo Domingo and Pojoaque. Although a highly detailed discussion of reservation data is beyond the scope of this study, suicide rates for four time periods from 1957-1979 are presented in Table 7. This table lists the reservations in order of crude rate for 1957-1979.

Several things should be noted from the table. First, the suicide rates are variable for each reservation over time. The only reservations with consistent rates are those with no recorded suicides over the 23 years. Second, some of the rates are outrageous due to very small population bases, a problem which has been mentioned previously. For example, Picuris with a total population of 817 and one suicide from 1973-1979, shows a rate of 122.4 per 100,000 for that time period. If a researcher had only looked at suicides for 1973-1979 or for 1977, the year during which the suicide occurred, it would appear that Picuris had a serious problem which would not be an accurate assessment. Third, the most impressive observation from the table is the diversity of suicide phenomena among the tribes which suggests that some of the high rates for the cultural groups may be due to excessive rates among only a few tribes and/or reservations and not the cultural group as a whole.

Table 8 is a replication of a table originally produced by Levy (1965). Levy conducted an analysis of the New Mexico Pueblos from 1954-1962, using only those tribal groups with a population exceeding 1,000. He found that the acculturated communities had the highest suicide rates and the traditional communities had the lowest suicide rates. A similar analysis in this study is presented for the period 1957-1979 for historical comparison and replication purposes. Before discussing the results, two things should be noted. First, since Levy did not define acculturation in his study, there is no way of knowing whether his definition and operationalization are comparable to the ones used in this study. However, it will be assumed that at least the definition of acculturation for both studies is probably similar. Second, two classification changes were made for the tribes included in this study, i.e., Zuni was classified as a "transitional" community rather than

a "traditional" community as in Levy's table because of increasing White, Navajo and media contact and a great deal of community change in the 1970's; similarly Taos was also classified as a "transitional" community in this study rather than one with "acute internal conflicts" for their contact with outside cultures has greatly increased.

The results found in this study are similar to Levy's results with the acculturated Pueblos showing the highest rates followed by the transitional Pueblos and then the traditional Pueblos. However, results from this study show higher rates for all tribes but Santo Domingo. In addition, while Levy's calculations placed traditional Pueblo suicide rates below U.S. suicide rates and acculturated Pueblo rates above U.S. rates, this study found all suicide rates, with the exception of Santo Domingo, to be above the U.S. rates. In general, this replication provides valuable insight into historical trends and acculturation theory.

DISCUSSION

In this study suicide rates for the Apache, Navajo and Pueblo Indians of New Mexico have fluctuated greatly from 1957 through 1979. A fairly steady increase can be seen for the Apache and Pueblo groups from the mid-1960's through 1979 and for the Navajo from the early 1970's through 1979. Apache and Pueblo rates have been higher than U.S. and New Mexico rates since the mid-1960's while the Navajo rates did not exceed national and state rates until 1972. Apache rates have consistently been the highest, followed by the Pueblo and then the Navajo. Native American suicide in New Mexico was found to be predominantly a young, male phenomenon with a male to female ratio ranging from 7.4:1 to 10.4:1 and 75.4% to 93.4% of the suicides occurring between the ages of 10 and 39 years. Age-specific suicide rates of all three cultural groups have increased among the younger age groups at a rate equal to or greater than U.S. rates. Also, suicides of Navajo and Pueblos aged 65-74 years appeared during 1969-1979. The females committing suicide were often younger than the males. While 75% of the Apaches, and 53% of the Pueblos committing suicide were single, 50.4% of the Navajos were married. A large majority of the individuals were not veterans and 20.4% were students. This study found that most suicides were completed by individuals who were born in New Mexico, and died near a home or residence. Most of the Apache, Navajo and Pueblo Indians who committed suicide lived in areas characterized by reservation conditions and died in these areas. Extremely lethal methods were most common, with firearms being the most popular method, followed by hanging. No unique patterns were found for month, day of the month, or day of the week of death. The suicide rates for the individual reservations indicate that each tribe within each cultural group has its own particular pattern of suicide.

Social scientists have postulated numerous explanations of the suicide phenomenon. Social integration and acculturation have been the most frequently suggested as possible explanations for suicide among Indians. We will now see if either of these explanations is supported by the findings of this study.

Many sociological theories of suicide suggest a link between social integration and suicide, i.e., as the level of social integration of a group decreases, the suicide rate increases (Durkheim, 1951; Gibbs and Martin, 1964, 1971; Henry and Short, 1954, 1957; Maris, 1969). This inverse relationship has also been suggested as an explanation for suicide rates among some Native American groups (Balikei, 1961; Leighton and Hughes, 1955; Levy, 1965; Levy and Kunitz, 1971). Traditionally, the Jicarilla and Mescalero Apache of New Mexico were nomadic hunters and gatherers. They were organized in self-sufficient bands whose leaders held limited power. The raiding complex established in these groups provided some transitory integration. The Apache believed in a supernatural realm, but their religion, which included no organized priesthood or religious societies, was not a cohesive force in their lives. Individualism was a highly valued trait (Burlison, 1973; Goodwin, 1969; Josephy, 1978; Opler, 1936, 1969; Schroeder, 1974; Sonnichsen, 1970; Wilson, 1964).

The traditional Navajo of New Mexico were nomadic hunters and gatherers who later settled down in hogans scattered throughout their territory where they engaged in pastoralism and agriculture. Although they had a band level of organization, their matrilineal clans exerted strong control over group members. Religion was important to the Navajo but they had no organized priesthood or religious societies. Individualism was important, but not to the extent seen in the Apache groups (Hester, 1971; Josephy, 1978; Kluckhohn, 1962; Vogt, 1961).

The Pueblo groups in New Mexico traditionally lived in compact towns and carried out an agricultural subsistence pattern. Religion permeated every aspect of their lives and provided a strong integrating force for the communities. Their organized priesthood and religious societies took care of all religious and civil matters. Individualism was discouraged and conformity to the group was the rule (Dozier, 1961, 1970; Josephy, 1978). If one were to rank these three groups in terms of traditional social integration based on these and other factors, it would appear that the Pueblo were the most highly integrated group, followed by the Navajo, and finally the Apache.

In contemporary times most Apache live in homes scattered about the reservation or in border towns where they raise livestock, cut timber, work in tribally-owned businesses, and engage in wage work. Formal tribal governments have been established for each tribe. Religion is still not a strongly integrative force and many Apache practice both their traditional religion and Christianity. Individualism is still a

highly desirable trait. Finally, the strongest social tie of the past, the raiding complex, has been eliminated from the culture.

Many Navajo continue to live in scattered hogans or small houses on the reservation and herd sheep, farm, make crafts, and engage in wage work. A centralized tribal government has been established, but local groups still control most of the daily affairs. Matrilineal clans exert less control now than in the past. Religion, which has incorporated some elements from Western ways and Christian religion, remains important to the Navajo, but is not as all-encompassing as the Pueblo religion. Individualism modified by clan and camp allegiance is still the norm.

Pueblo religion continues to permeate Pueblo life with even the contemporary civil government being influenced by religious leaders. However, there has been a decline in membership in some ceremonial associations and syncretism can be seen between native and Catholic religions. Many Pueblo Indians still live in their villages on reservations and engage in farming, raising livestock, making crafts, and wage work. A high degree of conformity to the group is still expected. Based on these and other factors, it would again appear that contemporary Pueblo society continues to be the most highly integrated, followed by the Navajo and then the Apache.

The social integration explanation of suicide seems to account well for the Apache having the highest suicide rate, but it does not account for the Pueblo having a higher rate than the Navajo. The acculturation explanation helps account for this discrepancy.

Level of acculturation has been discussed by some social scientists as a possible explanation for suicide rates among Native American groups (Levy, 1965; Levy and Kunitz, 1971; May and Dizmang, 1974; Webb and Willard, 1975). A direct relationship is generally postulated, i.e., more acculturated groups would exhibit higher rates of suicide while more traditional groups would have lower rates of suicide. One way to determine the level of acculturation of Native American groups is to look at the factor of White contact. Linton (1972, p.6) has stated, "acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first hand contact, with subsequent changes in the original culture pattern of either or both groups". Linton would consider the contact between Native Americans and Whites an example of directed culture change because the Whites were the dominant group actively and intentionally interfering with the Indian culture. With culture change, some Native American groups experienced losses of cultural traits without replacement as well as the inhibition of pre-existing culture patterns. For some groups this led to conflicts in values, stress and anomie for the individual

members and social disorganization and an increase in social pathologies, including suicide, for the group.

The Native Americans in New Mexico initially came into contact with the White man between 1400 and 1600 AD, but recently that contact has become more continuous and intense. When considering the time period of this study, 1957-1979, the Apache have been in close contact with the White world during the entire time period. Their reservations are small and surrounded by White communities and many Apache live in mixed communities of Indians and non-Indians. This high degree of contact along with their loose integration, may help account for the high rate of Apache suicide. The Pueblo have also been in contact with the White world from 1957-1979, but the intensity of that contact has increased during the time period. Many of the Pueblos are located near large cities like Albuquerque and Santa Fe where contact has increased by such things as wage work, education, improved transportation and communication. The Navajo had been the most geographically and socially isolated of the three groups until the 1970's when wage work and mineral exploration on the reservation increased dramatically.

In addition, the real and symbolic exposure to White culture has rapidly intensified in all three cultures with improved transportation and the expansion of mass media to the reservations. Many new and drastically improved highways were built to and within all of the reservations in the past 30 years. Further, if one agrees that there is a direct relationship between acculturation and suicide rate and that acculturation can be operationalized as intensity of White contact, then the Apache should have the highest suicide rate, followed by the Pueblo, and then the Navajo. This was the finding of the present study. Level of acculturation would also seem to account for the consistently high Apache suicide rate, the almost continuous increase in Pueblo rates from 1957-1979, and the substantial increase in Navajo rates beginning in 1972. The most convincing argument for acculturation, however, comes from the Pueblo data in Table 8. The more acculturated and transitional Pueblos have higher suicide rates than do the most traditional. Therefore, the actual level of acculturation of a Pueblo seems to correspond with the higher rates of suicide.

While it is likely that other factors, such as historical events, economic factors, personality characteristics, and the influence of suggestion (Phillips, 1974) have affected suicide rates of the Native Americans in New Mexico, the hypothesized influence of social integration and acculturation has been supported in this study. These findings suggest that while social integration may explain some of the variation in suicide rates among the Apache, Navajo and Pueblo groups in New Mexico, level of acculturation seems to be an increasingly more important factor in explaining variations both between cultural groups and with a cultural group. Similar studies

and data on juvenile delinquency (Jensen et al., 1977), general mortality (Broudy and May, 1983), substance abuse (May, 1982), and fetal alcohol syndrome (May et al., 1983) also appear to exhibit this pattern. When isolated from extreme acculturation pressures and possibly even prior to acculturation pressures, traditional social integration may explain much of the variance in suicide rates. However, in situations of increased acculturation pressures, not only are rates of suicide elevated, but the relative positions of the cultural groups and tribal groups with regard to these rates seem to change.

NOTES

[1]Comparisons of crude rates for the three Native American cultural groups and the general U.S. population should be viewed with caution. Since the Indian populations are much younger than the U.S. population, age-adjusted rates ideally should be used. Age-adjusted rates appear later in the data analysis.

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THE EFFECT OF DRUG ABUSE ON SUICIDE RATES AMONG BLACK YOUTH IN THE DISTRICT OF COLUMBIA

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My topic is that of suicide among Black youth, particularly among Black youth in the District of Columbia. What I intend to discuss with you may shed some new light on some of the causes of suicide among Black youth, to the degree that the pressures on youth in this city are in general similar to those in other major metropolitan areas.

Many theories have been put forward as to the cause of Black suicide, and each theory contains the germ of truth. A weakening of communal and familial ties has been said to be a major cause of suicide among Black youth. This weakening, in general, has been seen as alienating our children from the traditional, institutional structures, relationships and groups within the Black community, such as churches, social clubs, fraternal organizations, neighborhood and community institutions, along with strong, if not nuclear family ties.

A related view often mentioned is the stressfulness of the isolating effect of immigration away from the close-knit rural communities of the South into the impersonality of Northern city life. Another theory that draws on the same general point of view is that there is a direct relationship between the degree of integration and the amount of stress felt, particularly when monetary and social expectations have been raised, but not met.

We need to learn more about why the rate of suicide among Black youth is higher than that among older Blacks. This pattern is quite different from Whites, where the rate of suicide correlates with advancing age. While the overall White suicide rate is higher, a significant percentage is among the elderly, in marked contrast to the situation among Black youth, where a disproportionate number of Black suicide victims are young people.

We also need to learn more about why the rate of suicide among Black youth is increasing. This is a frightening

prospect. The suicide rate of Black youth between the ages of 20 and 35 in New York City exceeds that of White youth in the same age range. It may be this is the age range when young people unsuccessfully attempt to escape, via personal and social mobility, the restraints that society places on young Blacks, particularly young Black males.

The statistics relating to suicides among Black youth in the District may be meaningful in explaining why our youth are committing suicide. Essentially, what we have discovered is a very high correlation between drug use and suicide. Drug usage, particularly soft drugs, is a youthful phenomenon here in Washington, and it is these kinds of drugs that are commonly found in the bodies of young suicides.

Half, or 27 of the 54 suicides between 1982 and 1985 to date, involved drugs. The correlation increases upward by age until it begins to level off at age 30, and thereafter declines. Between the ages of 10 and 14, two suicides were committed between 1982 and now; both were drug free. In the next age bracket, 15-19, three of the eight suicides, or 37%, involved drugs, phencyclidine in one case, cannabinoids in another case, and a combination of those two drugs in a third case.

At the next, and largest age bracket, 20-29 years, 22 of the 40 suicides, or 55%, involved drugs. In 16 out of the 22 drug-involved suicides, or 72% of these cases, phencyclidine was found in the body. This is a stunning and challenging rate. Alcohol and cannabinoids were the runners up, with four each, or 18%. Both are drugs commonly taken by young people, often in combination with phencyclidine.

At the age of 30, the drug-involved suicide rate begins to decline, with drugs used in 50% of the four cases in which 30-year-olds committed suicide between 1982 and 1985 to date.

That drugs were found in no less than 50% of all suicides up through age 30 in this city in the last three and a half years is a startling figure. It tells us that adequate and effective drug prevention programs are highly necessary if we are to reduce the carnage among our young folk.

The kind of drug taken is also significant. Phencyclidine, or PCP, was found in the bodies of 18 of the 54 suicides. This amounts to 33% of the total suicides as well as fully two-thirds of the drug-related suicides. The next highest drug involvement was cannabinoids arising from marijuana consumption. It was involved in six cases, or 11%, of the total suicides and one-ninth of the total suicides among drug abusers. Alcohol lags behind in third place with involvement in five suicides, or 9% of total suicides and 18.5% of drug-related suicides.

It is crystal clear that PCP has a great deal to do with our high youth suicide rate. It also has a lot to do with the choice of suicide method. Statistics showing methods of suicide correlated against single or multiple drug involvement reveal that phencyclidine is the drug of choice for any method that can be accomplished with little forethought.

Gunshot wounds, jumping from windows or in front of trains, drowning and strangulation are all methods of suicide that take relatively little time and forethought. They are each methods in which phencyclidine played an important role. Phencyclidine use is characterized by impulsiveness, even in the final act in peoples' lives.

In 11 of the 26 gunshot wound suicides, phencyclidine was found to be present. In three out of the six jumping deaths, phencyclidine was present. In half of the two strangulation deaths, phencyclidine was present, and in the one case of drowning, phencyclidine was also present. It is interesting to note that 10 of the 13 hanging deaths were drug free, but in each of the three drug-involved hanging deaths, phencyclidine was present.

It was not a factor in any of the four deaths in this city directly caused by drug overdoses. Phencyclidine is much more likely to set off a chain of behavior that may lead to suicide by other methods.

PCP is currently the drug of choice among our young people. Given what we know about the psychotic behavior which PCP can easily bring on, and given its hallucinogenic and numbing properties, it is not surprising to find PCP so prominent among the drugs found in the body fluids of suicides.

One of the most frightening aspects of this discovery is the nagging question of whether many of those young people would have committed suicide, were they not using PCP. My suspicion is that if they hadn't been on that particular drug, we could have saved a substantial number of our youth. My other fear is that, given the ready availability and low price of PCP, we may well be in for a further rash of teen and young adult suicides.

We have learned that drug use must be counted among the significant factors involved in Black youth suicides. Whether the drugs pushed these young people towards suicide, or whether internal pain due to other circumstances drew these children towards drugs as an apparently unsuccessful means of relieving the pain, we will never know. We don't know if drugs were the cause or the result of the frustrations and pain that ended so tragically.

We do know from reviewing these statistics that we cannot and must not ignore the role that drug use plays in teen suicide. Our work must be to train our young people away from

drugs, and particularly away from the use of phencyclidine. Given the rising tide of its use in this city, I can only pray that the efforts of my agency in cooperation with the DC public school system will have some deep effect as we seek to educate our young people away from health-robbing activities and towards body and mind-enhancing, positive ones.

The District of Columbia has one of the highest rates of Black youth suicide in the country. We must seek every means at our disposal to dry up the drug plague that is helping push this suicide rate ever higher.

SUICIDE AMONG HISPANICS

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The National Center on Health Statistics has no data on number of suicides by Hispanics. They are currently conducting a survey that may shed some light on the extent of the problem, but the study will not be ready to be analyzed until 1986.

For the time being, we will examine some environmental factors that contribute to suicide among Hispanic youth and some effective efforts that may be used to reduce the rate of such suicide.

ENVIRONMENTAL FACTORS

. The breakdown of the traditional family: where family tradition is strong, the adolescent has a feeling of security and a sense of belonging. The Hispanic family has long been a source of comfort to all members and this often includes the entire extended family.

. The lack of effective adult role models: a parent figure of the same sex is important to provide an example of adult responsibility. Where the Hispanic youth does not see "positiveness" in either parents, teachers, or significant others, he may not feel valued.

. Having an alcoholic parent or parents may be a factor.

. Coming from broken homes contributes to suicide.

. Early marriages may have a destructive impact.

. Failure to learn in school is a negative factor. The most important reason for a child's doing well in school is the parents' interest in the learning process.

. Unemployment, or the inability of the adolescent to find work, is another factor which may influence the Hispanic adolescent to suicide. No job will lead to depression.

EFFECTIVE EFFORTS TO REDUCE SUICIDE

. Use of natural support systems (such as compadres and comadres) as trusted significant others to stay with arrested adolescents. The number of suicides or attempted suicides will surely be reduced if adults stay overnight with jailed adolescents.

. Culturally relevant suicide prevention centers: trained and bilingual counselors will more easily gain the Hispanics' trust and confidence.

. Early intervention programs: the most useful long range effort to prevent suicide is to assure that Hispanic children are well-cared for and not abused.

. Use of church-related functions and groups: religion is quite culturally relevant to most Hispanic youth, whether in an urban or rural setting.

JUVENILE SUICIDES IN ADULT JAILS: FINDINGS FROM A NATURAL SURVEY OF JUVENILES IN SECURE DETENTION FACILITIES *

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INTRODUCTION

The practice of jailing juveniles with adults has long been of concern to practitioners in the juvenile justice field. The physical and sexual abuse of youth in jails led to policies of separating youth from adult inmates. However, there is much anecdotal evidence that this separation of youth may increase the likelihood of juvenile suicide "Youth hangs self," 1979; Wooden, 1976; U.S. Senate Committee on the Judiciary, 1971.) This national scope study was performed to test empirically the widespread suspicion that juveniles in adult jails have a suicide rate higher than that of juveniles in the general population.

METHODOLOGY

The study's sample was drawn from the U.S. Department of Commerce, Bureau of the Census "Criminal Justice Agency List," a compilation of all U.S. institutions involved in criminal justice. The sampling frame included 3,493 jails, 13,383 lockups, and 372 secure juvenile detention centers. It would have been impractical to attempt data collection from all 17,248 facilities in the sampling frame; therefore, random samples were drawn from the larger strata. Specifically, these strata were:

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* Prepared for The Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, by the Community Research Center, University of Illinois, Urbana-Champaign

1) All juvenile detention centers;

2) All jails with an average daily population of 250 inmates or more;

3) A 20% random sample of jails with an average daily population of less than 250 inmates;

4) A 6.8% random sample of lockups.

The responses from the last two strata were statistically weighted (as suggested by Kish, 1965) to achieve representativeness for the total sample. Data were collected from all strata by mailed questionnaires, and the study achieved an overall response rate of 77.4%.

FINDINGS

The Number of Juveniles in Adult Jails and Lockups.

There is great variation in the estimates of the annual number of children who are held in adult jails and lockups. Perhaps the highest projection is that of Sarri (1974), who suggests that 500,000 juveniles are incarcerated in adult jails and lockups each year. In contrast, Poulin and his colleagues (1979) estimate that 120,000 children annually are held in jails only. Neither of these projections, however, is based on primary research. Rather, they are based on syntheses of secondary sources. Lowell and McNabb (1980) conducted a nationwide survey, and they project a one day count of 4,061 sentenced persons below the age of 18 in jails. Unfortunately, apart from ignoring the many unsentenced juveniles in adult jails, their study had a response rate of only 51%, and they admit that their data seriously underestimate the parameters in large urban areas.

This study documented 383,328 children in secure juvenile detention centers during 1978. Given the response rate, the actual total is estimated to be approximately 392,662. The study documented 170,714 juveniles in adult jails. Again, given the response rate, the actual number is estimated to be 266,261. That yields an overall estimate of 479,908 persons below the age of 18 who were held for any length of time in an adult jail or lockup during 1978. All of these projections are based upon linear extrapolation from the data.

The Incidence of Juvenile Suicide

Table 1 presents the suicide rates for children in adult jails, lockups, and juvenile detention centers during 1978, and the suicide rate among youth in the general population of the United States during 1977. Information on the general population from 1977 was used because final mortality data for 1978 had not, as yet, been computed by the National Center on Health Statistics. The number of suicides among children in the general population during 1977 was obtained from the unpublished data at the Center for Health Statistics, and the number of children in the general population of the United States during 1977 is available in published form from the Bureau of Census.

The rate of suicide among juveniles in adult jails during 1978 was 12.3 per 100,000 which is 4.6 times larger than the suicide rate of 2.7 per 100,000 among youth in the general population during 1977. From tabulated sums of Poisson probability values (Abramowitz and Stegun, 1965), we find that the difference between those two suicide rates is statistically significant with a $p<.00003$. The rate of suicide among juveniles in adult lockups is 8.6 per 100,000 which is more than three times larger than the rate of 2.7 among children in the general population, and that difference is also statistically significant with $p<.004$. Unexpectedly, the suicide rate among children in juvenile detention facilities is only 1.6 per 100,000, which is lower than that of the general population. Using a critical value of .05, this difference is not statistically significant with $p<.145$. The suicide rate of juveniles in adult jails is almost 7.7 times larger than that of juvenile detention centers, and that difference is statistically significant with $p<.005$. Similarly, the suicide rate among juveniles in adult lockups is more than five times larger than that of juvenile detention facilities, and that difference is also statistically significant with $p<.03$.

An Approximation of Longitudinal Design

All records of juvenile detention are either sealed or destroyed when the individual becomes an adult. This fact, coupled with the anticipated difficulty in completing our questionnaire, led to the use of a cross-sectional design when a longitudinal or time series design would have been preferable. In order to contextualize the 1978 data, suicide rates have been calculated for children in the general population of the United States from 1968 to 1977, and this information appears in Table 2. The relevant data were obtained from the National Center for Health

Statistics. Apart from statistical variation, there appears to be a trend toward an increasing rate of suicide among youth in the general population, and the 1977 figure of 2.7 per 100,000 is the highest value in Table 2. Yet, the suicide rates for juveniles in adult jails and lockups during 1978 are both considerably higher than that value, and statistically significant differences remain even if the value of 2.7 is arbitrarily raised to 4.0 per 100,000.

DISCUSSION

There is support for the hypothesis that the rate of suicide among children held in adult jails and lockups is significantly higher than that among children in juvenile detention centers and children in the general population of the United States. However, the data do not indicate that the suicide rate among youth placed in juvenile detention facilities is greater than that of children in the general population. Several comments are pertinent to these observations. First, bear in mind that even the confidential admission of the occurrence of a juvenile suicide in an institutional setting is deeply embarrassing. To the extent that our data are characterized by response bias, such bias would, in all likelihood, contribute to an underestimate of the suicide rate in jails and lockups. Second, the data indicate that the average length of stay for children in jails is approximately seven days while the average length of stay in lockups is less than two days. In contrast, the average length of stay in juvenile detention facilities is 17 days, and the suicide rate for children in the general population is calculated for an entire year or 365 days. In other words, children in adult jails and lockups kill themselves more frequently than do children in juvenile detention facilities and children in the general population, despite the fact that children in jails and lockups have less time in which to commit suicide. Third, one must also bear in mind that it is more difficult to commit suicide in jails and lockups than it is in the general population simply because the techniques at one's disposal are much more limited. Together, these considerations imply that the problem of juvenile suicide in adult jails and lockups may well be even more serious than is suggested by the data per se. Fourth, the validity of the primary hypothesis is bolstered by the fact that 17 of the suicides occurred despite the fact that in these cases sight and sound separation had been accomplished. Finally, the low rate of suicide among children in juvenile detention centers may be attributable to the greater supervision which is available at those facilities, and to the participation

by juveniles in the ongoing youth activities at those facilities as opposed to the isolation which they would often confront in adult jails and lockups.

POLICY IMPLICATIONS

These data suggest that the policy of incarcerating children in adult jails and lockups maybe contributing to a relatively high rate of suicide among those children. Further, eleven of twenty-two children who killed themselves while in jails and lockups had not committed a felony, which implies that many of those juveniles who are imprisoned in jails pose little threat to their communities. These findings also indicate that the problem of juvenile suicide is no more acute in juvenile detention centers than it is in the general population.

As noted earlier, environmental and staffing limitations are common adult jails and lockups. The effects of such living conditions worsen when isolation also occurs. This study has determined that the suicide rate for juveniles held in adult jails is about 4.6 times greater (12.3 per 100,000) than the suicide rate among youth in the general population (2.6 per 100,000). This high rate cannot be attributed to secure confinement alone since the suicide rate in separate juvenile detention facilities is well below that of the general youth population. Given this disparity in secure settings, it must be assumed that the high rate of juvenile suicides is attributable to the environmental and staffing conditions present in most adult jails and lockups.

The important point here is that nearly 500,000 juveniles experienced these detrimental conditions each year. If the physical and emotional well-being of juvenile offenders is to be a matter of concern, every effort must be made to prohibit the jailing of juveniles.

TABLE 1

SUICIDE RATES FOR CHILDREN IN ADULT JAILS, LOCKUPS, AND JUVENILE DETENTION CENTERS DURING 1978, AND CHILDREN IN THE GENERAL POPULATION OF THE UNITED STATES DURING 1977

Population	Number of Children	Number of Suicides	Number of Suicides per 100,000 Children
Children in adult jails during 1978	170,714	21	12.3
Children in adult lock-ups during 1978	11,568	1	8.6
Children in juvenile detention centers during 1978	383,238	6	1.6
Children in the general population of the United States during 1977*	49,008,000	1313	2.7

*The number of children in the general population of the United States during 1977 represents all persons between the ages of 5 and 17, while data for children in adult jails, lockups, and juvenile detention centers during 1978 represent persons below the age of 18.

TABLE 2

SUICIDE RATES FOR CHILDREN IN THE GENERAL POPULATION OF THE UNITED STATES FROM 1968 to 1977*

Year	Number of Children	Suicides	Suicide Rate per 100,000
1977	49,008,000	1313	2.7
1976	49,851,000	1097	2.2
1975	50,368,000	1126	2.2
1974	50,949,000	1081	2.1
1973	51,480,000	1013	2.0
1972	52,012,000	950	1.8
1971	52,383,000	908	1.7
1970	52,545,000	806	1.5
1969	52,386,000	763	1.5
1968	51,976,000	668	1.3

* The term "children" refers to persons between 5 and 17 years old.

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SURVIVING COLLEGE:
TEACHING COLLEGE STUDENTS TO COPE

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Of all the population groups in American society, college-age groups have one of the highest suicide rates. Four major points to consider are: (1) basic statistics about this problem in colleges; (2) the special stresses of college students; (3) warning signs; and (4) steps we and they can take.

Approximately 10,000 college students per year attempt suicide in the United States. Of that number, some 500 to 1,000, in fact, are successful and complete the suicide. Sometimes it's hard to know for sure that it's been a suicide because it may have been masked as an automobile accident, sometimes under the influence of alcohol. Suicide has been steadily rising among the 15 to 24-year-old population with now, at last, some signs that it's peaked. In 1980, more than 5,200 youth in the 15 to 24 age range killed themselves. There are some studies that indicate that youth that are in college are more likely to commit suicide than are their non-college-going peers.

To give you some specific data at my own university, in the last six or seven years, we have noted no marked increase in suicide attempts or completions. There have been two suicides at our university in the last seven or eight years. Both of these involved men, both of them were international students, both of them involved jumping to their death, and they were both done off campus. We know that each year there are about 20 to 25 suicidal gestures. In addition to that, there are eight to ten actual suicide attempts each year at our university. Of the 460 students each year who come to our counseling center for aid, about 72 have had some relationship in the last several months with suicide. Seven had made a recent attempt, and six had seriously contemplated it.

We have a hotline system staffed for students by students who have been trained to handle a wide and diverse array of emergency calls. If the call is serious enough and goes

beyond the training that the student volunteer has received, the student is instructed to refer the caller to professional counseling. During this last academic year, 2% of the calls dealt with suicide. The most common precipitant of suicide in the college group is loss of or lack of a peer/love relationship. The most common suicidal condition among college students is the influence of alcohol. The prevalence of alcohol in suicides among college students is overwhelmingly great.

Many of the special stresses that college students experience relate to the passage of late adolescence, a time that's normally, naturally chaotic and characterized by an emphasis on action rather than reflection and deliberation. The most important developmental tasks at this time involve independence, the definition of self, and an intimacy with peers. Some of the specific stressors that can, in fact, lead to suicide among college students are the following: the loss of, or the lack of a peer/love relationship; culture shock, which occurs among both international and domestic students; homesickness and loneliness; academic pressures; a dramatic decrease in the status of the student in college compared with what the student had enjoyed in high school; dread of returning to a native country, or the dread of returning home; fear of the real world after graduation.

Family conflicts are profoundly important. A year or so ago, we conducted an anonymous poll in our university asking the students what concerned them most in life. The media have told us about many things that disturb youth. The thing that came out as the dominant concern, not just from the suicidal youth, but all of the youth, was the stability of their mothers' and fathers' home and marriage. It seemed to weigh heavily on the minds and conscience of the young people.

Suicide is preceded by many warning signs: depression; withdrawing from people; alcohol and/or drug abuse; talking about death or suicide itself. These warnings take on a particular significance for any student who has made a previous attempt to commit suicide; who has had a significant person in his or her life attempt suicide; who has a history of being impulsive; who is overly concerned about being a perfectionist; who suffered the loss of a parent, especially if it occurred before the youngster was 12 years of age; or who has a troubled relationship with his or her parent.

A responsible college, university or high-school can address this problem in three ways: prevention; early identification; and treatment. Of those, only treatment is solely the province of professional psychologists and counselors. Prevention and early identification can be carried out best by peers. The most effective preventive

strategy is a campus with a sense of community and a diverse support structure. The perception that at least one person on a campus understands and cares, will dramatically decrease the risk of suicide. Students are the key to the solution and in a university setting, this seems to be especially true for the resident advisors, the people who have control and responsibility for a particular floor in a dormitory. The R.A.'s, as we call them at our university, play a critical role. In addition to prevention, they play an important role in early identification of the problem.

The support network must be diverse, since different people know different students in different ways. Important elements in the network would include the following: other students; R.A.'s and dorm counselors; a hotline phone system; faculty and faculty advisors; clubs and organizations; parents; campus ministries; and the Center for Psychological and Counseling Services. To aid in prevention and early identification, we have set up a training program for students so that they can serve as well-informed, trained peer counselors. Participants include all of the staff working in the dormitories and all of the staff who work in one way or another with student counseling. If there is any single key to our relatively good success, this training has been it. The University Counseling Center is also vital and it is available 24 hours a day. A student can go there anonymously, privately, confidentially, without fear of embarrassment. Parents, of course, also play a vital role. They should be talking with the university counseling people as appropriate.

Almost all studies indicate that before a youngster, college student, or younger, commits suicide, that person will say to the world, "I'm thinking about it." The key to our success in preventing suicide is to be aware of that, learn to watch for those warning signals and act upon them. We need to teach all of our youth that life is better, infinitely better than death; suicide solves no problems, it simply closes all options.

SUICIDE AND THE DISABLED

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Basically, disabled people are just like the rest of us. They have relationship problems, personality and behavior disorders, depression, addictions, loneliness and all other factors that lead to suicide. That is probably the most important thing to remember. At times, there is a tendency to be more accepting of the suicide of a disabled person because of the question of the quality of life. This acceptance may influence a situation toward suicide. However, there are particular times when suicide possibilities are higher among the disabled.

The onset of a disability is a critical moment. When someone learns that he won't be able to walk, will lose a limb, have a body deformity and experience chronic pain, he suffers severe damage to his self-concept. It is not uncommon for people to ask, "Do I want to live this way?" Most people obviously do want to go on with their lives and get through what may be a serious suicidal episode.

Chronic pain is difficult for anyone to endure. It is demoralizing and depressing. People living with chronic pain should be continually observed for episodes of depression. Families, as well as treating personnel, should learn the symptoms of depression. The depression should be treated and a careful evaluation made of the suicide potential.

Exacerbation or worsening of the disability or pain is, of course, discouraging and can bring on depression. Again, it is important to be alert to signs of depression.

Treatment team discouragement often affects disabled patients. When doctors, nurses and physical therapists become discouraged in their limited effectiveness toward making someone well, they may have a tendency to detach. When patients feel

the doctor is losing interest, they may also give up on themselves. Also, chronically disabled people come to develop relationships and depend on the people who treat them; loss of these relationships can induce suicidal reactions.

Agencies providing services are like treatment persons. Disabled people may more likely be dependent on agencies for financial help, transportation, social activities and rehabilitation programs. If these services are withdrawn, people who depend upon them may be left in desperate straits. For example, when there was a severe cutback in Social Security benefits a few years ago, many disabled were reported to have been suicidal and some suicides were directly attributed to this sudden loss of income.

Everyone goes through episodes of trauma and transitions. Loved ones die, we get sick, depressed, lose jobs, go through divorce, have family problems. Some have more burdens to bear than others. Disabled people have all of the above plus physical limitation and pain. It is more a matter of degree than difference. We all get along most of the time, but we all need help to get through the hard times. Disabled people may need a bit more.

ALCOHOL, DRUGS, AND ADOLESCENT SUICIDE

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INTRODUCTION

Alcohol and drug use, abuse, and dependence are major factors in adolescent suicide, as they are with adults. The epidemiology, or sociology of alcohol and other drugs as a factor in adolescent suicide is poorly understood. There is reason to believe, however, that it is at least as great a problem for adolescents as for adults.

A continually vexing question in reading the literature on substance abuse and suicide is the extent to which substance abuse is etiologic, enabling, or merely an incidental finding. If the last-mentioned proves to be true, the hypothesis would be that, since substance use and abuse are widespread, one would expect to find substantial numbers of adolescents with both of these problems. However, the two types of variables would show no other necessary relationships.

TREATED POPULATIONS

To what extent is drinking alcohol or using drugs a corollary of teenage suicide? The answer depends upon the population studied, and how the question is asked. Certainly, if the probands, or identified subjects are culled from a population coming for treatment, the numbers are significant. Ryser (1983), in a secondary analysis of students treated in hospital emergency rooms, demonstrated a significant rise in the teenage abuse population from 1974 to 1980. Fifty percent of the students using drugs ingested them in a suicide attempt, or had ideas of suicide concomitantly.

Garfinkel, Froese, and Hood (1982) studied a large group, 505 children and adolescents in the pediatric emergency room of a large city hospital, the Hospital for Sick Children in Toronto. They selected an equal number of controls, matched for age and physical or psychiatric ills, but excluded psychiatric illness in the controls. They then conducted a retrospective chart review.

Among the findings in this latter group of significance are the following. Three times as many girls as boys were present among the subjects. Over half of the subjects had a family history of mental illness, and 12 could be identified as substance abusers based upon the chart review. "Among members of families who had psychiatric illnesses, drug abuse/alcoholism predominated: 32.6% of mothers; 59.1% of fathers; 24.2% sibs." Thus, if half the children had family psychiatric illness, and 60% had alcohol-drug abusing fathers then 30% of the entire sample had drug-alcohol abusing fathers. "Significantly more individuals in the index group had used alcohol or drugs at the time of admission, 11.3% vs. 1.3%, $p<.01$. Alcohol was the most commonly used drug, 44.8%. Eight adolescents had used multiple drugs."

The Toronto study, notable for its use of matched controls, also followed up on its subjects. Their findings were, "one to nine years after the index admission, eight of those who had attempted suicide and five of the controls were dead. The means of death in the index group were four hangings, three motor vehicle accidents, and one drug overdose. Among the controls they were two CHF, two leukemia, and one CNS malignancy."

These findings are of interest in several respects. First, it is clear that the total number of completed suicides among the index cases is small, 8/505, or 1.6%, over a nine year period. This numerator-denominator problem, which has long plagued the effort to predict adult suicide, is obviously a major difficulty in identifying high risk candidates among children and adolescents, too. However, we note the very significant differences in the two groups. There is practically no overlap. That is, all of the deaths in the first group were clearly suicides, or occurred in high risk-taking situations. In the control group, all of the deaths were attributed to physical illness, as one might expect from how the controls were chosen.

A similar type of problem arises when the investigator attempts to diagnose parental contribution to suicide of adolescents. McHenry and Tishler (1982) compared the parents of 46 adolescent suicide attempters with an equal number of non-attempters. The adolescents had come to the Emergency Room at Children's Hospital, Columbus, Ohio, between 1979 and 1980. Their findings suggested that fathers of attempters were more depressed, had lower self-esteem, and consumed more alcohol. They also found that mothers were more anxious, had suicidal ideation, and consumed more alcohol.

In a study from abroad, Hawton, O'Grady, Osborn and Cole (1982) examined 50 consecutive adolescent suicide attempts admitted to Oxford, England General Hospital. In contrast to Garfinkel and associates, they found little psychiatric illness, and little alcohol/drug use. "Compared with adults,

alcohol consumption was rare." In only three instances was alcohol part of the overdose, and in only seven cases was alcohol ingested within six hours of overdose. By contrast, paracetamol derivatives were the overdose drug of choice. These authors concluded, "The small number of subjects who had problems with alcohol suggests that the increase in adolescents of self-poisoning is not closely related to the growing problem of alcohol abuse among adolescents in general." Among the limitations of their study, we note that they apparently did not interview the parents of the adolescents. Also, although they claim to have used a standard interview schedule, they do not indicate which one, nor what questions about alcohol and drug use were asked.

Using a different approach, Yesavage and Widrow (1985) identified 45 males admitted to a Veterans Administration Medical Center for depression, as diagnosed by the "Diagnostic and Statistic Manual-III" of the American Psychiatric Association. They examined multiple factors, and found that 44% of the variance in a multiple regression equation could be accounted for by the combination of childhood discipline and parental fights under the influence of alcohol. They concluded that these childhood episodes of severe discipline were more important than early losses in relation to self-destructive acts as adults. Here, not only is the design retrospective, but the variables are many, there is essentially no control group, and the significant variables may be chance findings from a large group of possible ones. At the very least, such findings require replication.

BROADER POPULATION BASES

The effort to broaden data to include other sources of identified suicides within the community is also fraught with the peril of uncertainty. In a recent example, Thornton (1982) attempted to compile statistics on drug-related admissions, deaths, arrests, emergency room and school reports in New Orleans. In the Public School volunteer program, the numbers of students with alcohol and drug problems actually declined from 1981 to 1982. The number of homicides remained the same, 44% involved with alcohol, 20% with drugs, similar to most studies, which show high percentages of each. Eighty suicides were reported, of which almost 37% involved alcohol, with yearly differences not noted.

The data in this important area are clear that alcohol and drug use and abuse are significant among a substantial minority of the population. Adolescent suicides may be proportional to this use, greater, or lesser. Also, it may be that these groups have some overlap, but that the correlations are only rough ones; or, that most adolescents in either group do not take on the characteristics of the other over time; or, that those who do so are difficult to identify in advance.

Following another avenue of research, Tsuang, Boor, & Fleming (1985) recently examined the traffic death toll. The better a study is controlled, the more equivocal the answer seems to become about whether motorists use their vehicles in significant numbers to commit suicide; and the extent to which those who do are characterized by diagnosable alcohol/drug abuse and other psychiatric disorders. In an older study, Murphy and Wetzel (1982) were able to interview the relatives of the deceased who became coroners' cases. More recently, Shafii, Carrigan, Whittinghill, and Derrick (1985) conducted a similar study on 20 adolescent suicides. In 70% of the cases, drug or alcohol abuse was significant. These data provide perhaps the clearest indication of correlations. However, these studies, although with matched controls, were of necessity retrospective judgments, and could not be blind as to the hypotheses under study. Nonetheless, they are probably among the best to date which attempt to answer the pertinent questions.

TREATMENT AND PREVENTION

Assuming that substance abuse problems do contribute to adolescent suicide, how should treatment and prevention be designed? First, it may be useful to think of substance abuse treatment as tertiary prevention of abuse; that is, an effort to retard or prevent further worsening of the problem. If suicide really is an outcome of deteriorating abuse or dependence, then alcohol/drug treatment may also be primary or secondary prevention for suicide. That is, it may reverse the downward spiral, or prevent suicide from happening.

The two main approaches to treatment and prevention can be broadly categorized as substance abuse-oriented on the one hand, and mental health-oriented, on the other. The first group of professionals believes that substance abuse problems are primary ones, not necessarily caused by anxiety, depression, and other mental health problems, or environmental stressors. The product of this type of thinking is treatment that is aimed directly at the behaviors of taking alcohol and drugs, not excluding stressful events that might occur in conjunction with these behaviors, but considering them essentially parallel events. The mental-health oriented approach considers substance abuse to be a symptom, and treats it analogously to other symptoms, assuming the primary or psychologically causative factors to be depression, anxiety, or stressful events. Since these two approaches have been little studied comparatively in any systematic way, it is very hard to choose between them. This is true despite the fact that advocates on both sides of the fence are adamant and vehement that their methods are successful, and that the opposite camp is bankrupt and a failure. In fact, both approaches are probably modestly successful, at least as measured by relatively objective outcome criteria, and more

light could probably be shed on the subject by trying to parcel out which people in need are best served by which approach.

Where family members can be engaged in treatment, it can be plausibly argued that family psychological treatment is both warranted and desirable. How can this be set up and carried out? In our program we have evolved a "Family Contract," which is signed by all parties at entry into the program. In this contract, the facility specifies what it promises to do for the patient and his family, mainly a complete evaluation, physical and mental, and offers a range of well-described therapies. The patient's and family's parts include their regular cooperation and participation in treatment, and, as part of this, their regular attendance at Alcoholics Anonymous, or Narcotics Anonymous for drug abusers.

In Figure 1 is shown an example of such a contract. Although the contract can be modified to fit individual situations, we have found that major demands for modification are also an indication of ominous negative ambivalence about entering treatment. In these cases, we often say, "Well, we understand that you may not be ready for treatment. Why don't you come back later when you are?" This may be just the right fillip to induce agreement.

In other publications we have described how the family contract approach may be used with substance abusing or dependent adolescents. Frequently parents or other family members are co-abusers. Engaging the whole family is an effort to modify a system that is inadvertently supporting dysfunctional, destructive behaviors. Whereas it may be extremely difficult to help one person to change his behavior in the face of undermining by spouses and siblings, if all must confront their own contributions, more may be accomplished. In Figure 2 we tabulate some preliminary results of the family approach as a method of treatment in both adults and adolescents (Hertzman, 1980).

Another net in which adolescents with serious abuse problems may be snared is the school or workplace Employee Assistance Program. The basic idea of such a program is that supervisors identify employees who are having work problems. This may include poor performance in the face of the capability for better, absences, illnesses, and the like. A neutral party, counselor or other professional, who keeps absolute confidence of the employee, helps triage and sort out the issues which may be causing the employee to feel under stress. In a significant number of these instances, perhaps as many as half, the employee or one or more family members is a substance abuser. Since there is a certain amount of pressure upon the employee to correct and improve his work performance, if an adolescent in the family is a cause of stress, there is

more motivation on the adult's part to do something definitive about it. Also, there is the help of a counselor, or a referral to an appropriate treatment agent, to assist in providing backbone to undertake difficult confrontations, or other unpleasant, but necessary helping actions to get family members into treatment.

Educational programs for substance abuse have had a checkered history, not always with successful results. Nonetheless, efforts continue to make the school an adjunct of preventive substance abuse work. Education wrongly conceived may actually increase the use of drugs by making them sound attractive, or suggesting ways that had not occurred in a crystallized form to experimenting adolescents.

"Programs to decrease substance abuse should recall the shifting authority figures important for early, middle and late adolescence. For example, one study found that peer disapproval contributed most, and parental disapproval least, to the control of adolescent drinking behavior. Legal sanctions and school policies do have an effect on adolescent substance abuse. However, role models appropriate to the setting, such as 'streetwise' models in inner-city neighborhoods, are essential for much impact on the problem" (Hodgman, 1983).

CONCLUSION

The relationships between substance abuse, particularly alcohol, and suicide are tantalizing. They clearly exist, but their nature remains quite poorly understood. In some situations, such as automobile accidents, they are at least facilitating. In others, they may be directly causative, by releasing aggressive impulses that otherwise would have been held in check. In still other instances, abuse may be an incidental finding, given the widespread experimentation with drugs among teenagers. For example, probably over 90% of all high-school-age children have sampled marijuana by the time they graduate, and a small but significant percentage are regular, heavy users of marijuana, alcohol, or other drugs. There is a major need for thoughtful research upon these relationships. Thorough scholarship has all the promise of contributing to the heated arguments that continue as to the best ways of treating drug abuse and suicide among adolescents, measures for prevention, and public policies that ought to stimulate or encourage prevention, or be directed towards regulation that might be preventative.

FIGURE 1

DRUG ABUSE CONTRACT

Name _____ No. _____

I, _____, agree to follow the recommendations below for treatment of my drug abuse.

1. To participate in the program as outlined for at least two weeks.

2. To detoxify from the drugs abused and to participate in plans for post-detoxification.

3. To attend all scheduled family assessments.

4. To attend all assigned therapy sessions and ward meetings.

5. To remain on the unit for two weeks without unaccompanied passes. Staff accompanied passes (i.e., one patient is accompanied by one staff member) may be granted at the discretion of the treatment team, but are difficult to implement because of staff time requirements.

6. To receive no visitors for two weeks other than family members who are on the unit for a family assessment meeting.

7. To have all packages brought to the unit searched by the staff.

8. To have mail opened in front of staff members in order to check for drugs.

9. To have no drug paraphernalia on the unit.

10. To allow staff to search my person and my possessions at their discretion.

11. To give urine specimens when requested.

12. To allow serum drug screens to be drawn when requested.

I understand that if I am unable to meet these expectations, I may be discharged from the unit. This decision will be made by the staff.

FIGURE 1 (Continued)

WITNESS _____ SIGNATURE _____

DATE _____

FAMILY AGREEMENT FOR DRUG ABUSES:

I/We _____ family members of _____ agree to participate in active family treatment during and following his/her hospitalization.

I/We have also read the agreement signed by _____ and agree to support these guidelines.

WITNESS _____ SIGNATURE _____

DATE _____ SIGNATURE _____

FIGURE 2

SYMPTOM IMPROVEMENT

Change in PSS,* All Scales

No Drugs	25%
Prescription Abuse	54%
Alcohol Abuse Alone	28%
Single Drug Abuse	1%
Poly-Drug Abuse	32%**

Change in PSS, Only Scales
Where 80% of Patients Report Symptoms

No Drugs	20%
Prescription Abuse	37%
Alcohol Abuse Alone	16%
Single Drug Abuse	38%
Poly-Drug Abuse	33%

* Psychiatric Status Schedule, Spitzer (1968)

** The largest difference, between "No Drugs" and "Poly-Drug Abuse" categories, had Chi Square = .537 ($p<.05$)

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SUBSTANCE ABUSE AND YOUTH SUICIDE

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In youth and at all ages, there is no one cause of suicide; rather, there are multiple causes, such as stress factors, family disruption, school failure and peer rejection. There are also vulnerability factors, such as severe developmental dysfunction, autism and affective disorder. In evaluating suicide potential, and especially in attempting to make long range predictions of suicide risk, one adds up the various stress factors and vulnerability factors including the easy availability, in the youth culture, of alcohol and street drugs.

I will address the following issues: (1) The recent increase in youth suicide appears in the older ages, that is, over age 16; (2) these are the ages (16-19) of introduction to alcohol and drugs with abuse increasing with age; (3) clinical studies associate alcohol and drug abuse with depression and youth suicide; (4) drug abuse medicine and drug abuse counseling services are essential aspects of an overall suicide prevention program.

Table 1 indicates that in a four-year period, July 1965 - July 1969, there were 56 suicides in Los Angeles County in the age range up to and including 16 years. In a similar four-year period, 1978-1982, there were only 43 suicides up through age 16. Note, however, the rise in suicide in ages 17-18 and the substantial rise in age 19. Similarly, in 1,000 consecutive calls to the Suicide Prevention Center, there were 54 calls concerning persons through age 15, and alcohol and drugs were not significantly mentioned. In the adolescent teenagers, 16-19, there were 96 calls, of which 40% mentioned alcohol and/or drugs as part of the problem. For ages 20, 21 and 22, there were 100 callers, with 50% of them mentioning substance abuse as part of the problem. A number of studies by various members of the Suicide Prevention Center staff (Peck, 1982; Peck & Litman, 1974) have indicated that most of the increase in youth suicide has occurred in persons with

negative personal relationships and multiple adjustment problems, including drugs and alcohol as prominent features.

It is hard to decide on any one correct diagnostic label for these substance abusing suicidal patients. In a current research project, collaborating with cellular biologists at the City of Hope on the association between mutant brain proteins and affective disorders, I had great difficulty in trying to distinguish retrospectively between primary substance abuse and primary affective disorder in persons who had committed suicide. Which came first? Which was more important? Do people abuse drugs because they are depressed and wish to self-medicate? Or do they get depressed because they have abused drugs and in that process lost the love of other persons and lowered their own self esteem? Is it possible that substance abuse and affective disorder and borderline personality are all different aspects of a related group of underlying psychobiological disorders?

DSM II in the chapter on substance abuse disorders puts it this way, "Depressive symptoms are a frequent complication of substance abuse disorders, and partly account for the high rate of suicide in individuals with substance dependence. Suicide associated with alcohol and other substances can occur in both intoxicated and sober states."

In 1983 I reported psychological autopsy studies of deaths related to propoxyphene or codeine or both in combination in Los Angeles County. There were 100 consecutive deaths in which propoxyphene or codeine was found in the blood of the deceased; however, in 17 of these deaths, the blood finding was only incidental to the cause of death. In those deaths in which the drugs contributed significantly, about half were "suicide" and about half were "accident." We found that there was a long history of abuse of these drugs in both the suicide and accidental death categories. Drug abuse must be considered as a sub-intentioned form of high level risk taking. The mortality of young persons who are engaged in substance abuse is about one to two percent a year, a considerable rate. Los Angeles is the codeine death capital of the country. Many of the chronic opiate abusers in our study began as polydrug abusers around age 16-19.

The association between drugs and suicide attempts was emphasized by McHenry, Tishler and Kelly (1983), who found that adolescent suicide attempters were more inclined to use drugs, and adolescent drug abusers were more inclined to make suicide attempts as compared to the control groups. Similarly, Frederick, Resnick and Wittlin (1973) reported that suicide attempts were common in drug abusers, while Garfinkel, Froese and Hood (1982) found more psychiatric illness and alcoholism in the families of youth suicide attempters and also more substance abuse in the young patients themselves compared to non-suicidal patients.

My special experience with serious drug abuse in young people began in 1969 when I was confronted by three younger persons who had some things in common: they were born in 1950, reared in West Los Angeles in prosperous homes, and they were heroin addicts. They had been treated unsuccessfully by psychiatrists and in drug-free programs, and they had all made suicide attempts. At the same time, the crisis telephone counselors began to receive increasing numbers of calls concerning suicidal drug abusers. Out of these experiences, the staff and I developed a large and comprehensive drug abuse treatment program, including methadone maintenance, with special attention to pregnant, drug abusing mothers and their pre-school children.

The therapeutic answers must be multi-dimensional, including education in the schools and media. Teachers and families and doctors need resources to refer young persons at risk. The need for comprehensive services was emphasized most recently by Stephenson and associates (1984) focusing on case finding and treatment of intoxicated adolescents. We have continued training counselors and expanding programs, including several rather large non-medical anti-drug abuse counseling programs, located in what we call the "Dignity Center," with a staff of more than a dozen counselors who have the cooperation of the local schools, probation officers, police and neighborhood merchants in programs that started originally as diversion counseling and now are very much involved with families, school activities, athletics and art projects. Important aspects are educational talks in the schools and role modeling, especially for youngsters who belong to ethnic minorities. Counselors pay home visits and go to juvenile hall and to the other placement centers for youths in trouble.

My impression is that it is important to supply both quality and sufficient quantity of human interaction. Often, group interactions are more effective than individual therapy. The more effort, the more time spent with young people, the better the result. However, when a young person presents with a combination of drug abuse and suicide attempts, there are usually multiple problems constituting a complex package of misery. Usually, the treatment will be prolonged and expensive. The best treatment approach is a multi-modality, anti-misery program.

TABLE 1

Suicides in Los Angeles by Age

Age	1965-1969		1978-1982	
12	2		0	
13	9		3	
14	12		7	
15	16		13	
16	17	56 (subtotal)	20	43 (subtotal)
17	25		34	
18	33		38	
19	47	105 (subtotal)	67	139 (subtotal)
Total		161		182

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Etiology and Psychodynamics

TEEN SUICIDE RESEARCH GOALS*

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The large number of people who are attending this conference have come for many reasons.

There are some who believe that they know a great deal about the subject and have come to help and tell others. Some know that suicide is not a mental illness and that it can happen to the youngster next door. They know that if only families and parents would be more attentive to their children, if only they would stop pressuring their children to do well, if only they would put up with their unhappy marriage and not think about divorce, watch their youngsters more closely to make sure that they do not listen to hard rock music, play fantasy games or take drugs or alcohol, then the problem of suicide would lessen.

There are others who feel sure that suicide is a consequence of anxiety about the nuclear threat, that it is a way our youth have of telling us that there is something wrong with our society. There are no doubt others who believe it is better to talk about feelings and thoughts rather than to hold them in, and that we should have suicide education just as we have sex education, do away with taboos and bring everything out into the open. Some feel confident they know what to tell teenagers to prevent them from contemplating or committing suicide. They know the warning signs and want to share this knowledge.

However, for all who have answers there are many more who have questions. There are parents and friends who have had personal losses. They ask themselves, "Did I do something wrong? Could I have prevented it?"

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There are others who spend their professional lives working with patients or clients who they fear may commit suicide and who may already have attempted suicide. They say, "I see so many teenagers who attempt suicide, many of them don't seem serious. Which ones should I be worried about? Are those warning signs really accurate? I have seen teenagers commit suicide who did not seem at risk. What treatment should I be giving to make sure it doesn't happen to my patient?"

There are parents, professionals working in schools or with groups of young people who have given no indication that they are, or ever have thought seriously about suicide, who want to know, "How can we keep them like this? Is it possible to prevent them from becoming suicidal? Can we teach them to help themselves get help? Will my program really help or will it simply put ideas in their heads and put them at even greater risk?"

Then there are people interested in research like myself who share all these questions and who are puzzled by the facts. Why has suicide become so much more common? Who are the youngsters who commit suicide? What experiences have they been through to make them vulnerable when many other, apparently more troubled, youngsters never contemplate or attempt suicide? Did they change, and if so, in what ways? Was there anything special about those changes or were they the same changes you see in teenagers who never think about suicide? Had they ever seen a professional and if so what for? What did the professional do, was it not enough or was it the wrong thing? How many made a previous attempt? Does suicide run in families? Is there a genetic factor? Is there some experience that the families provide which makes the child vulnerable?

The researcher and the sensible person will not be satisfied with answers unless they are supported by evidence. For this reason I find myself more in sympathy with those who are posing questions, and am less convinced by those who have the answers. As I see it at the moment, we really have very few answers that are backed up by good evidence.

DATA FROM DEATH CERTIFICATES

The most solid information we have comes from death certificate data. Although suicides tend to be under-reported by medical examiners, especially in the young (Shaffer and Fisher, 1981), there is no evidence that suicide data are subject to other systematic biases. Death certificate data may not give a precise incidence, but they do paint a broad and consistent picture. They show that males commit suicide more often than females; that suicide is rare before puberty and that it becomes increasingly common with each advancing year in the teens and early twenties, reaching its peak in young white males aged 24; that overall the rate in Whites is higher than it is in Blacks and that over the past 30 years

the suicide rate has increased among teenagers and young adults in the United States. Some inferences can be made from each of these findings.

SEX

The predominance of males to females is greatest between the ages of 10-14 (5:1). It then decreases to a ratio of 4.3:1 at ages 15-19 (Shaffer and Fisher, 1981) and continues to decline through the remainder of the life cycle, although it is more common in males than females at all ages (Segal and Humphrey, 1970; Shneidman and Farberow, 1965). We do not know why this is, although some explanations have been put forward. Gould (1965) suggested that females are not encouraged to show anger or aggressive feelings, including suicide. If we disregard this out-dated view of the origins of male aggression (Shaffer, Meyer-Bahlburg & Stockman, 1980), there may be some basis for this. A preliminary examination of our findings in the New York study (see below) suggest that a history of aggressive behavior is common in male, but not female, suicides.

Other suggestions include a female preference for so-called "passive" and less defacing methods, such as drug overdose ingestion, which are less predictably effective than the methods used by most males, i.e., hanging and shooting. This seems unlikely. Nationwide and across all ages, most suicides in both sexes are carried out by firearms, and our current New York study shows one especially lethal method, jumping from a height, is preferred by females.

AGE

Very few children under the age of 12 commit suicide (Shaffer, 1974; Shaffer and Fisher, 1981), but it becomes more common with increasing age through puberty and adolescence. The age specific mortality rate from suicide for children aged between 10 and 14 in the United States in 1978 was 0.81 per 100,000, which accounted for 2.4% of all deaths occurring in this age group. The number of suicidal deaths in the 15 to 19 age group is much greater. The mortality rate is 7.64 per 100,000 or 7.95% of all deaths in this range.

Age 10-14 year-old children constitute 8.5% of the United States population but only 0.55% of all suicides. Fifteen to nineteen-year-olds represent almost 10% of the total population, but only 6.18% of all suicides. There is, therefore, a moderate under-representation of suicide in the 15 to 19 year-old age group and a very considerable under-representation in 10 to 14 year-olds. One of the interesting features of childhood suicide therefore, is that it may eventually tell us about factors which protect the individual from suicide (Shaffer, 1985). This protection seems to be a universal phenomenon, for remarkably similar ratios of

child:adult suicide prevail in all countries from which reliable data are available (Shaffer & Fisher, 1981).

Suicide may be rare in young children for a number of reasons. If depression contributes to suicide and depression is uncommon in childhood, a low depression rate will produce a low suicide rate. A second possibility is that young children live much of their lives in a family and at school. Little time is spent alone. They are therefore protected from the isolation which is known to be an important determinant of suicide in adults. In a previous study I found that a high proportion of those children who do commit suicide (Shaffer, 1974) had experienced significant isolation during the days before death. A number killed themselves in an empty house when their parents were out at work.

It could be that a degree of cognitive maturity is required before a child is subject to such feelings as despair or hopelessness and that these ideas develop along with the general growth of thinking that occurs in adolescence (Shaffer, 1985). Among the thinking abilities which develop at this time are the ability to show foresight and planning, a greater awareness of the self as seen by others and a preoccupation with abstract notions. Each of these changes could increase a person's vulnerability to suicide. At a clinical level, the finding that suicide is rare before puberty is important because it enables us to manage the very young child who has suicidal thoughts or who has made a suicide attempt with more confidence.

ETHNICITY

Suicide is less common among Black than White Americans in most age groups. We can immediately see that any explanation which invokes family and social stress, such as being brought up in a single parent home, economic need, competition for jobs and educational opportunities, is unlikely to be true. Black Americans, on average, experience far more of these stresses than Whites.

It has been suggested (Shaffer, 1985) that Blacks may enjoy some "protective" factor. Two hypotheses have been proposed. The first, based on the original Freudian dynamic model, is that there is a reciprocal relationship between inwardly and outwardly directed aggression. It should follow that because Black adolescents have high rates of delinquency, i.e., outwardly directed aggression, they will show low rates of suicidal behavior, i.e., inwardly directed aggression. However, Breed (1970) found that 50% of the Blacks who attempted suicide had recently been in conflict with the law, compared with only 10% of Whites. Shaffer (1974) also noted that a majority of children who commit suicide displayed antisocial behavior before their death. Other studies linking suicidal behavior and aggression have been referred to above. In summary, suicide and depression seem to go together, rather

than compensating for each other, so that the idea that Blacks are protected from suicide by aggression is improbable.

A second hypothesis is that special cultural factors or convention make suicide a less acceptable behavior for them. This is supported by Shaffer and Fisher's (1981) findings that low suicide rates among Black adolescents in the United States are confined to those living in the South. Blacks living in the Northeast and Northcentral States, where it is reasonable to assume that there has been a greater degree of decultura-tion, have similar suicide rates to White adolescents.

CHANGES OVER TIME

The increase in suicide rates among young people over the past three decades has been well described. The finding is more complicated than it appears. In thinking about a cause we have to think of one that has selectively or at least predominantly affected one ethnic/sex group, i.e., White males. This makes some of the more general "social" explanations, such as the increasing divorce rates, less likely. After all, divorce affects as many girls as boys.

There has been a relative increase in the proportion of youth suicide deaths which are attributable to firearms. However, increased availability of firearms may not be the reason. The proportion of firearm deaths may simply have risen because deaths due to drug overdoses have fallen with improvements in treatment and reduced access to the especially dangerous barbiturates. More precise analyses of time linked data may be revealing, matching changes in suicide rates with other secular changes such as ethnic/sex corrected drug and alcohol use patterns.

IMITATIVE FACTORS

Death certificate data have been used by Phillips (1974, 1979) to demonstrate that the reporting of suicides in newspapers may produce a significant increase in suicide rates within the area that the news story is distributed. Furthermore, this effect seems to follow the general rules of imitative learning (Bandura, 1977), that is, that factors such as the popularity or attractiveness of the suicide victim and the prominence with which the story is displayed influence the extent of the increase. Our studies (Gould & Shaffer, 1986) suggest that fictional stories of suicide on television can result in imitative deaths and attempts.

Imitation may be the mechanism through which successive suicides occur within a high-school district or other small geographical areas. We do not know what proportion of teen suicides occur in clusters. We hear about some clusters in the newspapers, but there may be others which go unreported. This is an area of considerable potential importance because it may offer a way for us to intervene to prevent one suicide

influencing others. We may also be able to learn how to present stories about suicide which do not lead to imitation, but will instead have the reverse effect and reduce that possibility.

The findings on imitation are also important because they indicate that we cannot assume that to talk openly about suicide will have no repercussions. Just because a given film or educational program has a preventive goal does not guarantee that that is what its effect will be.

PSYCHOLOGICAL AUTOPSY STUDIES

The ideas outlined above are all derived from the interpretation of death certificate data. This is a tantalizing process because it is rare that one can get more than suggested answers. Other research approaches are needed to find out more about the problem.

For example, sophisticated social-psychological and epidemiological research may be able to answer our questions about imitation and clustering. Biological work on neurotransmitter metabolites and genetic pedigree studies may tell us to what extent biological factors predispose to suicide. However, what we most urgently need is to obtain simple descriptions about the condition. This will help us answer such important questions as which background or life events contribute to suicide; what are the behavioral warning signs which may be identified by mental health professionals, teachers and parents; and what treatments may have been ineffective.

The technique for studying the backgrounds of suicide victims is known as the psychological autopsy. It was first described by Shneidman & Farberow (1965) and involves interviewing those who knew the suicide victim well to reconstruct his past life and background and the circumstances which surrounded his death. To interpret this information for research purposes one needs to elaborate on the procedure in various ways (Fisher & Shaffer, 1984). For example:

(1) The individuals who are studied need to be drawn from a well described and defined geographical area. This will enable others to know to what extent the findings from a given study can be generalized to another location.

(2) One must make every attempt to study every consecutive case within a given time period. Unless one does this, only families who are easy to contact or relatives who are well disposed towards an inquiry will be researched and this will give biased results.

(3) The study should be a large one. There are certain groups such as females and Blacks who have low rates of suicide and unless the study covers many cases, the numbers in these subgroups will be too small to analyze.

(4) A standardized and reliable method should be used to evaluate each case.

(5) If one is going to investigate the deaths of teenagers it is important to ask questions not only of parents, but also of other teenagers who knew the victim. They may know a lot that the parents don't know.

(6) It is important to have a control group. If there is no control group, one will not know whether any correlates that are found are specifically related to suicide.

THE NEW YORK STUDY

We have been conducting a study with all of these features at New York State Psychiatric Institute/Columbia University since June, 1984. The study encompasses all suicides under the age of 19 registered in the States of New Jersey, Connecticut, in New York City and the surrounding counties in New York State. There are two control groups; teenagers who are randomly selected using a telephone survey method, and teenagers of the same sex, age and ethnic group who have made a serious suicide attempt. The study is funded by the National Institute of Mental Health.

Over 90 suicides have so far been identified for study and we anticipate that we will eventually be able to study over 150 cases. Although we have obtained detailed information on over 60 cases, detailed analyses of the research material and information from controls is not yet available. Thus, even though we have formed some overall impressions, we cannot yet draw any firm conclusions. However, based on informal observations made so far, it seems as if we can group the deceased children into four very broad categories.

(1) The largest group are teenagers who have had many problems in their lives. They have not done well at school. They have often been in trouble, exhibiting impulsive and at times aggressive behavior. They have shown extremes of emotion, often reacting to stressful events with very intense feelings. Many of them had feelings of depression before their death, although it was unusual for them to show the full clinical picture of a major depression. They often killed themselves after getting into trouble.

(2) A second large group did not cause concern to their parents or teachers. Their characteristics were almost the reverse of the first group. They were perfectionists and probably subject to considerable anticipatory anxiety before they did important things like take tests. They also experienced intense anxiety while waiting for their results. They misperceived their abilities, often thinking that they had done badly at an examination, when in fact they nearly always did well. They were rigid and found change difficult. Their anxiety and rigidity may have contributed to their

death. It seems that many committed suicide while waiting to hear the outcome of some event, or just before some anticipated major change in their lives.

(3) A third, not very large, group suffered from the classical features of depression without added complications. A number of the girls seem to be in this category.

(4) A fourth, very small group, suffered from manic depressive psychosis; had had a good deal of treatment for their condition, which is often difficult to manage in adolescence. They were likely to commit suicide during a depressive phase of their illness.

It is fair to say that very few of the youngsters would be regarded as having no mental health problems and a high proportion of them had seen professionals in the past.

As we have indicated, these findings are very preliminary and may not be sustained on further analysis of the data. They may prove to be non-specific for suicide and it may be that we will find similar characteristics in one of the control groups. However, if these impressions are supported, the findings are likely to have an impact on prevention. Some of the characteristics shown by the youngsters are those that we have been led to expect from the usual lists of warning signs, but many are not. The warning signs may have to be changed. The study will eventually tell us more about what, if any, specific features were present in the youngsters' backgrounds. This information too will contribute to our attempts at primary prevention. The New York study will not answer all of our questions, and like all research its findings will have to be confirmed by others, but it will be a start.

CONCLUSIONS

Our main goal in addressing this Conference has not been to present you with inferences drawn from demographic and death certificate data, or to give you preliminary information, as yet incompletely analysed, from our study. Rather it has been to alert you to the enormous gaps in our knowledge.

The areas of ignorance are enormous. There is no well-conducted research to tell us which are the high risk youngsters, or what the warning signs are. There has been no research at all on school-based prevention programs. Although the directors of those programs may feel that they are doing good, and they may well be, their assumptions have not been supported by reasonable research. We have scanned the literature and have not found a single properly conducted evaluation study on any school-based prevention program. As a result we do not know if they are effective, ineffective or even if they are dangerous. If school-based prevention programs were being marketed commercially and were advertised as effective, they would be in breach of "truth in advertising" regulations. If

the programs were drugs regulated by the F.D.A., they would never have been approved, because they have not been tested.

Our ignorance is not confined to prevention, it applies with as much force to treatment. We do not know the best way to treat suicide attempters. For the most part it seems as if we do not treat them at all. They are seen in emergency rooms across the land, but limited research by our group suggests that they do not return for the appointments that they are given to see a psychiatrist or psychologist.

One of the greatest disservices that we can do to ourselves as concerned professionals or individuals and to the teenagers whose deaths we mourn, and to those alive whose deaths we so badly want to prevent, is to deceive ourselves that we know more than we do. Answers must come from systematic and adequately funded research. At this time, it is our information that the National Institute of Mental Health, the principal source of quality mental health research in the United States, is now funding only nine projects on suicide of which only two are on youth suicide. The annual research expenditure on these projects totals less than a quarter of a million dollars.

Treatment and prevention programs are often funded at state or local levels. Funds for these programs rarely include dollars for program evaluation. We believe strongly that it is a false economy to support intervention and prevention without at the same time insisting upon and supporting quality program evaluation. Evaluation costs are trivial when compared to the costs of any intervention, and without research those intervention dollars may be being wasted. The great interest now being shown by the NIMH and other federal agencies in the problem is a most hopeful development. Given the right type of support the questions that concern us most can and will be answered.

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PREVENTING YOUTH SUICIDE: A COLLABORATIVE EFFORT

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"I am a drain and a burden to my friends. The guilt and resentment are overwhelming. Everything I see seems flat. There is no color, no point to anything. Things drag on and on interminably. I'm exhausted, dead inside. I desperately want to sleep to escape, but if I could, I must wake again to the dullness and apathy of it all. I completely doubt my ability to do anything well. My mind has slowed down and burned out. It's virtually useless. The wretched thing works only well enough to torment me in a dreary litany of inadequacies and to haunt me with the total hopelessness of it all. What is the point of going on like this? It's crazy."

These are the kind of thoughts often conveyed in the suicide notes of young people. They reflect an overwhelming despair and hopelessness for which death appears to be the only solution.

One sad reality of youth suicide is that one cannot interview or study the person who suicided. It is a lethal condition. For this reason, efforts directed at understanding the reasons for youth suicide have been difficult.

Scientists have studied serious suicide attempters; however, these individuals might be different than those who successfully suicide. Research on serious suicide attempters who failed to kill themselves, for example, one who jumped out of a window or shot himself, has provided some knowledge. One of the major models of research at this time is the "psychological autopsy." Research teams interview members of the dead youth's family, friends, teachers and significant others in an effort to reconstruct the life history of the person prior to the fatal act.

The goal of all such research is prevention. What are the factors that make a young person at risk for suicide? Only with such knowledge is there hope of early recognition and intervention. Only with such interventions can the incidence of teen suicide be lowered.

There remain cases of youth suicide that appear to be unexplainable. No apparent clues or risk factors can be identified. For many, though, we are beginning to recognize categories of such risk factors.

Suicide is the tenth leading cause of death in the United States and the third leading cause of death of young people ages 15-24. The rates of suicide in this age group have tripled over the past 30 years.

One characteristic of the current suicide problem, suicide clusters, merits serious concern. Suicide cluster refers to the phenomenon of one suicide appearing to trigger several other suicides in a group, school or community. Very little is known about this apparent contagion effect of suicide among adolescents. Suicide clusters have recently occurred in the past two years in Plano, Houston, and Clear Lake, Texas, Westchester County, New York and Minnesota.

For example, in Westchester County, New York on February 4, 1984, a 13-year-old boy hanged himself. February 14 a 14-year-old boy hanged himself. A 19-year-old young man shot himself February 16, and on February 21, a 17-year-old boy hanged himself. Then on February 24 a 19-year-old youth hanged himself. Alarmingly, in a period of three weeks, four out of five youngsters in the same community hanged themselves.

None of these youngsters appeared to know each other, but they did know of each others' deaths through the media. This illuminates a possible mechanism for the suicide cluster. Media publication of one suicide in a community may trigger subsequent suicides. Studies have shown that when a suicide is publicized on the front page of the newspaper, more suicides follow in the community. Some experts think that some young people who are particularly vulnerable may identify with the suicide of another youth, particularly if it is dramatically portrayed as an option in the media. However, the mechanism of these epidemics needs further study so that young people as risk can be identified and communities can respond quickly and effectively to this crisis.

There are many factors which increase the risk of suicide among young people. These are complex, highly interrelated, and only partially understood. These factors include psychosocial, biological, family history and genetic and psychiatric predictors for suicide.

Psychosocial factors include feeling alone, hopeless and rejected, being a runaway, experiencing an unwanted pregnancy, being the victim of child abuse, having experienced a recent humiliation in front of family and friends, having a family

life in which there is parental discord, disruption and often separation and divorce.

Biological factors include the finding that there is a decrease in a key chemical messenger in the brain, serotonin, in some people who attempt suicide or kill themselves by violent methods. There appears to be a link between increased aggressiveness, decreased serotonin and suicidal behavior. These possible biological markers offer promise for detection and treatment strategies. A family history of suicide is a significant risk factor for suicide, increasing the risk six-fold.

The most powerful predictor of suicide in young people known currently is the presence of a mental disorder. Current evidence suggests that most adolescents who commit suicide were suffering from a mental disorder at the time of their death. Among these mental disorders is clinical depression.

The suicide rate for people with serious depression is 25 times greater than in the general population; 15% of patients with major depression will kill themselves. Since one out of ten Americans will have a major depression over their lifetime, this represents a significant loss of human life.

The term depression can be used to describe a normal mood. All of us have ups and downs, experience disappointments and losses, and have good and bad days. It is often very appropriate to feel sadness, especially at times of separation and loss. Where does normal sadness end and abnormal sadness begin? No one can clearly draw a boundary.

The syndrome of clinical depression in young people is the persistence of certain signs and symptoms for at least two weeks. These symptoms include appetite or sleep disturbances; loss of interest in activities that usually give the young person pleasure; difficulty concentrating; feelings of hopelessness, worthlessness, low self-esteem; lack of energy or sometimes increased agitation; feelings of self-reproach and self-blame.

The presence and persistence of these signs and symptoms interferes with the youngster's ability to function at school and to relate to family and friends. Sometimes the young person might seem quite sad, and at other times there may be a fluctuation between indifference and apathy on the one hand and talkativeness on the other. The youngster may appear very angry and full of rage, or may be very sensitive with an inclination to over react to criticism. The young person may report feelings of inadequacy, dissatisfied ideals, poor self-esteem, feelings of helplessness and decreased peer support. He or she may experience ambivalence between dependence and independence, feelings that life is empty and that there is no future. Reality becomes distorted, leading to hopelessness and despair.

Sometimes depression in young people may first come to the attention of adults by the persistence of certain bodily complaints such as headaches or stomachaches. When depression persists and goes untreated, a young person may feel suicidal, may wish to end his or her life and may, in fact, make plans to do so.

Depressed adolescents may come to believe that there is no solution to serious life problems and then view suicide as a way out of an intolerable situation. Low self-esteem often accompanies depression, so that the person adopts a negative sense of self, the world, and the future which is often associated with self-reproach and self-blame. For example, a young person may dislike himself or herself when depressed. These negative feelings may take the form of an active self-reproach. In a mild state, self-dislike is characterized by feelings of disappointment. For example, "I've let everybody down. If only I had tried harder I could have made the grade." In severe forms of self-dislike, the youngster may feel a kind of self-hatred, "I'm despicable, I loathe myself." The youngster might feel like a total failure and a burden to others. Feelings of hopelessness, helplessness and loss of self-esteem are characteristic of adolescent depression.

For some young people who kill themselves, death may be seen as a temporary release from hopelessness, a form of revenge or a response to disordered thinking or depression in an impulsive way. Many youngsters don't understand that their decision will be forever. If they are particularly impulsive, the first thing they may think about is ending it in a violent way. Many youngsters who kill themselves have disorders of conduct and are impulsive and aggressive.

Fortunately, there are a variety of very effective treatments for clinical depression. It would seem that our task should be simple. One of the most important predictors of suicide is clinical depression; depression is a clearly delineated syndrome; excellent treatments are relatively easy to provide and not that expensive.

Unfortunately, this knowledge seems to be one of the best kept secrets in the United States. Less than one in three people who suffer from clinical depression seek treatment of any kind, neither from general doctors, mental health professionals, pastoral counselors, nor others in the general helping professions. Less than half of those people actually see a mental health professional. The number receiving good treatment for depression is vastly smaller, perhaps one in 10 or one in 20. We are faced with a disorder with excellent, efficacious treatments for which something less than one in 10 or one in 20 people is actually receiving treatment.

First, people don't recognize clinical depression as a disorder distinct from the suffering caused by the normal ups

and downs of life, or the symptoms of depression resulting from other conditions such as poverty.

Second, even if the individuals or their therapists recognize their suffering to be clinical depression, all too often neither the doctor nor the patient is aware of the existing effective treatments.

Third, mental illnesses, depression included, are discriminated against in medical insurance policies, limiting availability of care.

At the National Institute of Mental Health, we are currently in the planning stages of a major campaign, Project Depression. We hope to vastly increase the awareness of clinical depression among the general public, general health care providers, and mental health specialists. We also hope to increase knowledge of the effectiveness of treatments and their availability.

I look forward to chairing Secretary Margaret Heckler's Task Force on Youth Suicide. This Task Force will take the lead in coordinating activities and promoting collaboration about suicide among various federal, state, and local governments, private agencies and professional organizations. We must assess and synthesize current information, identify areas of study, and make every effort to see that research is conducted. We must assess all current models of early recognition of youth at risk, intervention strategies and treatment efforts, and learn what can be done better and in a more effective manner.

Teen suicide is a tragedy because of the loss of the individual and because of the pain and suffering of the survivors. There is no greater challenge for the Department of Health and Human Services than to decrease the rate of suicide among America's young people.

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SOCIAL STRESSES AND YOUTH SUICIDE

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Drugs and suicide in the nation's youth reflect a very desperate psychic condition and we have to do something about it. First we must understand it. The "substance" that equips us all for life is a good home life, good parenting, good mothering, good fathering, a solid home, solid family. There are all kinds of terms applied to the developmental processes, but if all goes well we internalize the magnificent experiences provided by our mothers and fathers and by home life. Those experiences in turn give us courage, the capacity to trust others, the security to handle challenges of life.

Now, consider what is happening to our society: the break-up of homelife; the soaring divorce rate; broken homes; partial homes; the ravages of inflation that have forced families to devote so much of their energies and time to simply making ends meet. The bottom line is the children are coming off pretty short. Young people are approaching adolescence and young adulthood psychologically ill-equipped to undergo the wrenching process of separation from the family. Object constancy and a steady home life during the early years of life make separation possible. Many young people are facing the terrible stresses of separating from the home, going out into a frightening world, never having undergone some of the very crucial and essentially psychological processes which define normal childhood development. They are especially vulnerable to the many stresses of society, as they achieve autonomy and become independent.

Eventually, these stresses and the separation and adaptive challenges that face them conflict with their substantially less than perfect intra-psychic condition and they begin to feel defeated. On the way toward the ultimate state of defeat, they do many things: adopt non-conforming life-styles; engage in sexual promiscuity; take drugs; engage in criminal or anti-social behavior. All kinds of signs of

disturbed psychic life begin to appear. The end point of this disintegration or retrogression is the state of absolute hopelessness.

Many people live lives in a state of desperation, but manage to juggle it from day-to-day and avoid a sense of total defeat. For many, something tips them over the side and they become gripped by an acute sense of despair in which there is no hope for a future and they kill themselves. Some people plan their suicide and finally do it, but many people do it on impulse and therein lies the great danger for young people. Many youngsters tend to be impulsive because they have not built in the kind of internal controls which are a result of good family life. We are, therefore, seeing an increase in youth suicide.

Adolescence is a period of synthesis, a time when the various elements of the personality are drawn together. Such processes need stability and constancy. Much of what is happening in our society reflects instability, ambiguity and uncertainty, even in the classroom. Violence and drugs are problems in the schools. The curricula are undergoing substantial changes. Youngsters are being challenged with impossible and absurd classroom activities which add to their instability, for instance, nuclear war courses. These exercises only add to their sense of despair, their sense of hopelessness about the future.

Some of our most cherished values are being challenged in the classrooms and this is very unsettling for children. I don't advocate jamming the "good old values" down any youngster's throat, but you have to teach children some- thing. You have to give them a base on which they can adapt and master the future. Children are not born with inherent wisdom. They have to learn the best of what we can teach them; then they can challenge what they have been taught, and through the creative process bring new and higher standards of living, new and better values to our society.

I am a psychoanalyst and I have probed deeply into the human mind for about 30 years. To probe the depths of the mind is a risky undertaking. You have to do it very carefully and the person or persons who are doing it must know what they are doing. I wish to sound a cautionary note, that when we take on the suicide problem in the classroom or in whatever

context, we must approach it very carefully. Clearly, we must be able to identify the disturbed youngster and offer something that is constructive to prevent a tragedy. Be very careful about discussing the causes of suicide in too much depth because inexperienced people are going to get in over

their heads. They are not going to know what to do with the information and feelings a young person brings to them. If you open up a human psyche, you have to then be ready to stand by and do something helpful and constructive.

I have seen some terrible things happen to people's lives at the hands of psychoanalysts and other mental health professionals. These highly trained people opened up the human mind, but didn't give adequate help to the individual to cope with that which came pouring out. This could happen in the classroom. Some youngsters are unstable and if you open up the subject of suicide and start probing for the causes of despair, they will walk out the door with nowhere to go with all that agony. Identifying the troubled youngster is crucial, but solving his or her problems is entirely different. It is something we must approach very, very carefully.

Because of the profound instability and dissolution of family life in our society, millions of children are filled with despair and uncertainty; they fear the challenges of life and many give up and commit suicide. Schools inescapably have the responsibility to identify high risk children. Solving the child's mental and life problems should not be attempted in the classroom, but should be relegated to competent professionals only.

SUICIDE CLUSTERS

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Suicide statistics are imprecise and could be improved by developing a uniform set of criteria for the classification of suicide, by eliminating delays in reporting of suicides, by developing surveillance systems sensitive enough to detect potential suicide clusters, by collecting data on suicide cases that would allow delineation of high risk groups, and by establishing a data base for information on suicide attempts.

"Clusters" refers to groups of suicides that occur close together in time and place. They might occur close together by chance because they have a common cause, or because each one somehow contributed to causing the next one. In addressing the question of suicide clusters, researchers must address the following questions: (1) what is the effect of a suicide on individuals within the same family, school, or community; (2) can we identify those individuals at highest risk for subsequent suicides after an initial suicide; (3) can we characterize these individuals by risk factors such as early parental loss, family characteristics, history of mental illness, school problems, or drug abuse; (4) how do adolescents differ from other groups for whom suicide risk factors have been characterized?

We don't know how frequently suicide clusters occur or how many suicides are influenced by exposure to previous suicides. Unlike some other public health problems, suicide clusters are not a "reportable disease" and there is no systematic way to detect them or count them. Understanding more about the patterns and mechanisms behind suicide clusters is critically important for developing interventions to prevent youth suicides. For example, right now, it is not clear whether the immediate response to an initial suicide in a school should involve widespread discussion of the student's death and the problem of suicide, or whether the school should take a low-key approach and avoid increasing the attention given to the subject of suicide. Will the school's response put additional students at risk? Is it possible to identify a small group of high-risk students on whom to focus preventive efforts? What should these preventive efforts consist of?

What do we know about using education approaches to prevent suicide? We need a much better idea of what has already been done in this area, what works, the risks and problems of such educational ventures, and the questions such a curriculum might effectively address. For example, should such a curriculum address the problem of how adolescents can identify their own everyday feelings? What are the normal emotional reactions to the death of a friend? How can they recognize their own need or desire for help and how might they get that help?

Finally, research must address the question of whether or not suicide prevention centers are effective in saving lives and whether or not particular components of these centers and their multiple activities are effective. If particular types of suicide prevention center activities are effective, then these particular activities should be supported and increased.

Research in this area is tremendously important and deserves the full and active support of all persons concerned with youth suicide. Persons interested in both research and preventive programs share the common goals of wanting to help shape and direct effective interventions to prevent youth suicides. These problems are too pressing to wait for all the answers to be in. At the present time, we can make the following suggestions for schools and communities:

1. Develop a plan for how to respond to the problem of teenage suicide. Knowing that a plan exists can avert panic and be a calming influence.

2. The plan should be developed by the community and/or school board.

3. The plan should identify and assess community resources for coping with the problem. Specifically:

    a. Identify a spokesperson for the school or community and a procedure for dealing with the media and concerned individuals or groups.

    b. Try to identify those students at highest risk: students who are close friends of the suicide victims, and students who appear to be particularly troubled by the event or somehow most susceptible to suicide themselves.

    c. Make counseling services available to those students at highest risk, as well as to the wider student body and community.

    d. Offer help to survivors, including family and friends.

    e. Work with mental health and public health agencies actively involved in studying this problem to derive

> from this year's tragedies useful knowledge for tomorrow's prevention.

A concerted effort on the part of researchers and the public will make a very real and important difference in this area. We want to make the prevention of youth suicides more than just this year's fad. We want to make a difference.

Treatment Considerations

CLINICAL AND EMPIRICAL CRITERIA FOR ESTIMATION OF SUICIDE RISK IN ADOLESCENTS

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Persistently increasing suicide rates in youth and repeated rashes of adolescent suicide in limited geographical areas have forced an intensified examination of suicide in the young. This examination has sharpened the issues of recognizing vulnerability in young people, picking up clues to their distress, and taking appropriate measures, which often implies getting them to a source of help. At that point, an estimation of suicide risk must be made, as the degree of risk dictates to a large extent the nature of the helping effort. This discussion considers the observations used by clinicians in making that judgment, and what empirical data may supplement their decision regarding the likelihood of suicide.

CLINICAL ESTIMATION OF SUICIDE RISK

In the absence of any recognized measuring instrument, clinicians tend to use essentially the same criteria for adolescents as for adults, including but not limited to the following:

The clinical picture: 1) signs and symptoms of depression or psychosis, recognizing that these may present differently in the young; 2) feelings of hopelessness; 3) suicidal thoughts or impulses; 4) a suicide plan; 5) an available weapon or other means; 6) termination behavior such as giving away belongings or writing a suicide note; 7) a recent suicide attempt.

High stress life circumstances: 1) serious loss, threat of loss, or other severe stress; 2) absent or inadequate support system; 3) inadequate coping skills; 4) abuse of alcohol or drugs; 5) change in characteristic behavior patterns; 6) severe guilt or low self-esteem.

High risk background: 1) from broken or stressful home setting; 2) prior suicide attempt or psychiatric hospitalization; 3) suicide or emotional disorder in the family; 4) chronic alienation, instability or isolation from others; 5) history

of impulsive behavior.

In routine clinical work a final decision regarding risk is based on the total picture, but tends to draw strongly from the criteria above. In a survey of 65 pediatricians, a prior suicide attempt, severe psychiatric disorder, and alcohol or drug abuse were considered indicators of "extreme risk" by a majority of the respondents (McIntire et al., 1984).

EMPIRICAL ESTIMATION OF SUICIDE RISK

Four studies attempt to empirically identify characteristics of completed adolescent suicide as an aid to risk assessment. Three of these are retrospective (Sanborn et al, 1973; Shaffer, 1974; Shafii, 1984), and one is prospective (Motto, 1984). This paucity of reports can be attributed to serious obstacles to the investigation of adolescent suicide, specifically, the low base rate, prolonged time period required for prospective studies, limited access to subjects or data, and relatively few investigators. The 1984 annual meeting of the American Society of Adolescent Psychiatry had no reports on adolescent suicide. Though a number of studies of suicide attempts are found, "The... characteristics of suicide attempts are so different from actual suicides that causes and prevention strategies need to be considered separately" (WHO, 1982).

Sanborn et al (1973) examined the nine male and one female suicides, ages 10-19, in New Hampshire between 1968 and 1970. Some of their findings supported earlier observations that scholastic records were poor, and there was a high incidence of suicide threats and parental discord. Contrary to earlier findings, most victims were enrolled in school. There was a low incidence of psychiatric treatment or suicide in the family, and no history of prior suicide attempts or parental loss. Only one victim was known to be involved with drugs. These investigators felt that it was disheartening that "apart from an outright threat of suicide, it was almost impossible to distinguish the suicidal adolescent from the 'normal' adolescent."

Shaffer (1974) studied 21 male and 9 female suicides of 12-14 year olds in Wales during 1962-68. These suicides included a disproportionate number of children with superior intelligence, tall for their age, engaging in antisocial behavior and in over one-third of the cases reacting to a disciplinary crisis. Prior suicidal behavior was noted in 40% of the cases, and there was a high incidence of depression, 20%, and suicidal behavior, 13%, among parents and siblings. Among the male cases, eight fathers and one mother, or 43%, were heavy drinkers.

Shafii et al (1984) examined 20 adolescent suicides, 16 male, 4 female, aged 10-19, that occurred in Jefferson County, Kentucky, during 1981 and 1982. The findings included:

1) ages 17 and 18 appear most vulnerable; 2) symptoms such as sleep disturbance, pain, allergies, irritability and depression preceded the suicide; 3) breakdown of communication with parents or friends; 4) direct or indirect mention of suicidal intent; 5) prior suicide attempts; 6) large amount of alcohol consumed in final few hours; 7) major confrontation with a meaningful person during last 24 hours; 8) desperate attempt to contact a friend by telephone in final hours.

Motto (1984) reported a prospective study of 335 adolescents aged 10-19 with a detailed analysis of the 122 males, including 11 suicides. The four suicides among the 213 female subjects were too few to analyze statistically. Nine variables associated with suicidal outcome in males included: 1) if a prior suicide attempt was made, the intent was clearly communicated; 2) if a prior suicide attempt was made, help was actively sought first; 3) fear of losing one's mind or having a rare disease; 4) feelings of hopelessness; 5) apathy or psychomotor retardation; 6) increasing amount of financial resources, over $100; 7) increasing hours of sleep, over six hours per night; 8) moderate ability to communicate with others; 9) a negative or mixed attitude toward the interview.

These findings suggest that suicidal behavior in adolescent males is not simply an impulsive act that comes as a complete surprise to others; that very specific depressive manifestations that may be overlooked tend to precede suicide; that adequate sleep and financial resources are not cause for reassurance; that a limited ability to communicate with others is a recognizable risk factor; and, that a negative or ambivalent attitude toward being interviewed by a potential helper is cause for concern. Statistically, five of the variables could be found at the .05 level of significance by chance, so we cannot be confident that all nine variables indicated are dependable criteria of risk.

It is of interest, as regards "ability to communicate with others," that for both males and females, of the 47 rated "high", 20 males, 27 females, none subsequently suicided. Narrowing this to "ability to communicate with interviewer," of 60 rated "high", 24 males, 36 females, none suicided. This seems to give credence to the frequent observation that communication difficulties or breakdown are involved in an adolescent suicide. It is suggested that if a youngster's skills are low, alternate means of expression may be developed, thus, those with moderate skills are most vulnerable.

CONCLUSIONS

There is a reason for confidence that adolescent suicide risk assessment can be aided by empirical studies. While continuing to rely on clinical skills for making judgments, we can provide models for young people in communicating and relating to others. We must remain unswervingly optimistic in our task, both because it is important and because it provides

still another means of modeling. The way to approach problems with no apparent solution is simply to keep working on them until our efforts bear fruit or time resolves them for us.

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CLUES TO ADOLESCENT SUICIDE *

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In America more than 13 out of every 100,000 persons died last year by suicide. Estimates of the ratio of suicide attempts to completed suicides vary from 10 to 1, to 100 to 1. Most of us do not like to be confronted by death in any form. We strongly defend against thinking about it, and often shy away from dealing with it. The rising rate of adolescent suicide doesn't allow us this luxury.

Self-destructive behaviors take many forms other than evident suicide attempts and obvious suicide completions (Farberow, 1980). Many fatal one-car accidents may be suicide. In some cultures in which murder is defined as masculine and active, and suicide is seen as feminine and passive, victim-precipitated homicide can be seen as a form of suicide. The juvenile diabetic who discontinues his insulin or overdoses himself is another example. Our statistics, while alarming in themselves, are surely gross underestimates of the true magnitude of the problem. Evidence is often concealed by parents seeking to avert the stigma of suicide. The rich and powerful may influence a coroner's verdict or a doctor's note on a death certificate. The poor may escape tabulation by failure to come to the attention of the local authority. Quite typically, unless suicidal intent can be proven, the official notation on death certificates is often "accidental death." Home accidents may reflect suicide intent. Alcoholism, drug addiction, unnecessary heroism, choice of dangerous occupations and hobbies, and serious accident-proneness clearly belong on the spectrum of suicidal behaviors.

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* The views expressed herein do not necessarily reflect those of the National Institute on Alcohol Abuse and Alcoholism, nor the Department of Health and Human Services.

Adolescent suicide is particularly challenging to parents, educators, and health professionals because such persons occupy critically important positions in the world of children and adolescents. Adolescence is a time of physiological, sexual, social and psychological change. The child achieves independence from his family, struggles with adaption to a social and sexual identity, and is required to learn different modes of dealing with the world and himself in the pursuit of these goals. It is a period of chaos, of an intense investment in the "now," and a time of strong yet ambivalent feelings. Parental relationships are often severely tested and may fail to provide the support needed for growth and security. Peer relationships may also fail. In the early grades, contact with one's teacher may be greater than with one's parents. A patient teacher, willing to listen, who forms an acceptable role model is often sought out by the student and entrusted with his problems.

To understand why a person takes his life, we must first reflect on what death means to that person. The child's concept of death is different from that of most adults. Before the age of one year, a child responds to separation with reactions suggesting that he equates absence with non-existence. However, most often the person who has left soon returns. The age at which youngsters comprehend the finality of death varies. Cultural factors, relationship with parents, presence of older siblings who engage in self-destructive behavior, and exposure to violence all play a part. The idea that death is reversible makes any threat or attempt a dangerous one in that the child may not provide for his rescue, as older adolescents may. It is commonly believed that, before the age of five, death is denied, seen as temporary and reversible. Nagy (1959) notes that children of this age see death as gradual; namely, one doesn't die all at once. Between the ages of five and nine, death is imagined as a distinct person. It is often thought to have some relationship to night and darkness, and is not yet seen as an inevitability. At this age, the child accepts the existence of death, but sees it as remote and outside of himself. From about nine years of age, the child appreciates the universality of death, its operation within man, and its definition as the cessation of bodily activities. Nagy cautions that it is neither possible nor wise to conceal death from the child. Natural behavior and explanation in a framework the child understands can diminish the impact of death for children.

If many children who make suicide attempts do not appreciate the irreversibility of death, what is their motivation? A common fantasy in children is: "If I die, my parents will feel sorry." Punishment of parents and authority figures is a common motivation for suicide attempts in youth. This

behavior may also represent an assertion of independence, or a means of running away. The child may be punishing himself for guilt related to negative thoughts or acts. He may be identifying with a parent who had engaged in suicidal behavior, or expressed suicidal thoughts at home. He may desire to rejoin a dead relative. Many attempts are impulsive and may be triggered by what we adults see as a small problem; for the child, it may assume major proportions.

In adolescent girls, the notion of death seems to be immature and romanticized. Rejection after a failure to fulfill important expectations is a common precipitant of suicidal behavior in this group. Parents may communicate in any of several ways that the girl was unwanted. Furthermore, rejection by a boy friend or lover is thought to be another common precipitant, because the boy friend may be regarded as a partial parental substitute. The adolescent may have transferred her dependency needs from her parents to her boy friend. Rejection by him may serve to confirm her notion of rejection by her parents. When school failure is cited as a precipitant of suicidal behavior, it will likely not relate to the standards of the school but rather to extraordinarily high standards maintained by the adolescent to satisfy parental expectations.

The suicidal child is often characterized as an unhappy, helpless, hopeless youth who wants to change something, yet is unable to do so in a constructive way. The boy who is referred to a counselor because of aggressive behavior is a common prototype. The quiet boy who disturbs no one, but is moody and withdrawn, though obedient, is usually not recognized when he is suicidal. The immature, impulsive child who reacts excessively to minor stresses is another prototype. What is clear is that most unhappy, isolated adolescent boys do not commit suicide. However, most suicides in adolescent boys occur among isolated, uncommunicative teenagers.

Hopelessness, depression and a sense of being unpleasantly different from others make up the emotional constellation which typifies an adolescent suicide attempt. While it is essential to note that there is no specific personality picture in the presuicidal child, there are a number of practical guidelines which can be used as clues for recognizing potentially self-destructive youth (see Table 1).

Another way of grossly categorizing the clues is to divide them by age groupings: young children, puberty, adolescence, and late adolescence. The underlying scheme here is that for the youth who will likely make a serious suicide attempt, or

TABLE 1

CLUES FOR RECOGNIZING POTENTIALLY SELF-DESTRUCTIVE YOUTH

1. An inability to communicate verbally with parents.
2. Giving away a prized possession.
3. More morose and isolated than usual.
4. A sudden drop in grades; or a sudden decrease in general efficiency and school work.
5. Recent involvement with drugs, or increased alcohol or drug use.
6. "Accidental" self-poisoning.
7. Homes in which child abuse is suspected.
8. Evidence of desire for revenge with parents.
9. Not finishing anything on time.
10. Subjective complaints; declarations of self-hate, coupled with noticeable lack of energy.
11. Major loss of a steady boy friend or girl friend.
12. A move to a new neighborhood or town, which increases isolation and therefore, loneliness.
13. Parental depression.
14. Each year can be an anniversary of a death or the loss of a loved one, especially during the holiday season. An annual period of grief is normal but should not last more than two weeks to one month.
15. Symptoms of sadness, guilt, and apathy.
16. Symptoms of withdrawal or agitation, crying spells and general slowing of speech and action.
17. Insomnia or a change in sleeping patterns.

Table 1 (Continued)

18. Loss of appetite or weight. A ten pound weight change during a month's time, when a diet was not planned.

19. Impaired bowel function.

20. A negative self-image, a negative view of others, and a pessimistic view of the future with concurrent feelings of helplessness and hopelessness and often suicidal thoughts.

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commit suicide, a variety of depressive symptoms and their equivalents can serve as clues. Table 2 denotes these symptoms and their equivalents.

In the young child, colic, crying, and headbanging, along with eating and sleeping difficulties may be the only signs one will see. At puberty, withdrawal, apathy, regression, boredom, restlessness are major symptoms of underlying depression.

For the young adult, more specific clues have been elucidated with specific suicidal death prediction scales (Lettieri, 1974). For the young male adult, being married, displaying omnipresent suicidal thoughts, confusion in thinking, aggressive and criminal behavior, and overstrenuously accepting social roles, and hence, feeling culturally trapped are the predictors for suicide completion. Contraindications to suicide include planning a dual suicide, or planning to kill someone else, in addition to self. For the young female adult, the predictors for completed suicide are: lacking close friends in the vicinity, being highly independent, displaying little or no irritation, rage or violence, planning to kill someone else in addition to self, a history of prior suicidal behavior, and the absence of criminal behavior.

In children, as in adults, loss is frequently the precipi-precipitating event in depression. Death of a significant other is an obvious loss. Less apparent, but equally as serious are the loss of close friends through school

transfers, and the loss of older siblings through marriage, college, military service. While many children may not react to loss with depression or anger, the hallmarks for concern and closer scrutiny of the child are evidenced if helplessness, resignation, and apathy follow the loss, and the child begins to see himself as evil to justify his loss, thus setting the stage for some self-destructive behavior to confirm his negative self-image. Although drug use plays a role in many sensational accounts of suicide, it plays a very minor causative role in adolescent suicide. Alcohol and drug abuse is best seen as a coping strategy to deal with some other underlying problems the youth is confronting. When these coping strategies fail, the risk of suicide is greater. On balance, substance abuse is best understood as a byproduct or consequence of deeper perturbation, rather than the cause of such.

The family backgrounds of suicidal children differ widely. What is important is how the child perceives various familial stressors. Divorce, separation, moving around from city to city, intense family quarrels, substance abuse by the parents, family instability and disorganization are best understood only in terms of how much conflict they generate in the child. At base, the essential feature is whether these events cause the child to feel unloved, unprotected, or harshly or unjustly punished. And if so, whether the child wants to escape. One must assess how great is the need or desire to flee? Will it entail the ultimate escape, suicide? Or will a suicide attempt suffice as a signal of the youth's cry for help to be rescued from the intolerable family/peer situation? These are the fundamental elements and clues that need to be fully evaluated and attended.

TABLE 2

DEPRESSIVE SYMPTOMS AND EQUIVALENTS

YOUNG CHILD

- Colic
- Crying
- Head Banging
- Eating and Sleeping Difficulties

PUBERTY

- Withdrawal
- Apathy
- Regression
- Boredom
- Restlessness
- Difficulty in Concentration

ADOLESCENCE

- Behavior Problems
- Temper Tantrums
- Truancy
- Running Away From Home
- Accident Proneness

LATER ADOLESCENCE

- Delinquent Behavior
- Sexual Promiscuity
- Associated Character Disorders

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TREATMENT OF THE SUICIDAL ADOLESCENT

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INTRODUCTION

There are two crucial stages in the treatment approach to the suicidal adolescent. The first stage is the recognition of the active state of suicidality. This state of mind includes an active interest in self-destruction. When an individual is in this mind set, the act of committing suicide feels like a solution rather than a problem, although this solution is usually viewed ambivalently. The fact that death is sought by the adolescent makes this state of mind a medical emergency, while the fact that the youngster usually feels some ambivalence, makes the condition treatable.

After the acute emergency state is managed, many adolescent patients will require further treatment for an underlying psychiatric condition. In many cases, especially the depressive illnesses, this psychiatric condition has played a major role in precipitating the emergency state of suicidal ideation.

THE SUICIDAL EMERGENCY

A preoccupation with suicide as the solution to problems usually arises in adolescents who feel unhappy about themselves or about their environment, or both. This unhappiness is usually accompanied by a felt sense of helplessness to change the self or the external conditions. Under these circumstances, the idea of self-destruction provides a sense of relief and a potential escape from an unbearable situation. To some extent, it appears that this frame of mind includes some genuine wishes to die, but also includes other emotional elements. The consideration of self-destruction, and especially the threat to commit suicide, often mobilizes support in parents and others around the adolescent and functions as the well known "cry for help." The suicide gesture or attempt often includes a further, almost magic element, in which the adolescent poses a question to faith, God, or some other outside agency, "Should I live or should I die?"

EVALUATION OF SUICIDAL RISK

The evaluation of the degree of risk in a given adolescent patient depends on an overall clinical evaluation of that patient and should be strongly influenced by an intuitive sense of the adolescent's degree of desperation, especially when the evaluation is done by an experienced clinician. A number of risk factors have been identified which help inform this clinical judgment. One of these is the patient's stated wish to die. This information can be obtained only in an individual interview and with patient exploration which convinces the adolescent of the examiner's wish to ascertain the youngster's true feeling state. Adolescents will rarely confess their strong wish to be dead in the presence of their family or in the presence of other people. The sincerity of this expressed wish to die can be measured further by inquiring about specific plans, availability of instruments of death, and of course, previous attempts.

The presence of concurrent heavy drug use is a high risk factor, as is a history of suicide in close friends or admired public figures. The history of a suicide in a close family member greatly increases the likelihood of a serious suicide attempt. A related situation occurs in communities where there have been large numbers of adolescent suicidal deaths, the so-called "cluster" phenomenon.

Important losses, either of close friends or loved ones, or of important personal goals or achievements, create a vulnerability in the adolescent. This vulnerability is particularly dangerous in adolescents who have poor support networks or who themselves have difficulty in turning to others for help.

MANAGEMENT OF THE EMERGENCY STATE

If the patient is felt to be at risk for an actual suicide attempt, this opinion should be clearly and forcefully expressed to the patient. This opinion is unlikely to be a surprise since, as mentioned earlier, much of the information about the seriousness of the patient's suicidal intent is derived from skillfully interviewing the patient, facing the issues tactfully but directly, and following up on the clues that the patient offers. In other words, step by step the patient has told the examiner quite directly that he or she is seriously considering a suicidal act.

The next step is to take an active position against the suicidal wish and suicidal thoughts. This opposition should be based first of all on reason, namely that the state of mind is temporary and that the underlying problems are solvable and require only time, appropriate help, and perseverance. This is particularly important in depressed people, since the illness is very treatable, but one condition of the illness is a feeling that nothing will help. The therapist may also consider utilizing other appeals, such as noting the possible

impact on family members and other moral concerns that might influence the patient to resist the suicidal wish.

Even more important than these statements are the therapist's actions. The therapist needs to intrude directly into the patient's life, rather than being passive and non-directive. The extent of the intervention depends on the particular patient. In some patients, a contract that the patient will not hurt himself or herself without coming and talking to the therapist in person first is sufficient. In other cases, it is important to mobilize the family or spouse so that the patient is supervised at home and all materials which could be self-injurious are removed from the patient's access. In other cases, nothing short of hospitalization with 24-hour supervision would be safe.

TREATMENT OF THE UNDERLYING ILLNESS

In most patients, management of the suicidal crisis alone is not sufficient. Many suicidal individuals have other underlying psychiatric illnesses which must be treated once the crisis has been adequately managed.

The most common condition underlying suicidal behavior is depression. Although many depressed adolescents will have a history of difficult or anti-social behavior, careful evaluation of the history and direct interviewing of the adolescent will reveal traditional symptoms of depression, including feelings of sadness, changes in sleep pattern, loss of interest in activities, irritability, fatigue, excessive guilt, and the like. A family history of depression also supports the diagnosis, as do positive biological tests such as the dexamethasone suppression test.

Treatment of depression varies with the nature of the depressive illness. The major affective disorders are treated with a combination of medication and supportive psychotherapy. The anti-depressants and lithium are most frequently used. Situational or neurotic depressions are often treated with psychotherapy which supports self-esteem, corrects distortions regarding the self and builds greater adaptive skill.

The second most common emotional disorder in suicidal adolescents is conduct disorder. It should be remembered first of all that this is a descriptive diagnosis and that in long term follow-up it has been demonstrated that up to 20% of youngsters with apparent conduct disorders turn out to have major psychiatric illnesses five years later. This is explained to some extent by the adolescent's tendency to externalize emotional discomfort and to deal with life's problems through action techniques.

Other conduct-disordered adolescents do not have major psychiatric illnesses. They have severe problems with their sense of self-esteem and personal competence so that they rely

on omnipotent defenses, drug use, and manipulation of others in order to maintain a precarious sense of self-worth. Many of these youngsters fit the diagnostic criteria for narcissistic or borderline personality disorders.

Treatment of these youngsters is quite complex. The treatment usually involves a prolonged period of time since major elements of re-education and personality growth are necessary for the youngster to learn new methods of adaptation. The treatment usually includes elements of limit setting on the destructive behavior, the development of a trusting transference, re-educational techniques and family therapy.

Finally, some suicidal adolescents are actively psychotic and are suicidal because of their response to delusional or hallucinatory experiences. Proper management of these youngsters is, of course, the active treatment of their schizophrenic or toxic psychosis.

As mentioned above, many youngsters with serious suicidality have a concurrent problem with substance abuse. It is important to remember that substance abuse is highly correlated with both frequency and lethality of suicide attempts and that any observed chemical dependency should be directly and aggressively treated in any suicidal adolescent.

SUMMARY

The treatment of suicidal behavior in adolescents is a complex undertaking involving management of the suicidal crisis often followed by the need to treat underlying, sometimes chronic psychiatric disabilities. Treatment is often difficult and demanding. However, since it is frequently a life saving intervention, the importance of early effective treatment cannot be overstated.

STRATEGIES FOR TREATMENT OF SUICIDAL CHILDREN

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Suicidal behavior is a very complex multi-determined symptom. Because it is so multi-determined, it involves a multi-dimensional treatment approach. Acute suicidal behavior does not last a long time but during one's life-threatening period, the first goal of treatment is to protect the youngster from harm. In addition, simultaneously and subsequently, the risk factors that increase the possibility for suicidal behavior must be evaluated. Among the risk factors are depression, suicidal behavior of people who are emotionally important to the child, and death preoccupations.

Suicidal behavior does not indicate a specific disorder or a specific problem, but rather it indicates that the child is experiencing intense stress. Therefore, diagnostic assessments of suicidal risk must include factors related to psychiatric diagnosis, other symptoms, and social stress. Of highest priority is the need to directly interview a youngster about suicidal ideas or behavior. The meaning that suicide has to a child, the circumstances under which the behavior is contemplated, and the child's concepts of outcome if the behavior were carried out need to be evaluated. Other factors for assessment are the child's degree of intense or morbid pre-suicidal behavior. Children, even as young as two and a half years, have concepts of death. If the child can conceptualize an idea of death then the child can enact behavior to achieve the goal of dying. Therefore, a child can be considered to be suicidal if there is a death concept and a wish to die.

Other aspects of treatment involve working within a system. Although this is also true for children with other psychiatric problems in general, it is mandatory with

suicidal children. Working with a system involves a network of people. Primarily the treatment focuses on the individual work with the child as the center of focus. However, other areas require attention. It is essential to work with the family. The needs of the family and their style of functioning must be evaluated. The quality of interpersonal interactions must be determined. Other issues to be evaluated include the parents' degree of psychopathology and the state of the marital relationship.

As noted, treatment is a multi-faceted undertaking. A dynamic approach with an interpersonal focus is necessary. Use of medication may be indicated. The choice of a specific medication is determined by the psychiatric disturbance. Group therapy is another modality and has the advantages of enhancing socialization, increasing peer relations, and developing better coping skills. An educational approach of learning to cope has great advantages.

Finally, an important issue for prevention is how to build protective barriers against suicidal behavior in children and adolescents. In previous times, there seemed to be greater social and religious barriers to suicide. This made suicide an unacceptable and inconceivable act. Currently, the lessening of such barriers may have contributed to greater possibility for contagion and to an increase of suicidal behavior. Currently, we need to create approaches to building barriers to suicide so that within the framework of one's lifestyle, suicide is not an alternative form of coping.

SURVIVAL: STRATEGIES FOR HEALING

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I've come to share what I've learned about surviving after the death of a loved one by suicide. I believe everyone in this room is a survivor of some tragedy, crisis, or loss. We survive by helping one another. We survive by finding the balance between research and experience. We survive by sharing what we know best. We survive by supporting one another. We survive with unconditional love.

Our stories are unique, as are the experiences of all those who mourn. One develops his own process, makes his own ways, in his own time. My hope is that I might add a dimension to the healing of others through affirmation of themselves and their own process, or through renewed hope of survival.

Jerry Motto says that suicide is a private and public anguish; and so it is. Last year, at least 35,000 people completed suicide. For every death, hundreds of lives are touched: family, friends, teachers, clergy, police and medical personnel. It is essential that we not only focus on prevention and intervention, but that we deal with the aftermath of suicide and come to view postvention as prevention.

People who have survived the suicide of a loved one are frequently at risk for suicide themselves. It is our task as caregivers, friends and professionals to do what we can to help those individuals survive. We can help them choose between allowing themselves to be destroyed by this event, or reframing it and making meaning out of such an act. That's a choice each individual will make.

There are no perfect formulas for living through the loss of a loved one. There are no absolutes, no real guidelines, only the sharing of common experiences and reactions that occur.

No words can adequately explain the phenomenon of self-destruction. No spoken language can tell a family how to survive. We must be satisfied with partial explanations, guesses, and the knowledge that each incident is different.

True, there are common denominators, but ultimately we must search for our own piece of the truth by living through the questions. When you are searching for truth, Richard Felder, M.D., of Atlanta recommends that: "Whatever you can find out about your feelings, or find inside yourself about the suicide, is the only way you can ever be real about it. Face it, whatever it is."

What is certain is that death is a life event, a life change, a rite of passage. It elicits powerful feelings from deep levels within ourselves, feelings not usually evident in day to day living. A suicide in the family may magnify these feelings and impose a heavy burden on those left behind. The deed may involve more than the destruction of the person who pulls a trigger or takes an overdose. Too often, it destroys others in the family, devastating them with the stigma of suicide, of personal guilt, plus the shattering of lifetime relationships. A father whose 16-year old daughter took her own life says, "Suicide is not a solitary act. A beloved person thinks he or she is killing only herself, but she also kills a part of us."

Much has been written about the stages of grief. I'll summarize the impact of grief as I experienced it. I remember the words of Jeff, a young man whose mother had died a year earlier, "You build your own grief process and you build your own recovery. It's not right or wrong, good or bad. It just is."

The impact of suicide begins with shock and disbelief. The questions of how, when and where are immediately asked. Accurate information usually is not available as one tries to understand what has happened. Finally, when the truth sinks in, the mind pleads for an answer to "why?" What a mystery is encompassed by that tiny word. You will repeat it again and again, sometimes for months, often for years, until finally you understand enough of the truth to go on living.

Most people move unconsciously from the "why" question to "what do I do now?" A small minority may even declare, "I no longer care what happens!" Regardless, whatever happens next is blinding, maddening and paralyzing for almost everyone.

There may be confusion, guilt, anger, depression and despair. There may be embarrassment, a sense of isolation. There may be resignation to the reality of the event, eventually leading to acceptance of the act and hope for the future survival of oneself.

Eight years ago my own 20-year-old son chose to end his life. He was a beautiful, attractive young man with musical talent who was popular and loved by many friends. His girl friend had ended their relationship three weeks before his death. He seemed to be mourning appropriately. He had masked his deep despair and, when he shot himself in his bedroom in our home,

we were stunned. Our family was in shock as we struggled with the "why" and with our guilt and anger. I was the Director of The Link Counseling Center in Atlanta, Georgia. I felt as though I had failed my son, myself, my family, and my Center. I felt foul to the world, a personal and professional failure. I too wanted to die, to give up on life.

We mourned individually, in our family and in our community. How does one survive, mourn, heal? I'll tell you what our family learned:

1. You can survive. You may not think so, but you can.

2. Struggle with the why it happened until you have ideas or guesses about it that you can live with.

3. Know you may feel overwhelmed by the intensity of what you're feeling. Know that all feelings are normal and common. You are not crazy. You are in mourning.

4. Be aware that you may feel angry at the person or may be angry in general; at the world, at God, at someone else close to the person. This is common.

5. You may feel guilty for what you think you did or did not do. You are not to blame, and knowing that you did the best you could, in your humanness, may help you let go of the guilt.

6. You may feel hopeless and depressed. You may think of giving up on life yourself. Be assured these feelings are common, and in time may pass.

7. Remember you are a person of worth, even though you may not feel like it.

8. Express your feelings to others. Denying or hiding feelings may lead to isolation or depression. You may talk, write, or express your feelings through creative activity.

9. Remember to take one day at a time, one moment at a time. It takes a long time to heal.

10. Learn about the grief process so that you know what to expect.

11. Call on your personal faith to help you through this trauma.

12. Allow friends and family to take care of you. This helps you, and them too. They are a part of your support system.

13. Professional help can be another part of your support system.

14. There are support groups all over this country that may be helpful, such as The Compassionate Friends or Survivors of Suicide. Check for referrals in your area. They provide a safe place to talk, share, or listen.

My family went through all of the stages of agony, anger, guilt and despair. Somehow we made it through that process and, in so doing, made a choice to survive. We made a commitment to life. We decided together to reframe this terrible experience; to make a tribute to Mitch's life rather than to focus upon his death. In that process I decided to return to Emory University in Atlanta to study in this area. I completed my Masters Degree in the field of Suicidology, and have since chosen to work with young people, survivors, and other professionals.

Two ideas for research may be crucial information for prevention of suicide. The first is to ask young people why they do not choose to die. When they are hurting and hopeless, what keeps them from completing suicide? Do others reinforce their choice to survive, through loving support, or is there an internal strength which helps them endure?

The second idea involves youth in struggling with the questions: why is suicide happening today; and what do they think can be done about it? Let's involve young people in the solution to this tragedy.

I have written a privately published book entitled "My Son ... My Son: A guide to Healing After a Suicide in The Family." The writing helped in my own healing and hopefully will assist others. I'll share the opening page:

> I don't know why
> I'll never know why.
> I don't have to know why.
> I don't like it.
> I don't have to like it.
> What I do have to do is make a choice about my living.
> What I do want to do is accept it and go on living.
> The choice is mine.
>
> I can go on living, valuing every moment
> in a way I never did before,
> or I can be destroyed by it and,
> in turn, destroy others.
>
> I thought I was immortal.
> That my family and my children were also.
> That tragedy happened only to others.
> But I know now that life is tenuous and valuable.

So I am choosing to go on living,
making the most of the time I have,
valuing my family and friends in a way
never possible before.

My 96-year old aunt said:

"These days are the winter of the soul,
but spring comes and brings new life and beauty
because of the growth of roots in the dark ...
spring comes and brings new life and beauty,
because of the growth of roots in the dark."

ORGANIZING A SURVIVOR SUPPORT GROUP: FIRST STEPS

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I have taught courses in general death education since the early 1970's and have been more specifically involved in the field of suicide since 1979. In late 1980, I began a survivor support group in my Maryland county. It was from this experience that I learned about and became sensitive to the issues facing parent survivors.

Survivor groups can be of great value to grieving individuals and ought to be an available support mechanism in every community of any substantial size. I say this based on my own experience and the anecdotal stories of numerous survivors. I would also like to cite research to that effect, but, unfortunately, I am not aware of any controlled studies that have analyzed the direct and comparative benefits of the various models of suicide survivor groups. I would welcome such studies in this field, which is experiencing a burgeoning of the number of survivor groups and the attention being paid to such groups, most notably by the American Association of Suicidology and the Dayton Suicide Crisis Center of Dayton, Ohio. National efforts to unite survivor groups or, at least, to initiate closer contact for mutual benefit are underway at this moment.

Survivor groups "make sense" for a number of reasons. Perhaps the most obvious explanation of the potential value of a survivor support group is the mutuality of its membership. Mutual help groups of all kinds, such as alcohol and drug abuse groups, men's and women's support groups, holiday depression groups, have become a popular means of seeking help and self-understanding. Compassionate Friends, a successful mutual help group, serves the needs of many parents who have suffered the death of a child by any means. Many parents who have experienced the suicide death of a child have found support and understanding at Compassionate Friends meetings.

However, suicide survivors have told me that they felt "different" and "uncomfortable" at times in sharing their sorrow with parents whose children had died in early childhood or by natural or accidental causes. Suicide survivor groups increase the feeling of mutuality among these "special" survivors in a culture which defines suicide as a less acceptable mode of death. Interestingly, I have seen participants of a suicide survivor group pair off by age and relationship of the deceased, an effort aimed at further maximizing likeness of experiences.

Survivor groups are an acceptable way of seeking help and support in a culture that sometimes sees psychology and counseling as unacceptable. Anyone working in the adolescent suicide field has met the wall of resistance thrown up by troubled youths and their families when therapy is suggested. Preventive mental health is still a relatively alien concept.

Grieving is not a process that automatically requires professional intervention, although, in the aftermath of a sudden and unexpected death, professional attention can be a great benefit to those who are willing to accept it. Survivor groups are not a form of group therapy. Rather, a group of similarly experienced people share their similarity for mutual support. More people are choosing this means of coping. Many times I have seen one family member bring others in the family to subsequent meetings once they have been convinced that a survivor group is a safe place.

I do not believe that survivor groups should make an attempt at therapy, though this is very tempting to professionals facilitating such groups. Survivor groups are, nonetheless, therapeutic. Participants share their pain, their struggle, their tears, and feel relieved and less alone for it. The process of emotional cathexis is not mysterious. It is merely a more technical explanation of the old saying: "A joy shared is a joy increased; a burden shared is a burden lessened."

Therapeutic benefits result from a maximization of empathy and understanding among the survivors. Little can be shared in a suicide survivor group that will not immediately be understood or experienced by someone else. The decision not to change anything in the deceased's bedroom for many months or, conversely, the decision to redecorate a room filled with tragic memories are both readily accepted. Other heads nod with true empathy on recounting imagined footsteps or table settings absently set for one too many. Among the participants in a survivor group, all the details that plague the days and nights of the survivor can be freely revealed.

Importantly, too, survivor groups provide models of surviving. A student once asked, "How can parents go on after their child has committed suicide?" Many parents have asked this question when faced with the reality of this crisis. It may seem to many that the answer is, "they can't." Parents can and do, however, survive the suicide death of a child. They can experience positive growth within themselves and in their relationships in the process. When doubts predominate, it is helpful to see evidence of the healing process in parents for whom the loss is less recent.

If there isn't a survivor support group in your area, consider being part of an effort to begin one. Anyone with interest and energy can initiate a survivor group. Participants from the group can usually be counted on to facilitate and maintain the group over time. A listing of survivor groups around the country has been compiled by the Dayton Suicide Crisis Center. Group leaders can give you an idea of the various "models" for survivor groups. Some groups meet continuously once or twice a month; participants join or drop out as the need arises. Some groups bring 10 to 12 people together for an intense weekly group meeting over a two month period. Groups are facilitated by survivors or by professionals. They may be large or small.

With a group name, a place and a meeting time selected, a group can begin with a few informal referrals from clergy or counselors. Most participants in a survivor group are not far enough along in their own grieving to decide and implement the immediate growth and direction of a new group. I recommend that organizers worry less about democratic ideals at the beginning and choose instead to broaden the referral base of the group.

One good way to facilitate awareness of a survivor's group is to promote its name and purpose through radio and TV public service announcements. Letters of explanation to specific radio and TV talk show producers help to create interest. Appearing on a talk show may seem immodest or unnerving, but the size of the audience reached is worth the effort.

Informational flyers can reach the public and those in referral positions such as clinical social workers, counselors, psychologists, medical and mental health professionals, high-school principals, counselors and all local college counseling centers.

The local mental health association included our group's flyer in their routine mailings. The area funeral directors' association and several church denominations distributed the flyer along with their member mailings. The local police department sent flyers to numerous officers through their interagency mailing system. Stacks of flyers were left in several hospital emergency rooms, large organization employee

assistance offices and in all county libraries. Special permission was obtained to leave flyers at our county-owned liquor stores.

All publicity efforts and flyer distributions were set in place three weeks prior to our first meeting in February 1981. Thirty-five survivors, from as far as 50 miles away, attended that first meeting. That group, and a second group established in a nearby city, continue today to meet the needs of many survivors in their area.

YOUTH SUICIDE: A PSYCHOSOCIAL PERSPECTIVE

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I draw on my studies of suicide in the Scandinavian countries, in Harlem, among White middle-class high-school and college students, and among the elderly to bring a psychosocial perspective to bear on the problem of suicide among the young. At the heart of such a perspective is the fact that the psychological and social differences in suicide between the young and the old, among cultures and subcultures, are at least as important as the similarities.

In addition to keeping a focus on the individual young person who is suicidal, a psychosocial perspective on youthful suicide requires us to be aware of five major points.

First, that the increase in suicide among the young has been accompanied by a rise in other serious problems among the same age group, such as drug abuse, alcohol abuse, delinquency and crime, all of which have come to be considered as barometers of social stress.

Second, the rise is among young adults, not simply adolescents. The increase in the rate of suicide of young people 20-24 has been even greater than in those 15-19.

Third, the conclusions of earlier generations concerning a supposed inverse relationship between suicide and the overt expression of violence have been revised, particularly among the young. Studies of the biological correlates of suicide and aggression provide the potential basis for a bridge with psychological and social knowledge in this area.

Fourth, there is convincing evidence that one source of stress among the young between 1955-1980 relates to the increase in the percentage of young people in the population. Demographers hypothesize that an increasing percentage of young people in the total population increases the competition among them for desirable adult options, with a resulting increase in all forms of stress.

Fifth, although our attention has been drawn to White, middle-class youngsters in suburban communities, the rise in suicide among the young has taken place in every socio-economic segment of our society. In fact, one should be cautious in generalizing too freely about suicide among the young if one sees mainly the White, middle-class youngsters that may eventually arrive in the clinician's private office.

To illustrate the necessity of a psychosocial perspective, I will contrast the results of my study of suicide among young Blacks with my studies of White middle-class high-school and college students.

In New York City, for the first 70 years of this century, the suicide rate for urban Blacks between 15 and 30 was consistently higher than for Whites of the same age. Similar high suicide rates for young urban Blacks have been found in other metropolitan centers. The low overall suicide rate for Blacks had obscured that fact. Age 15-30 is also the period in which the high homicide rate for Blacks reaches its peak.

Clinical study of young suicidal Blacks indicates a connection between these two problems. Among young Blacks, suicide was usually the outgrowth of a devastating struggle to deal with conscious rage and conscious murderous impulses.

Young suicidal Blacks have a striking history of violence in their childhood; fathers who were physically violent, many of them dying violent deaths, and mothers who were brutal or left their children in the hands of others who were brutal to them, recur in the stories of such patients.

The study of young suicidal Blacks in the ghetto reveals that their consciousness is flooded with angry homicidal impulses. What they find most disturbing is the feeling of being overwhelmed by the loss of control over such impulses, and what they describe seems to be a fear of ego disintegration. Seeing such young people after they have been violent, one is impressed with how often their concern is not about the consequences of their violence, but about the feeling that they could not predict or control what they did and that it threatened their capacity to function. Suicide can function as a means of control of violent impulses by people who feel torn apart by them.

The culture's overt rejection of Black people all too often reinforces feelings of rage and worthlessness that are already present; feelings that the culture, operating through the family, has insidiously helped to produce. In their most repetitive self-images, the young suicidal patients saw themselves as black bugs or black rats. While those images appeared in dreams as symbols linking sexuality, destructiveness, and Blackness, it is no accident that these symbols originate in the most despised and unwanted living things in the Harlem tenements, rats and roaches.

The picture that emerged of young suicidal Blacks struggling with conscious murderous impulses helped us to revise earlier formulations concerning a supposed inverse relation between suicide and homicide. There are now advances in the knowledge of the relation of suicide to violence and the impossibility of understanding one without understanding the other.

The young suicides who have been the focus of recent social concern are White, middle-class youngsters who, besides seeming to have advantages in life by virtue of economic and social circumstance, often have not prior to their suicide or suicide attempt behaved in ways that are socially disturbing, yet they are determined to end their lives, and often do. The family situation of such suicidal youngsters usually reveals profound, if less obvious, difficulties in the parent-child relationship going back to the early life of the child. The dreams and experiences of such youngsters repeatedly involve parental figures who were frustrating, rejecting or unkind.

Often the parents seem to want the child's presence, but without emotional involvement. They want him or her to be there and not there at the same time; to be under their control and to fulfill parental expectations, though as parents they have given little incentive for doing so. The youngsters may incorporate parental expectations in a mechanical manner, but derive little pleasure or satisfaction from fulfilling them. At the same time, they do not feel free to act in ways that would separate them from their parents. Such youngsters may make few emotional demands, but become withdrawn instead, depressed and quietly preoccupied with death and suicide.

Life and growth inevitably mean emotional separation from parents. For suicidal youngsters, separation, loss and death are intolerable and leave the youngster feeling desperately out of control of his life. Suicide can be used to control others or to maintain the illusion of control over one's own life.

In treatment, one often finds the unspoken message that "unless someone can undo, make up to me or change the past frustrations of my life, I won't go forward with it." Such youngsters try to freeze time by deadening themselves long before they try to kill themselves. Finishing high school, starting college, graduating from college are to them conflicted events that threaten to thaw their emotions and break their bonds to their pasts.

Although the roots of adolescent suicide usually originate in early childhood, adolescent suicide attempts must be seen in the context of the necessity in Western industrial life for young people to separate from parents and establish their own autonomy or identity as adults. Although the struggle to do so can be for some a lifetime endeavor, it is a struggle that

is most intensive for young people between 15 and 30. Young suicides in their rejection of adulthood and life dramatize the conflict most tragically. Elderly suicides are preoccupied with conflicts centering around the end of their lives; young suicides are determined not to allow their lives to begin.

If, as some behavioral scientists believe, we are seeing unhappy families, absent parents and unwanted children in increasing numbers, a case could be made for pessimistic predictions that the suicide rates among young high-school and college students will continue to rise. A somewhat different perspective on both the family and suicide among the young is provided by a demographic view of the problem.

The rise in the suicide rate among the young between 1955-1980 took place at a time when there was a dramatic increase both in the number and the percentage of young people in the population. Demographers relate the stress on any birth cohort to the size of the cohort. They see a generation born in the baby boom as liable to be adversely affected when it reaches adulthood. The young people face different odds in competing with each other for a limited number of new and challenging positions. Psychological stress among young adults will be comparatively severe, and suicide, crime and feelings of alienation will be high.

The suicide rate in the 15-24 age group has in fact gone up and down with the percentage of 15 to 24 year-olds in the population. Since the late 1950's, we have been experiencing a decline in the birth rate. Current figures suggest that the suicide rate of the young is no longer increasing; it is too early to tell whether it has begun to drop significantly.

A psychosocial perspective permits us to see suicidal patients in both a wider frame and a sharper focus. That fresh vision is necessary for therapists in their task of helping young people find ways to express their anguish, connect with the full range of their emotions, and untie the knots that bind them to past unhappiness. While exploring why they wish to die, ultimately therapy must help such youngsters to seek satisfaction in new possibilities, and in so doing, to accept the promise of a future.

Programs

RECOGNIZING SUICIDAL RISK IN RUNAWAY AND HOMELESS YOUTH

June Bucy
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National Network of Runaway and Youth Services, Inc.
Washington, DC

The problems of runaway and homeless children and youth are extremely alarming. According to the most reliable statistics, there are between 1.3 and 1.5 million runaway and homeless young people in our nation each year. The needs of these troubled young people are varied and complex. Across the nation, shelter care services are assisting runaway, homeless, and other troubled youth with their problems. Most shelter care facilities provide a wide variety of services. Besides providing food and a safe place to stay, shelters provide individual counseling, family counseling, employment training skills, education, health care, mental health referrals and a variety of other services.

This service system has developed rapidly; many of the original shelter "houses" have become comprehensive youth service programs. One of their major characteristics is that young people often are self referred to the centers. They know they will find people who will listen to them and help them sort out their problems. Parents often refer their children to centers, and community agencies use the available services to complement their work.

Youth come to runaway centers with a variety of presenting problems. Often skilled intake workers and counselors can press beyond those presenting problems to issues which are more fundamental and troubling to the young people. In short, runaway centers are, and should continue to be, a major intake point for seriously depressed adolescents, for youth who are having family problems, or for those who have run away or have been pushed away from their living situation.

In January of 1984, the New York Psychiatric Institute reported the results of its study, "Runaway and Homeless Youth in New York City." This important research was funded by the Ittleson Foundation. The principal investigators, David Shaffer, M.D. and Carol Caton, Ph.D., discovered alarming information concerning characteristics of parents and other family members, the experiences youth had encountered on the

streets, and the physical and mental health of the young people. According to the report:

"More than half of the youth we studied came from homes characterized by violence, drug and alcohol use, and many have moved from one living situation to another and will continue to do so. A substantial number have endured violent behavior at home, and encountered difficulties with the law. They are emotionally troubled and a very high proportion of them have either attempted to end their lives or have thought of doing so."

In relation to the devastating problem of adolescent suicide, youth were asked whether they:

"Had ever felt so depressed or so anxious that it had interfered with their being able to get on with their lives; whether they had ever attempted or contemplated suicide; if they had ever received care for a psychiatric condition; if they had ever been treated with psychotropic drugs; and whether or not they desired help for an emotional problem."

To conclude the interview, youth were asked to complete the Child Behavior Checklist, a self-report behavioral assessment inventory which serves to indicate behavioral problems and social competence of children aged 6-17. According to the Checklist, 82% of the shelter users had scores indicating significant psychiatric disability. "No fewer than 33% of the girls and 15% of the boys had previously attempted suicide. A further 33% of the girls had thought about suicide and how they would commit it, and 33% of the boys had contemplated or threatened suicide."

Results prove the youths themselves are aware of their feelings of anxiety. Thirty-eight percent of the youth said they needed assistance with emotional problems. Forty-seven percent wanted counseling for problems with thoughts and feelings.

The New York Psychiatric Institute is conducting further research on adolescent suicide. Current data from other studies indicate that approximately 5,000 American adolescents commit suicide each year, and as many as 500,000 may attempt it. This tragic reality necessitates the upgrading of skills and capabilities of shelter care workers to ensure clients with mental health problems will be more quickly and accurately identified and provided with appropriate care.

The youth who come to crisis intervention centers are obviously at special risk. The National Network of Runaway and Youth Services is seeking to alert local shelter staff to the risks and to prepare them to identify risk factors and help the youth who are in such psychic pain. Funding for this effort has been awarded to the Network by the Ittleson Foundation.

These funds have enabled us to supply information, training materials, and technical assistance to our members.

The National Network is a national, non-profit membership organization comprised of over 500 agencies and coalitions of agencies that deal with runaway, homeless, and other troubled youth. The National Network's primary objective is to increase and improve the social, economic and legal options and resources available to all youth, their families, and their communities.

A Health/Education Research Project, begun in 1984 by the National Network, addresses the needs of member programs. A portion of a service delivery survey explored the area of "health services," which refers to medical, dental, mental health, nutritional, and other related services. Centers were asked whether depression was a common problem among the youth they served, whether the youth entering their facilities expressed suicidal tendencies and whether the centers offered suicide awareness staff training. The following statistics represent the results of the survey:

* 108 of 139 centers noted that depression was a common problem among youths they served

* 76 of 139 centers noted suicide tendencies as a common problem

* 47 of 139 centers felt that, although not frequently seen, suicide was a serious concern

* 119 of 142 centers offer suicide awareness training for their staff

On August 1, 1985, small subcontracts were awarded on a competitive basis through the Health/Education Services Project to assist a few test site agencies to meet their particular needs. Three agencies received resources to implement an adolescent suicide prevention program.

The Springfield YWCA Runaway Adolescent Program in Springfield, Massachusetts has established health/education groups. These groups are comprised of the youth in residence, neighborhood youth, and past clients of the center. The program deals with a number of health issues, including sexual awareness, personal health care, and mental health. A major component of their mental health activities includes suicide awareness and prevention techniques. As a part of suicide prevention, staff will be working with youth on the idea of self-concept, handling stress, relaxation techniques, communication skills, brain function, and assertiveness skills. These workshops will be a community-wide effort and should be helpful to many youth.

The second agency to receive assistance in suicide prevention services is Catholic Family Services, Inc. of Amarillo, Texas. Their workshops will basically provide the same services as the Springfield health/education groups. In addition to the services mentioned above, Catholic Family Services, Inc. will also be installing a clinic to provide health care and other medical and mental health awareness activities to children and youth in their shelter residence.

The final agency to receive suicide prevention resources through the Health/Education Services Project is Janis Youth Programs, Inc. of Portland, Oregon. This youth service agency is establishing a linkage with an alternative school located in the neighborhood where most of their clients live. Such a program will enable staff to conduct better outreach and suicide awareness and prevention programs by having staff work with the entire student body of the alternative school.

Each of the three agencies mentioned above received materials to assist them in implementing their suicide prevention program. Materials distributed included:

1. "Preventing Teenage Suicide" by William Steele, M.A.
2. "Lifelines Program" by Maureen Underwood
3. "Adolescent Suicide Prevention Program" by Myra Herbert
4. "Runaway Suicide Prevention Newsletter"

The "Suicide Prevention Newsletter" is a publication which began in August of this year. The concept originated as a result of discretionary projects funded by the Office of Human Development, initiated to enhance the ability of runaway centers in assisting adolescents demonstrating suicidal behavior. The Newsletter provides a concrete method for disseminating data among grantees, the nation's runaway shelters, cooperating and interested organizations, and professionals. It is a publication of the Human Services Development Institute, Center for Research and Advanced Study, University of Southern Maine, one of the OHDS grantees.

In November, 1984, the National Network conducted a comprehensive survey to determine the needs of member agencies which provide services to runaway, homeless and other troubled youth. One of the major areas addressed was whether or not youth seen by the centers are more troubled than in the past, and if so, what was being done to help them. The survey asked programs to respond to the following question:

"During the past year, the National Network staff and others in Washington, D.C. concerned with runaway and homeless youth services and policy have heard comments from shelter care workers to the effect that the youth they serve 'are more troubled, have more serious problems, and require more specialized services' than the youth who were coming to the shelters five or six years ago. Does the experience of your program during the past year agree or not agree with this

generalization? If it agrees, how? For example, some staff identify a greatly increased number of referrals from juvenile court; others note more youth with serious drug and alcohol problems have accelerated staff burn-out. What disturbing trends have you seen in the youth your agency serves, and how has your program tried to address those problems?"

Over 61% of the responding agencies cited the fact that they were seeing more troubled youth with more serious problems than the youth they were servicing five to six years ago. There is a strong feeling among shelter care workers that more staff training is needed, especially to deal with those youth who may need the most skilled counseling because of the severity of their past experiences. According to the survey, 74% of the responding agencies cited the need for additional staff training. Furthermore, 41% of the agencies cited the need for more mental health services to deal with those youth who may find themselves in a state of severe depression and/or may be experiencing suicidal thoughts or tendencies.

A report, "To Whom Do They Belong? A Profile of America's Runaway and Homeless Youth and the Programs That Help Them," will be released by the National Network in July, 1985. The purpose of the report is to provide a current overview of the success, needs and types of runaway and homeless youth programs that exist and the youths served by them. The National Network has demonstrated that runaway and homeless youth shelters provide an invaluable service to the troubled youth of our nation.

According to the survey, 57% of the youth served were reunited with their families or placed in a safe living environment. Most likely, this figure is lower than the actual number of youths whose lives have improved significantly as a result of a shelter care facility. Many shelters do not have the necessary resources to maintain contact with and track the progress of the youth and their families for an extended period of time once the youth leaves the shelter. This percentage rate provides strong evidence that shelter programs are an effective way of preventing these youth from a future of welfare dependencies, criminal activity, adult homelessness, and other personal and family tragedies which result in serious drains on taxpayers and the economy.

Many adults tend to view runaways as "bad kids" who are out on the streets seeking adventure or simply rebelling against their parents' wishes. This, however, is not true in most cases. Most runaways leave their homes for just causes. In an October, 1983 study by the Inspector General's Office of the United States Department of Health and Human Services, 38% of the youth who ran did so because of sexual or physical abuse, and 44% because of severe long-term family problems.

Prior to joining the National Network staff in 1982, I was the Executive Director of the Youth Shelter of Galveston, Texas

for 11 years, working with the troubled young people seeking help from that agency. My experience in that agency and in the visits and contacts with shelters across the country is that the crisis intervention techniques developed in runaway centers are effective in helping youth cope with their feelings and their experiences. The shelters, with their homelike atmosphere, are comfortable places for youth in crisis situations. Parents respond very positively to the assistance they receive in understanding their youth and in learning more effective parenting skills. Schools, courts, and social services call upon the professional skills of the youth service providers.

These agencies can upgrade their staff sensitivity to the danger signs in the behavior of suicidal youth so that these youth are enabled to bring their anxieties to consciousness and openly deal with them. The youth service providers are also valuable to the community as trainers for school or other community professionals working with adolescents. Many do a particularly good job of training young people themselves as peer counselors, enabling them to assist their friends and acquaintances who may share their suicidal thoughts with another young person.

The runaway centers are not, and should not become, mental health centers in the clinical sense. They are, however, probably our most effective and responsive nationwide system for addressing the crisis needs of youth in America. As such, they should be supported and valued by their communities, and each shelter should have concrete plans for maintaining and increasing its ability to respond effectively to the growing need of youth suicide prevention. The activities of the National Network and of the current demonstration projects are dedicated to that end.

A SUICIDE PREVENTION TRAINING PROGRAM FOR RUNAWAY SHELTER PERSONNEL

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The growing rate and incidence of youth suicide across the United States is a frightening and troubling phenomenon. Most adults cannot believe that young people can feel such an intense degree of sadness and despair. Yet, periods of deep depression and hopelessness are, in fact, common for many of America's teens, and are especially so among those youth who seek runaway shelter services.

While there are as many precipitating causes for this despair as there are teen suicides, certain problems are now identified as characteristic among suicidal youth. These include low self-esteem, feelings of failure, significant losses, alienation, loneliness, lack of self-confidence and family conflict. The runaway population demonstrates a higher incidence of such problems than the general youth population. In addition, a large percentage of runaway youth also have a history of parental neglect as well as physical, sexual and emotional abuse. Based on this information, teens who seek runaway shelter services must be considered a group at particularly high risk of suicide.

Unfortunately the study of adolescent suicide and the development of effective guidelines for prevention is relatively new. Personnel at runaway shelters are often among the large number of professionals who are currently supervising and counseling suicidal youth without adequate training or skills for identification, assessment or intervention. The high risk nature of this population makes it essential that staff become informed as to the causes and signs of suicidal depression. This is the first step toward prevention.

San Mateo Suicide Prevention and Crisis Center (SPCC) has taken an active role in creating model programs for youth suicide prevention. Our first program was initiated in 1975 and focused on early detection using a health education approach in public high schools. This program's objective is to help school personnel recognize and respond to suicidal youth and to help students better understand and cope with their own or a friend's suicidal impulses. The major elements of this school program are now being incorporated into a student curriculum, teacher training, and parent awareness package which will be made available to high schools throughout California.

This year, as part of a nationwide effort by the Administration for Children, Youth and Families to provide resources and training to runaway shelter personnel on youth suicide, SPCC use the techniques and approaches that have proven effective in educating school personnel and youth in California, and adapt them to create a training package and youth workbook on teen suicide for runaway shelters.

The training method developed by SPCC combines didactic presentations of material with an experiential approach to learning. Our past experience tells us that during the training we must not only impart knowledge and skills, but even more important, we must impact attitudes and behavior. By involving personnel in the learning process and by helping them relate the information presented to their own life experiences, our objective is to give the participants a clearer understanding of their own depressive behavior and feelings, and thereby to help them understand and recognize signs of depression in the youth they are trying to help. At the same time, this method works to eliminate the fears and misconceptions that too often prevent adults from effectively intervening with suicidal teens.

The time that shelter personnel have to work with and counsel runaway youth is often extremely limited. To a great degree, the runaway or homeless youth will rely on his or her own survival skills or on the help of a peer when coping with suicidal feelings. Under this project, SPCC also plans to work with shelter personnel and youth to develop a self-help workbook aimed at helping youth to cope more effectively with their own suicidal feelings as well as those of friends, family members, or other runaway youth. The contents of this workbook will address the fears and difficulties faced by a youth when a peer threatens suicide but, at the same time, either refuses intervention or swears the listener to secrecy. It will impart information about the possible methods of

intervention they may encounter, as well as their right to receive medical attention. Finally, we hope to effectively address the feelings of fear, shame and guilt which young people associate with suicidal thoughts and with the act of asking for help. We want to replace these feelings with the understanding that hope remains, even amidst the most overwhelming depression. We want to convey that suicidal feelings are, in fact, common. They will not last forever and they are neither criminal nor evidence of a psychological disorder. There are knowledgeable people who care and who can be trusted to help.

The staff at SPCC have a great deal to learn about the runaway population. We will be working closely with four shelters in our local area in the development of these materials. It is important to note that there are eight other such projects sponsored by the Administration for Children, Youth and Families, currently underway in different parts of the country.

It is our hope that by concentrating the knowledge and experiences of so many people on the prevention of suicide among shelter youth we will increase the chances for survival for a group of kids who have seen too much of the hard side of life. We should be able to place new skills and resources in the hands of those shelter personnel who are trying to make the world a more hopeful and positive place for runaway and homeless youth.

YOUTH SUICIDE PREVENTION AND THE PUBLIC-PRIVATE SECTOR PARTNERSHIP:

THE CALIFORNIA MODEL

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It is an honor to be here representing California Governor George Deukmejian and the California Department of Mental Health. In particular, I want to thank Ann Kahn, President of the National Association of Parent Teacher Associations.

This conference brings national attention to a national tragedy. Its organizers should be recognized for their work in putting together this two-day session. Margaret Heckler, Secretary of the Department of Health and Human Services, should be commended for her commitment in co-sponsoring this event, along with the newly established Youth Suicide National Center. I am confident that the Center's work will move forward under the leadership of Dr. Seymour Perlin, Chairman of the Board of Directors, and through the guidance of Charlotte Ross, the Center's President and Executive Director.

I will outline the plans California has developed in its statewide campaign to prevent youth suicide. Two elements will be discussed: first, our current statewide system, which mandates all public high schools to develop youth suicide prevention programs; and second, our new plans to build on the programs in the high schools.

Before I proceed, however, allow me to divert slightly from my notes to explain from a personal standpoint my involvement in youth suicide prevention. Earlier this year, I received a call from the Undersecretary of Health and Welfare in California, James Stockdale. He had met with Ms. Ross, and, understandably, had been impressed by her knowledge of the subject, and the depth of her commitment to help prevent young people from taking their own lives. Mr. Stockdale asked me to meet with him and Ms. Ross to discuss the potential for the State Department of Mental Health to develop a program on youth suicide prevention.

Immediately, I grew concerned about the priorities of the State Department of Mental Health, the agency I was appointed to lead. We have embarked on a comprehensive five-year program to have all five state hospitals achieve national accreditation, along with our extensive commitment to community mental health services, and research into the causes and potential cures for mental illness. When I became Director two years ago, I began mapping out a strategic plan for California's mental health system.

Youth suicide prevention did not fit into that plan. But after the first meeting with Charlotte Ross, it was not a question of whether youth suicide prevention fit into our Mental Health Initiative. It became its own priority, and has since become an integral component of our evolving Mental Health Initiative in California. I have adopted this program as my own personal project.

My active interest as a newcomer and "eager novice" in youth suicide prevention stems from several sources. First, I am a physician and committed to the preservation and sanctity of human life. When I read reports of teenagers and young adults talking their own lives, my commitment to help becomes stronger. Second, as a psychiatrist, I have been responsible for programs caring for children and youth. I have seen and treated severely emotionally disturbed kids in state hospitals, kids who desperately seek help, who find it difficult, and sometimes impossible, to cope with their illnesses. Finally, I am the father of two teenagers. My concern for their lives, their welfare, their happiness, their personal growth and development, is immeasurable.

From my work in California, and my grasp of the issues at this conference, one thing is evident: the national picture is grim. The suicide rate in the 15-24 year age category, has tripled over the past 20 years. This year, more than two million teenagers between 15 and 19 will attempt suicide; an even worse statistic, thousands will succeed.

In California, a survey of 5,000 students showed that one in ten had attempted suicide by the time they were in high school. In our state, as in others, suicide is the third leading cause of death among our 15-19 year olds. More than 200,000 California youth will attempt suicide in 1985.

CALIFORNIA RESPONSES TO THE TRAGEDY

California has responded to this tragedy by passing landmark legislation, and by initiating plans for an even more aggressive plan to help our troubled youth.

In October, 1981, State Senator Robert Presley convened a hearing of the California Senate Select Committee on Children and Youth to hear testimony on the youth suicide problem. As a result of that hearing, Senator Presley formed a State Advisory Committee on Youth Suicide Prevention. This broad-based committee was composed of 19 members, each of whom had a special interest and/or expertise on youth suicide. They represented parents of suicide victims, the PTA and its one million members in California, juvenile justice agencies, state and local governments, suicide prevention programs, and concerned citizens.

The committee essentially was community-based in its orientation and focused on working to solve the youth suicide problem by using clear thinking, good planning, team work and making maximum use of the partnership between the private and public sectors.

After one year of fact-finding and deliberation, the committee made several recommendations to Senator Presley. The result was a major piece of legislation, SB 947, which was passed by the State Legislature in 1983 and signed into law. This measure,regarded as the first major youth suicide law in the United States, designed a three-year pilot project calling for the development of a statewide program to deter youth suicide. The statewide effort has been coordinated by two sophisticated and well-established youth suicide prevention programs, the Los Angeles Suicide Prevention Center and the Suicide Prevention and Crisis Center of San Mateo County.

The first year was a year of planning and evaluation. The State Department of Education worked closely with the two programs and other community-based organizations. Suicide prevention programs were reviewed from high schools throughout California, and information from other states was collected.

In the second year, workshops involving parents, school personnel, and, of course, teenagers, were conducted in an effort to establish suicide prevention programs, or improve existing ones. More than 250 schools around the state are involved. Parents are a major resource and play a crucial role in every step of the process, from planning to implementation to evaluation of programs. Youth suicide prevention is a family affair.

The third year of the program will involve the evaluation of its effectiveness, and a comprehensive report to the State

Legislature. If the evaluation is positive, there most likely will be further legislation to ensure the continuation of the program.

I would like to share with you some of the program's many elements:

Assessing existing suicide prevention programs, developing criteria for new education programs, teacher and student training programs, peer group programs, hotlines, data collection, intervention and post-intervention services, and parent education and awareness.

The program was designed to allow school districts maximum flexibility and to fully utilize community resources. The role of the State Department of Education is to set broad criteria for programs and to provide adequate funding to ensure the operation of youth suicide programs. The State Department of Education also is charged with evaluating the programs and reporting its findings to the Legislature.

THE ROLE OF THE DEPARTMENT OF MENTAL HEALTH

At the present time, California is considering both a budget bill and policy legislation to expand our efforts in the youth suicide prevention area. Although these proposals have not yet received final approval, I would like to preview them for you.

We are considering launching a five-year youth suicide prevention program coordinated by the California Department of Mental Health. Our blueprint goes beyond the current program and will involve a variety of public and private resources in both the planning and implementation phases. We intend to include: parents of suicide victims, private sector corporations, community service organizations, social service agencies, mental health and alcohol and drug specialists, suicide prevention experts, teachers and teenagers and young adults.

The first year will entail a comprehensive evaluation of the problem in California from both a statistical and humanistic standpoint. We want to look into the types of young adults who consider suicide and the pressures they face. Moreover, we will be evaluating existing resources in schools and the community, along with needs of communities.

We also want to produce a broadcast-quality film on youth suicide that will appeal to teenagers and young adults. The film would be shown in high-schools and junior-highs throughout California and nationwide.

Although the planning phase of the first year will have a significant impact on years two through five, we have tentatively assigned work to be done in those years.

Year Two: Materials and program development for statewide marketing and distribution.

Year Three: Program implementation and mobilization involving training programs around the state utilizing local resources. This will address the needs of educators, parents, and mental health professionals.

Year Four: Ongoing implementation of programs, with the beginning of follow-up on programs to determine their effectiveness. Materials and resources may be revised and new material developed based on those evaluations.

Year Five: The program will undergo a comprehensive evaluation involving the collection and analysis of reports and other information from communities around the State. In addition, training programs will be completed and activities will be phased in to local communities.

Throughout the five-year program, we will adhere to the principles of community involvement, local flexibility, the mobilization of local resources and the partnership between the private and public sectors.

I appreciate the opportunity to share with you California's plans to help stem the growing tragedy of youth suicide. We cannot ignore this national problem, but must address it in a comprehensive manner appealing to teenagers and young adults. This conference has given me an insight into the problem nationally. Thank you for all I have learned and will take back with me to California.

YOUTH SUICIDE PREVENTION AND THE PUBLIC-PRIVATE SECTOR PARTNERSHIP:

FLORIDA STATE PLAN

George McKinney
Director
Switchboard of Miami
Miami, Fl

I've been involved on a local and state basis with the Florida Plan. I would like to share with you the legislation that was passed in the State of Florida, and the results of that legislation in terms of the plan that evolved. The legislation was titled, "The Florida Youth Emotional Development and Suicide Prevention Act." A relevant point of the legislation is that the suicide prevention program for Florida youth can best be accomplished by coordinating the educational program at the state and local level with the community suicide prevention and crisis center agencies. The crisis intervention and suicide prevention legislation centers on several things: defined responsibility for school counselors, better detection by students, timely referral, and cooperation between schools and non-professionals.

The Florida Department of Health and Rehabilitative Services (HRS) was given the responsibility to develop a state plan for youth suicide. In turn, they submitted the plan to the House of Representatives, the Governor, and the President of the Senate; the result was Senate Bill 529. Mental health centers local school boards, human rights advocacy committees, private or public organizations or programs including Parent Teacher Associations, law enforement agencies, and circuit courts were to participate in the development of the plan.

HRS was asked to develop an inter-program task force comprised of the offices of Children, Youth and Families, alcohol and drug abuse, mental health, developmental services, education and law enforcement. These offices were charged with the responsibility of generating the final plan.

Each of the HRS's service delivery districts was to set up its own task force, study the problem on a local basis, and make recommendations to the state inter-program task force. The final state comprehensive plan was to include a section reflecting general conditions and needs, an analysis of variations based on population or geographic areas, an identification of problems and recommendations for change. HRS and the Department of Education were mandated to work together to develop ways to inform and instruct appropriate district school personnel in the detection of youth suicide tendencies and recommended action. HRS and Education were to develop training for the educators in the state. Law enforcement and HRS were also to find ways of training law enforcement people in the state in the detection of youth suicide and intervention. HRS, in cooperation with other appropriate public and private agencies, would create a public awareness campaign utilizing existing resources. The Departments of Education and Rehabilitative Services were assigned the responsibility of developing curriculum materials for the schools.

Each of the 11 local districts was asked to include infor-tion about the magnitude of the problem and to survey all the current programs related to serving suicidal youth and prevention programs. They were to determine the cost effectiveness of the programs, their impact, and sources of funding.

Each district task force was to identify a model continuum of services that it would like to see in place and to rank priorities within that model continuum. Districts were to submit plans for meeting the needs, both with and without additional funding from the state, and a plan for alterna-tive funding. The district reports were to include a description of barriers to the implementation of their recommended plan and recommendations for changes that could be accomplished through legislative action.

The state plan starts with the basic philosophy that it's dealing not only with the subject of adolescent suicide, but also the issue of children in crisis. The plan identifies a model continuum of services that includes prevention, public awareness, peer counseling, community and agency coordinated education and training for school personnel and parents. The intervention component includes crisis hotlines, intensive crisis counseling programs, runaway shelters, crisis centers and mobile response units. The treatment services that are identified include emergency rooms, crisis stabilization units and in-patient treatment and hospitalization.

The identified needs and recommendations included using existing resources to create public awareness. In addition, the task force recommended legislative funding of $135,000 for the development of a state-wide, multi-media, public education campaign. It was proposed that $165,000 be provided for the development and field testing of a training package and the hiring of a state-wide training coordinator to implement that training. There were recommendations that college students who were studying education be given courses sensitizing them to the signs of emotional disturbance; that techniques of parent-teacher communication be included in teacher preparation work; and that the life management skills course offered to 9th and 10th graders throughout the state be expanded from a one-semester course to a two-semester course.

An appropriation of $400,000 was proposed to expand toll-free, 24-hour crisis line services into rural areas of the state that were not being served. There was a recommendation for the development of two model crisis centers, each to be funded for $250,000. An additional $30,000 was suggested as an appropriation to evaluate those two model crisis centers after two years to see how effective they were, and if they should be implemented in other sections of the state. An appropriation of $12,000 was suggested to create a uniform state-wide recording system to improve data collection, and $400,000 was proposed to implement a state-wide system of planning and coordination for children's issues by creating a task force, coordinating its efforts, and hiring a coordinator for each district.

Summaries of the 11 district plans, and reports of the subcommittees that were part of the inter-program task force are available. The state-wide plan was sent to the Governor's office, but it was not introduced for funding in the current session. It is still waiting to be acted upon; hopefully that will happen in the next legislative session.

YOUTH SUICIDE PREVENTION AND THE PUBLIC-PRIVATE SECTOR PARTNERSHIP:

THE NEW JERSEY PLAN

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Although New Jersey is one of the nation's smallest states in geographic area, ranking 46th, it is one of the largest in population, ranking 9th. In a state of such high population and limited space, one is keenly aware of and intensely affected by events in one's neighborhood.

In 1982, similar to statistics in other years in New Jersey, 114 young people took their own lives. Notwithstanding this fact, the reality is that statistics on suicide among the young are grossly under reported. Suspicious deaths not classified as suicides, such as drownings, single car accidents and drug overdoses, would add to the toll. The reverberations of these needless and often preventable deaths have been devastating to the victims' families, school systems and communities.

New Jersey's intense concern about our young people, coupled with courageous leadership exercised by our Legislators, has resulted in adolescent suicide prevention legislation, a state-wide response to this national tragedy.

The following is a report on the process of how Senate Bill #2005 became a Law and a summary of excerpts from the text of the legislation.

June 28, 1984 - State Senator Richard Codey, Chairman of the Senate Committee on Institutions, Health and Welfare, introduced a Bill, S-2005, to establish a Youth Suicide Prevention Program. He stated, "If suicide were a disease, we'd be spending millions to find the cause and treat it."

September 6, 1984 - Public Hearing on Proposed Adolescent Suicide Legislation, Trenton, NJ. Among those who spoke at the Hearing were former NY Lt. Governor Alfred Del Bello. He stated, "There are 17 to 18 young people killing themselves every day in all socio-economic groups, It's a national problem of epidemic proportions."

Parents whose children had killed themselves also testified. Margie Maloney of Berkeley Heights stated, "On February 26th, 1980, our son, one month short of his 19th birthday, drove the car into the garage, stuffed rags in the holes and laid down for the last time under the exhaust pipe." She continued, "Suicide is preventable, those who kill themselves only want to solve their problems."

Michael Salvatore of Clinton reported that his 14-year-old daughter committed suicide two years earlier on a day that he and his wife had taken their older son to visit a college. He stated, "There was no evidence of any problem other than what all teenagers go through. When we left that day she was very cheery and told us she would have dinner ready when we returned."

The mental health practitioners and school personnel who testified agreed that while not all suicides are preventable, their numbers can be reduced through organized educational programs in schools and communities.

It was decided the program would be placed under the Department of Human Services "to be administered by community mental health services providers in cooperation with local Boards of Education."

December 7, 1984 - The Bill passed in the New Jersey State Senate with a vote of 35-0.

May 13, 1985 - The Bill passed in the New Jersey State Assembly with a vote of 66-0.

Under the Bill, the Commissioner of the State Department of Human Services would establish a program of youth suicide prevention. The objectives of the program were to include, but not be limited to, the following:

1. Classroom instruction or materials designed to achieve the following objectives: to teach students facts about adolescent suicide and how to recognize signs of suicidal tendencies; to inform students of available community services aimed at prevention of suicide; and to increase students' awareness of the relationship between adolescent suicide and drug and alcohol use.

2. Training programs for classroom teachers and other teaching staff members in suicide prevention.

3. Non-classroom school or community based programs such as a 24-hour "hotline" telephone service staffed by trained professional counselors, crisis intervention and post-intervention services, parent education programs and programs for the families of suicide victims.

The Commissioner would request proposals from Community Mental Health Centers in conjunction with School Boards and would fund one proposal from the Northern, Central and Southern regions of the state.

Before the expiration date of the act, the Commissioner would be required to report to the Governor concerning:

1. The effects of the demonstration program on adolescents in the schools.

2. An assessment of the most efficient and effective methods for establishing youth suicide prevention programs in the schools and in conjunction with community services agencies.

3. The projected costs for establishing prevention programs throughout the state.

4. Recommendations for establishing a statewide youth suicide prevention program.

Part of the legislation would call for an establishment of a Youth Suicide Prevention Advisory Council:

1. The council shall: compile information on youth suicide prevention programs that are presently carried out in the state; disseminate this information and relevant information about the projects funded pursuant to this act to local school districts, community mental health services providers and the public; assess the most efficient and effective methods for establishing youth suicide prevention programs in other school districts and by other community mental health service providers; assess the cost for providing youth suicide prevention programs statewide; and advise and provide technical information to the Commissioners of Human Services and Education on matters pertaining to youth suicide, upon their request.

2. The council shall report to the Governor and the Legislature 18 months from the effective date of this act on the activities of the council, the effects of the three suicide prevention projects funded pursuant to this act, and the council's assessment of the most efficient and effective methods for establishing a statewide program and the projected cost for doing so. The council shall include in its report recommendations for legislative or administrative action that may be necessary to ensure that youth suicide prevention services are available statewide.

June 26, 1985 - Thomas Kean, The Governor of the State of New Jersey signed the Bill, which would appropriate $300,000 to combat the alarming upsurge in teenage suicides.

ROLE OF VOLUNTEERS IN YOUTH SUICIDE PREVENTION

Donna M. Alvarado
Director
ACTION Agency
Washington, DC

Recently eight U.S. cities were cited for the exceptional progress they have made improving the quality of life for their citizens. The mayors of these winning All-American cities were asked how they did it. Half of them answered, "We did it with local volunteers."

The mayor of Albany, Oregon added that in order to get volunteers, "needs must be publicly expressed." The fact that mobilizing community volunteers helped these cities solve their problems doesn't surprise us at ACTION. As the national volunteer agency, ACTION's mission is to promote the spirit and practice of voluntarism. We know what volunteers can do.

ACTION sponsors more than 380,000 volunteers through community projects, and we support thousands of others with small grants and technical back-up. Time after time we see volunteers making communities fully aware of pressing social problems, then taking action and tailoring strategies that fit conditions in their localities.

Our long experience helping neighborhood volunteer projects get started prompts me to stress a precautionary maxim: never recruit volunteers without first planning exactly what they will do.

With that said, I am pleased to report that there has never been a better time to build local volunteer programs around the issue of youth suicide. Never in our history have more Americans been willing to serve as volunteers. The latest statistics show that 92 million Americans volunteer their time to help others.

This surge in voluntarism is a rekindling of the spirit of neighbor helping neighbor that built our nation. It is a phenomenon due in large part to the leadership of President Reagan, who has challenged all Americans to find new ways to unleash the independent spirit of people. And in neighborhoods everywhere, as in the eight All-American cities, citizens are answering the challenge.
In proclaiming June 1985 as Youth Suicide Prevention Month,

the President pointed out the tragic scope of suicide and outlined the broad kind of public response it warrants. The President said, "Because the root causes of suicide involve so many different psychological, physical, social and spiritual dimensions, successful preventive action requires the combined efforts of individuals, families, communities, organizations and government at all levels."

Indeed, the experts gathered at this conference agree that the tragedy of youth suicide cuts across all levels of our society. So do local volunteers.

In every quarter of our society, citizens will step forward and stand together to protect their children. Few challenges are more formidable or more difficult than the alarming number of adolescent suicides.

Volunteers will make a great difference. They can help plan and execute local initiatives to reduce the incidence of suicide. Volunteers unite a community behind an issue in a way that outside advocates or government agencies can never do.

At ACTION, we see neighbors battling problems that were once thought insurmountable -- drug abuse, youth unemployment, widespread illiteracy, the hopelessness felt by emotionally disturbed children -- a whole range of problems, many of which are related to youth suicide.

We have seen volunteer action by local parents' groups break a tidal wave of drug use among children, a wave that had been gathering force for a decade. We have seen volunteers from Maine to Alabama helping low income, single mothers gain confidence, support and training that has taken them off the welfare rolls and into the work force. We have seen abusive husbands learn to control their lives and alter their behavior thanks to the work of volunteer counselors.

In any nationwide effort, such as the current drive to prevent youth suicide, volunteers can contribute in two basic ways: building public awareness of a problem, and taking action when specific problems are identified.

Eight years ago, drug use in American schools had reached epidemic levels. In 1977, one in nine high school seniors said they smoked marijuana every day. Parents were at a loss to change things. They knew little about drugs. Their children, on the other hand, were inundated with information that encouraged drug use. They learned about drugs in the streets and at school. They saw drugs glamorized on television and in movies. Children everywhere were getting the message that drug use was harmless. There were soft drugs and hard drugs, and it was easy to use the soft drugs responsibly.

That was eight years ago. Today, the number of daily marijuana users among high school seniors is down to one in 20.

On television, we now see Mr. T condemning drugs in public service ads. Accurate information about the drugs young people use is available in pharmacies, schools and libraries. Around the nation, thousands of local parents' groups are educating themselves and their neighbors about drugs, and opening lines of communication with young people.

These changes are the fruits of volunteer activity. Activity that in large part was inspired and sustained by the leadership of our First Lady. Mrs. Reagan recognized that a national effort was needed to educate people about drugs. She enlisted volunteer participation from every possible quarter. Corporations like McNeil Pharmaceutical launched national awareness campaigns, using local volunteers to distribute materials. Fraternal organizations such as the B.P.O.E., the Elks, put drug education on the agenda in every one of their 2,000 local chapters. PRIDE, the Parents' Resource Institute for Drug Education, set up a national toll-free hotline and a clearinghouse for drug information.

The National Federation of Parents for Drug-Free Youth was formed and began helping parents organize in neighborhoods around the country. Materials were provided by private industry. The work was done by community volunteers. Drug use prevention became a primary goal of established volunteer and non-profit organizations. Young people volunteered to distribute information in neighborhood drug stores. Other volunteers created and staffed crisis hotlines and emergency drug counseling centers. The whole movement was built on increased public awareness. Efforts to prevent youth suicide can proceed in the same way.

The war against drugs is still far from won. The effort continues to grow, and can serve as a model for all who would establish a national drive to prevent adolescent suicide.

Similar volunteer-based efforts, also national in scope, were made to promote child safety and prevent the tragedy of missing and exploited children. Here again, national information resources were developed through corporate, public and non-profit voluntarism. Child Safety Days were held in communities throughout the U.S. Parents were able to learn techniques for protecting their children. They were provided with information that could be used to help locate their children should they be missing or abducted. The backbone of the Child Safety drive was local volunteers -- firefighters, off-duty police officers, teachers, parents, Boy Scouts and Girl Scouts. Local businesses donated materials for "Child Safety Days," and clubs and shopping malls provided sites where activities could be held. Like the First Lady's battle against drugs, the Child Safety effort had an inspiring

national leader, Senator Paula Hawkins, who has given so much of her time to protecting America's children.

Functional illiteracy is another tragedy now under attack by community volunteers. With the help of national information resource and advocacy groups such as Laubach Literacy Action and Literacy Volunteers of America, hundreds of communities have established adult literacy training centers. In libraries and bookstores, in churches and synagogues, in civic clubs and private homes, tens of thousands of volunteer tutors are helping their neighbors become literate.

The battle against illiteracy also has had a leader of vision, Mrs. Barbara Bush. Mrs. Bush was a dedicated literacy volunteer long before her husband was elected Vice President.

I've been stressing volunteer programs aimed at young people. In developing such programs, we are wise to plan a major role for older Americans. One of our true, national treasures is the great number of retired men and women who serve, or who would like to serve, as volunteers.

Our ACTION programs alone sponsor more than 370,000 retired volunteers. A very distinctive aspect of their service is the work they do with troubled youth, with children who are emotionally or mentally disturbed, with young single mothers, and with youths who are incarcerated or in institutions. The chemistry between the older volunteers and the younger people often seems magical.

For example, Foster Grandparent volunteers work in one state hospital in the Northeast that houses emotionally disturbed teenagers, children who can't function in normal school settings. Many of them are abused children or chronically depressed. Officials at the hospital rarely saw these children give positive responses to anyone until the Foster Grandparent volunteers arrived. One of the youngsters in the hospital, a fifteen-year-old, wrote a letter about her Foster Grandmother.

The letter says, "She reminds me of my own grandmother, who I don't get to see very much. Grandma Graves needs me as much as I need her. She is one of very few adults who really try to understand young people." It is a message that we might remember as we plan local projects in which volunteers work personally with young people who are suicidal. Whatever the ages or backgrounds of volunteers, their potential for providing direct assistance to suicidal adolescents is clear.

Community volunteers work with people as friends and neighbors. They provide an element of caring and personal trust, however intangible, that simply cannot be given by professional care. That is what makes volunteers priceless components of any program or organized effort to help troubled young people.

Volunteers provide that extra element. They complement the professional services of health care personnel and can make the difference between hope and despair to people in homeless shelters, hostels for runaways, youth unemployment projects and safehouses for battered women.

It is obvious, then, that community volunteers are a prime resource for educating Americans about youth suicide, and for reaching out to young people who consider ending their own lives.

Strong leadership for reducing adolescent suicide is beginning to come forth. The new Youth Suicide National Center can develop a clear statement of the problems and ideas for citizens' involvement. To help get the message out across the country, the National Center can secure voluntary help from businesses and corporations, from national non-profit and fraternal organizations, from trade and professional organizations, unions, local and state governments, mental health organizations. All of these outlets can help disseminate essential information about youth suicide.

Through this awareness effort, communication on the issue of youth suicide will open between the National Center and hundreds of local outlets and volunteer sponsors. Existing crisis intervention centers and hotlines can immediately plug in to suicide prevention efforts. The National Center for Citizen Involvement, or VOLUNTEER, may be able to help with networking among community volunteer action centers, which in turn can mobilize local volunteers.

Once aware of the problem and of its particular manifestations in their communities, local businesses, newspapers and action groups will begin to get involved. New response mechanisms can be put in place. Local volunteer sponsors can plan projects. Local campaigns to recruit volunteers can begin. The National Center can sponsor public service recruitment drives once a network of local entities in need of volunteers is in place.

The first step is to build public awareness, nationally and locally. The second is to help communities analyze their situations and decide what kind of volunteer activities will be possible and useful. In most cases, the planners themselves will be local volunteers seeking to mobilize their neighbors.

In the end, community volunteers can have the same success reducing youth suicide as they have had fighting drugs, missing children and illiteracy. But they will depend on all of us here today for guidance and vision and national leadership.

UNION OF AMERICAN HEBREW CONGREGATIONS
YOUTH SUICIDE TASK FORCE

Rabbi Ramie Arian
Director
North American Federation of Temple Youth
New York, NY

BACKGROUND

In the past five years, suicide has become the second leading killer of young people ages 15-24, following accidents. Although the suicide rate for the population at large has remained essentially steady for many decades, for young people it increased 256% between 1960-1983. The Union of American Hebrew Congregations Board of Trustees expressed its deep concern about this epidemic of suicide among our youth in December 1984, by mandating the creation of Yad Tikvah and a Task Force on Youth Suicide to create a program of prevention on behalf of the Reform Jewish community.

Experts estimate that there are at least 100 suicide attempts for every completed suicide among young people. It is clear that very, very few of those who commit suicide really want to die. They feel trapped in an unbearingly painful situation, are incapable of seeing any other way out, and don't fully comprehend that suicide is a permanent "solution" to a temporary, albeit painful, problem. Most youths who attempt suicide do so at home, between the hours of 3-8 P.M., when the likelihood of rescue is greatest. The great majority leave a telltale trail of hints that they are contemplating the act, often actually telling one or more people quite directly about their intentions. Most young people who face a suicidal crisis can be helped to solve their problems, can get through the crisis, and go on to live normal, healthy lives. Alertness to the warning signs among those close to young people could save many who otherwise might succumb to what has been termed the leading preventable cause of youthful death.

The Task Force on Youth Suicide plans a four part program of education and awareness in order to combat the youth suicide epidemic. Materials and programming will be directed at those who have contact with young people: peers; parents; and professionals.

The final part involves viewing suicide not as a problem in itself, but as a symptom of a larger problem of increased life stress and decreased coping skills facing young people in today's world.

PEERS

In the vast majority of cases, youth contemplating suicide will confide in one or more of their peers, often extracting a promise of secrecy. Young people are thus the people most likely to be in a position to help friends in a suicidal crisis. Therefore, a variety of materials and programs are planned to teach young people the signs to watch for, what to do if a friend is in trouble, and to notify an adult if someone shares a suicidal secret.

First, a book titled "When Living Hurts" by Dr. Sol Gordon, is in preparation and will be available by October 1985. Dr. Gordon is a psychologist and a master of the art of communicating with young people. The book provides direct help for those themselves in suicidal crisis, instructions for those who want to help a friend, and a wealth of related information of vital interest to adolescents.

Second, a program to teach young people about the warning signs of suicide, and what to do about them, will be developed, and will be instituted in a variety of settings, including youth group events and religious school classes, beginning during the 1985-86 school year.

Third, a program targeted to high school seniors will be developed to provide orientation on what to expect in college life, and will include a segment on suicide prevention.

Fourth, a program on suicide prevention will be developed by NFTY and introduced at NFTY's MECHINA leadership training institute at Kutz Camp in June, 1985. This program will be replicated at NFTY regional events throughout the country beginning with the summer conclaves in August.

Fifth, existing resources, including the film "Inside, I Ache", will be publicized and distributed widely.

Sixth, a campaign will be organized around the slogan "Break the Silence", encouraging youngsters who have been entrusted with a suicidal secret to save a life by breaking the confidence. The campaign will include informational brochures and posters.

PARENTS

Clearly, youth suicide is a topic of vital concern for parents of adolescents. Therefore a variety of programs will be developed and implemented on a congregational level.

First, general information sessions on youth suicide will be presented to interested parents of teenagers, including what warning signs to look for, myths and facts about youth suicide, and what to do to help a young person at risk.

Second, more intensive support, through group discussion and by referrals through congregational and regional professionals, will be offered to parents with children at risk.

Third, consideration is being given to organizing support groups for survivors, family members of young people who have taken their own lives.

PROFESSIONALS

Rabbis, cantors, educators, religious school teachers, youth advisors, camp counselors, Hillel directors and others who work directly in close proximity to adolescents bear a special responsibility for helping with their healthy growth. They are frequently in a position to pick up early warning signs and take preventive action. They are also uniquely placed to carry out educational programs as listed above aimed at young people themselves. Therefore, a variety of programs and materials for professionals is planned.

First, a program for staff members of UAHC camps is now in preparation. The goal of the program is to ensure that camp counselors and other staff are prepared to pick up any early warning signs and take appropriate action. The program will be offered to the staffs of all UAHC camps at their orientation sessions in June, 1985. A version of this program will be adapted for religious school teachers, and will be available for beginning teachers' meetings in September.

Second, a kit of materials for professionals will be prepared and distributed. This kit will include the following: one or two booklets, written by authoritative suicide prevention agencies, describing warning signs and action to be taken; basic facts about suicide; bibliography for further reading; suggested formats for some of the congregationally based programs, including youth group programming and interim religious school curriculum; suggestions for involving the community in suicide prevention work; an overview of the Reform Jewish perspective on suicide; flyers on additional existing UAHC materials, "Help Me", and "Inside, I Ache"; a copy of the "Keeping Posted" issue on teenage suicide; and a preliminary listing of some referral resources in the local area. This kit will be distributed initially during the summer of 1985.

Third, an article in the September 1985 issue of "Reform Judaism" will draw the movement's attention to the suicide issue, and will serve to set a deadline by which professionals should have received and digested the kit mentioned above.

Fourth, awareness will be promoted through reports and presentations at the conventions of the various professional organizations, including CCAR and NATE.

LONG RANGE PLANNING

Suicide must ultimately be viewed as the extreme end result of a process that many young people go through. It is not only a problem in and of itself, but it is also a symptom of a larger set of problems, the increasing stresses and strains that accompany "normal" adolescence, and the breaking down of coping skills that once were routinely imparted in the growing up process. In order to work in this larger context, the Task Force also contemplates the following programs.

First, the development, through NFTY, of a variety of programs devoted to building self-esteem and coping skills in teenagers. These programs will be piloted through NFTY, and will then be available to the movement as a whole.

Second, greater attention to parent education through our congregations. A series of workshops is anticipated that will help parents to become more aware of, and more sensitive to, the various developmental stages their children are growing through. Workshops will begin for parents of preschool children. Workshops will be developed for parents of youngsters in the Bar/Bat Mitzvah class, introducing adolescence, and making parents aware of the major life changes young people are experiencing. Additional workshops will be developed for parents of confirmands and high school graduates concerning adjustment to separation and independence.

THE ROLE OF THE PTA AND YOUTH SUICIDE PREVENTION

Ann Kahn
President
National Congress of Parents and Teachers (PTA)
Chicago, IL

On behalf of the National Parent Teacher organization and its 5.6 million members, I want to tell you how seriously we view the problem of youth suicide and some of the constructive things we think are being done to alleviate it. We recognize that suicide does not happen in a vacuum. Unfortunately, suicide is a family affair and the results of it have an enormous impact. It is also our very strong belief that the prevention of it also rests within the bosom of the family.

We have many local PTA units and some 26,000 local school PTA's across the country to whom we have begun to give national assistance. Our national journal, "PTA Today" is an award winning publication, and covers the kinds of subjects that parents need assistance on in order to do a better job of parenting.

In the January, 1985, issue, we carried an article on teen suicide; what you should know, what you should do, and how PTA's help suicidal teens. That article was intended to sensitize our enormous membership to the fact that this is a problem that may touch you even though you are sure it is never going to happen to you. It may be your child, it may be a neighbor's child, it may be a friend of your child. There are things you can do. The article carried nine warning signs that professionals tell us to look for. For example, be aware if children give away prized possessions; when they experience changes in sleeping patterns, changes in eating habits, or changes in social activities; watch for serious personality changes.

Most of all we wanted to convey that if there has been a previous suicide attempt, you are dealing with a child at risk and that it is possible for you to be sure that there is not a second attempt. We tried in a number of places to recreate the kind of situations that such families face so that PTA's would feel there was something concrete and constructive that they could do about this.

In Plano, Texas, six teens committed suicide. This prompted

the principal of Richardson High School in Dallas to sit down with the PTA president and executive board, their program chairman and their parent education chairman, to discuss the problem. As a consequence, they developed a two-evening, five-hour program on suicide prevention aimed at bringing in parents and families. The goal was to present information on depression and how to effectively deal with it. The goal was to make parents sensitive to teenage depression whether or not a potential suicide was the problem.

The program consisted of presentations by professionals who talked about teenage suicide. They said in the last decade the rate of suicides among 15-19 year olds has doubled and there are pressures that push youngsters beyond the brink, thinking they simply cannot cope. They talked about what depression is and how depression really cries out for another adult, a parent, a counselor, a good friend to share the problem with, and that the isolation of a depressed person is the worst risk of all.

In the second part of the program, they focused on constructive ways that people could both identify and counsel someone at the teenage level who is suicidal. Some of the techniques that were used in training suicide hotline counselors were shared with parents and youngsters. We found peer advice often is the most effective when a depressed youngster cannot deal with advice from an adult. We said to teenagers, "Care about each other and the PTA will help you find ways to do that. If you have a friend who is depressed, these are the kinds of constructive, loving, caring things you can do that may bring about a happy ending instead of a tragedy."

Learn to be a good listener. Be straightforward. Allow the other person to express his feelings. Don't be shocked. Try and ask the direct question, "Are you really thinking about suicide?" One teenager can say that to another teenager and probably elicit a more honest answer.

There was a large turnout for that meeting, and it included 11th and 12th graders in that high-school who themselves now are sensitive to what they can do for others. We ran a column in the school's student newspaper so that other youngsters would have access to this information and would know there were people in that school, both adults and other kids, who really cared about them and wanted to help if they were in trouble.

In the state of California, a state in which we have a million PTA members, they have for three years been on the cutting edge of this subject and have been dealing with it not only in terms of the kinds of things that I told you about that are happening in Richardson, Texas, but also recognizing that legislatively more had to be done in California to provide the kinds of tools they needed to deal with this subject. With a

State Senator, an advisory committee on youth suicide prevention in the California Legislature was organized. That advisory committee was charged with research and the eventual drafting of a piece of legislation that developed two pilot projects on youth suicide prevention in that state, one in San Mateo and one in Los Angeles.

In 1983, the state PTA convention in California adopted an awareness of suicide resolution which committed those million members to become involved in the solution of this very great problem. During the past three years, they have done an enormous amount of work with those million parents. They have informed them of the kinds of programs available, and have shown instructive films. They have cooperated with local county agencies on prevention and education and encouraged localities to establish the kinds of facilities and assistance that are necessary. They have spoken at the youth suicide prevention clinics and involved over 500 PTA leaders in their state. The state PTA now has a representative on the California committee for youth suicide prevention.

The third way in which we have been trying to help is through a newsletter called "PTA in Focus" that covers all of the kinds of programs to which we as a national organization are committed, and gives constructive information about how local units can become involved. The 1984-85 Winter issue devoted the entire back page to the rise in teen suicides and how PTA's can help prevent them, in four ways: help adults learn how to listen to what teenagers are really saying; encourage school in-service training for teachers, principals, guidance counselors and all other school personnel; ask the business community to support teen stress projects; and tell students where they can go for help and what to do if friends tell them they are thinking of committing suicide.

For 12 years I have served on the school board of Fairfax County, the 10th largest school system in the country, a system with an enormous commitment to parent participation in all of the policy making decisions that are made. I have chaired that group for three years. Out of a concern that came from parents, students and professionals, a handbook called "Adolescent Suicide Prevention Program" was developed. Prevention is what this program is all about. It was developed by the school board on the basis of a policy, and implemented by a superintendent committed to total community involvement in dealing with this issue. The emphasis on prevention strongly includes a parent role in every single aspect of this program. Professionals cannot do it alone, and they cannot do it without the support of the parents in the community.

It has been said that when you lose a parent you lose the past, but when you lose a child, you lose the future. The PTA is devoted to strengthening the family and to the welfare of

children. It is a very serious commitment to try and reduce the number of children that we lose to youth suicide.

THE CALIFORNIA MEDICAL ASSOCIATION AUXILIARY YOUTH SUICIDE PROGRAM

Helen F. Karlsberg
CMMA Regional Director Children and Youth
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The California Medical Association Auxiliary (CMAA) is a non-profit volunteer organization of physicians' spouses. The Auxiliary's objectives are:

(1) To assist the CMA in its program for the advancement of medicine and public health.

(2) To promote projects of health education and other activities that improve the health and quality of life for all people.

(3) To cooperate with, advise and promote similar interests in its county auxiliaries.

In 1981 CMAA President-Elect, Lorraine Peters, aware of the epidemic tragedy of youth suicide, decided to make youth suicide prevention a top priority among CMAA's health projects. She appointed a state chairman to research and develop such a program. The outcome of that study led to a CMAA Youth Suicide Prevention Program based on Charlotte Ross' paper, "Teaching Children the Facts of Life and Death: Suicide Prevention in the Schools." *

The CMAA program was designed to utilize the structure and resources of the auxiliary in order to reach the broadest population possible, specifically those who come in close contact with our youth professionally, such as school administrators, teachers, physicians, nurses, counselors, coaches, clergy, social workers, and law enforcement agents; and those who share their lives in an even more personal way, parents and siblings.

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* In Peck, M.L., Farberow, N.L., & Litman, R.E. (Eds.). (1985). Youth suicide. New York: Springer.

Contrary to the cliche that "ignorance is bliss," we know that with regard to youth suicide, ignorance kills. The direction, therefore, of the CMAA program is prevention through education. Our goals are to (1) increase public and professional awareness regarding the magnitude and scope of youth suicide, (2) educate those who work most closely with youth to recognize suicide danger signals, identify teenagers under severe stress, intervene effectively, and refer the young people to reliable professional resources.

We also seek to educate our youth with similar knowledge and skills so that they would know when to refer their friends to, or seek professional help themselves.

We learned as we taught. We learned that a strong positive approach was essential to what is most often regarded as a fearful and negative subject. We learned that an experiential presentation involving audience participation on an individual and group basis simultaneously was much more effective than any lecture teaching suicidal warning signs and intervention techniques. We learned to use carefully selected films, "Suicide: The Warning Signs" and "Suicide at 17," to reinforce what was said and to cover what might have been omitted. We learned to work in teams: an auxiliary volunteer with a local professional expert such as a psychiatrist or psychologist with a special interest and experience in working with troubled adolescents. We provided a question and answer period, accepting written questions from those who were too shy or embarrassed to ask directly.

Each county auxiliary, with the aid of its local medical society, researched and presented local suicide statistics, information on counseling programs and a list of local resources for crisis intervention. In addition, everyone who attended a seminar was given a folder containing carefully chosen, pertinent articles, recommended reading lists, suggested audio visual aids, a post-test and an evaluation form.

We learned from those who attended that more than factual, useful information had been transmitted. Important new attitudes had emerged. There was understanding, hope, and most important of all, the belief that individuals and communities can make a vital difference in reversing the tide of youth suicide.

Our program developed over a period of three years. It officially began with a stirring keynote address by Charlotte Ross at the 1982 CMAA Fall Leadership Conference. This was soon followed by regional conferences in Northern,

Central and Southern California sponsored by the CMAA and local county medical auxiliaries, under the direction of staff members of the San Mateo Suicide Prevention and Crisis Center.

To stimulate requests for additional seminars in other counties, an experiential mini-workshop was given by the CMAA Program Chairman at the 1983 Fall Leadership Conference. This led to similar but expanded presentations in nine counties. Three other county medical auxiliaries developed programs in cooperation with their local suicide prevention centers.

As the program grew in 1983, the CMAA realized funds were needed to purchase its own educational materials, pay travel expenses of speakers, print guidelines, and brochures. The state Chairman applied for and received grants from the California Medical Education and Research Foundation (CMERF) totaling $15,000.

By June of 1984 the state Chairman had also applied for and received Category I Continuing Medical Education Credit from the CMA for physicians and nurses who attended auxiliary seminars. Educational credit for attending school personnel was also obtained through county schools and regional colleges.

In 1985, as part of its long range planning, CMAA set as a primary goal the development of a youth suicide prevention program (YSPP) in every county throughout the state by 1989. By the close of 1985, 14 counties had initiated a YSPP. Several of these are now involved in in-service teacher training programs. The preceding year the national organization, the American Medical Association Auxiliary (AMAA) passed a resolution to encourage such programs throughout the United States. In the fall of 1985, the State of Illinois began a similar program.

This report would be remiss if it failed to point out additional key factors that led to the program's rapid growth and also its greatest shortcoming. While the seminars are organized and funded by CMAA and CMA, through CMERF, the most effective programs are those that utilize existing community organizations such as county school districts, mental health associations, hospitals, churches, and court appointed youth advocates. Such coalitions expand the number of volunteers involved and the number of people reached. They also generate increased enthusiasm, momentum and resources for future programs.

Invariably, one county seminar has led to several requests for another, often within the same county or a neighboring

district. Indeed the request for such programs far exceeds the number of CMAA trained volunteers.

This year's CMAA's YSP emphasis must be on training more volunteers throughout the state. In turn, they will train others in their own communities. The possibilities are awesome. The training will begin at an all day conference in Sacramento on February 18, 1986 and will continue at the CMAA Spring Convention in March.

We are often asked, "Does your program really work? How do you know?" Perhaps the most dramatic testimony to the CMAA YSPP's effectiveness was that given by a 17-year-old student at a Senate Education Committee Hearing on SB 947 to introduce a Teen Suicide Prevention Education Program into the California high school curriculum: "If I had known six months ago what I learned at a recent CMAA seminar, my best friend would still be alive."

DELAYED UNRESOLVED GRIEF IN YOUTH: STRATEGIC INTERVENTION THROUGH FUNERAL SERVICES

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Every time suicide succeeds, it threatens to kill twice more, once as an immediate trigger to a second suicide, and once again as the latent "seed of suicide" in the unresolved grief of survivors. A recognition of the immediate triggering effect of suicide, especially among youth, and the long term risks of delayed unresolved grief, brought about our joint effort to minimize these effects through a coordinated interdisciplinary approach to prevention, intervention and postvention.

In the wake of a suicide death, typical postvention care most often waits for survivors to develop trouble and seek help themselves. Though crisis centers and survivor groups are developing more effective methods of outreach, there is still a great need for improved continuity of care, particularly among youth. Efforts to break the triggering cycle must be immediate and attempts to prevent delayed unresolved grief must be initiated with the very first response to death. For this reason, the arrangement and direction of the funeral is a key element in our interdisciplinary approach to suicide prevention, intervention and postvention.

The National Funeral Directors' Association stresses the importance of recognizing the needs of grief in youth, and of utilizing the therapeutic principles of the funeral to respond to them in an age appropriate fashion. A detailed protocol presented through case histories and involving funeral directors, clergy, self-help groups, school personnel and others, was described to demonstrate how cooperation among these individuals can help defuse a suicidal trigger and prevent the latent seeds of suicide from taking root.

Care extended to friends and classmates as members of a "peer family" is initiated within 24 hours of the death through a group meeting of young people facilitated by a trained counselor familiar with suicide and with suicide grief. Through this meeting and other special opportunities made available as part of the funeral, youth are provided with important information about suicide and grief, given ways and means to pro-

cess their feelings and offered sources of individual help that will be available to them on an immediate and continuing basis as needed.

Suicide education for youth and parents, as well as educators and caregivers, is an essential element in the success of this interdisciplinary response to suicide. When student support groups are in place and preventative education has been provided to students and faculty, when caregivers are prepared to respond to the special needs of youth, and when a true interdisciplinary spirit prevails, we believe that significant strides can be made in reducing the risk of repeated suicides. If it is true, as Dr. Edwin Shneidman has said, that "Postvention is prevention for the next decade," then all efforts to recognize and respond to youth as suicide survivors at risk cannot begin too soon. The life of the next generation depends upon it.

ARMY SUICIDE PREVENTION PROGRAM

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On August 27, 1984, Danny Holley, the 13 year old son of Sgt. Jonnie Holley, hanged himself in his parent's rented home in Marina, California, outside of Fort Ord. He had told his mother, "If you didn't have me to feed, things would be better."

The evidence shows that when the Army learned of the family's financial problems in July, it moved quickly to help. Local news media reported that the "Army did all it could be expected to do." Tragically, Danny never appreciated the significance of that help.

In spite of the national media attention that this case received, it was not the beginning of the Army's suicide prevention effort. A memorandum dated May 18, 1984, made recommendations for an Army suicide prevention program and, on July 15, 1984, six weeks prior to Danny's death, the Chief of Staff of the Army directed that training in suicide risk identification be included in Army leadership courses and that stress management training be included in all Army courses. He further directed that major commands train military leaders, school teachers, youth activities employees, and Army Community Services personnel in suicide risk identification using a team approach with chaplains and mental health professionals.

In order to understand the Army suicide prevention program, it is helpful to know something about the scope of the problem within the Army. The suicide rate for active duty Army males is lower than the rate for males in the general population. Furthermore, this rate has been declining since the mid-1970's and, at present, appears to be stable. The Army total suicide rate for 1982, the last year for which official data exists, was 11.4. In the same year, the total U.S. rate was 12.3. The estimated Army rate for 1984 is 10.5. It is perhaps more revealing to look at the suicide rates for males ages 20 to 24. In 1981 the Army rate was 13.5, while the rate for this age group in the U.S. population was 26.8.

The suicide rate for active duty females is half the rate of Army males and is about the same as that of females in the general population. The Army female suicide rate has been declining from a 1977 high of 15.2 to a rate of 5.5 for 1982, the last year for which complete data exists.

The suicide rates for Army family members and civilian employees are unknown. A large research project has been proposed to give us some understanding in this area. However, there is no reason to believe these rates are different from those of the general population.

It is the position of the Army that, although we certainly are doing no worse than the rest of society, we can and should do much better. We have a controlled environment and an active duty force composed of a prescreened, healthy population from which severely impaired persons have been eliminated. Furthermore, it is a population of relatively young individuals who are all employed. In such a group, a low suicide rate is to be expected.

The U.S. Army Suicide Prevention Plan was adopted in February 1985. The plan consists of 26 separate initiatives in the areas of prevention, data collection, and research and analysis of the problem. The cornerstone of the Army's entire suicide prevention program is that suicide prevention is seen as the responsibility of leadership and command. The key to the prevention of suicide is caring leadership and the early involvement of the chain of command. The exercise of such leadership should be assisted by mental health and other medical professionals, Army Chaplains, the Military Police, and a broad base of other community support agencies. Holding commanders responsible for suicide prevention assures a high priority for action and that available resources are focused on the problem.

Perhaps the main thrust of the Army prevention program is education awareness training. As directed by the Chief of Staff, all Army leadership development courses for officers and NCO's will include risk identification training. We are looking both at the Army schools and installation level training programs. The focus of local efforts will be to train leaders and supervisors, as well as school teachers, youth activity workers, parents, community service counselors, soldiers and military family members.

In order to accomplish the local prevention program, a suicide prevention task force will be formed at each installation which will consist of the post director of personnel, post chaplain, chief medical officer, mental health officer, military police, public affairs officer, staff judge advocate or legal officer, and other staff officers as appropriate. The purpose of this task force is to coordinate suicide prevention activities of the command and evaluate the needs of the installation. The task force will develop the installation

awareness training program and monitor the overall progress and effectiveness of the prevention program.

Much of the awareness training program will be conducted by Army Chaplains who have received additional training as needed from the local mental health officer. The cooperative effort of Army Chaplains and mental health is an essential feature of the program.

Other specific program initiatives include the following:

1. Production of a videotape on suicide prevention.

2. Publication of an Army Guide to the Prevention of Suicide. Advance copies are presently available.

3. Establishment of 24-hour "help" lines on all Army posts.

4. Provision of additional training for mental health and other helping professionals on child, family and adolescent counseling.

5. Immediate reporting of all suicides of soldiers, family members and civilian employees to Department of the Army by the Military Police.

6. Formal psychological autopsies conducted on all soldier suicides and equivocal deaths in order to better understand how the death may have been prevented.

7. A major research project initiated to study suicide and suicide prevention in active duty members, spouses, and adolescent family members.

The Army is committed to preventing suicides among its soldiers, family members, and civilian employees. Not only because of the tragedy of any individual suicide, but because we are told that for every completed suicide, there may be as many as 100 others who either attempt suicide or seriously contemplate the act. This represents a lot of people who need help, and it is help that we can provide, for the most part within existing resources. Ultimately, the readiness of the Army to perform its mission depends on our ability to take care of our soldiers and their families.

PREVENTING YOUTH SUICIDE: DEPARTMENT OF DEFENSE DEMONSTRATION PROJECT

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Suicide has been the third leading cause of death of persons aged 15 through 25 years during the past 10 years. The rate of teenage suicide has escalated rapidly over that period of time. Suicide incidence has increased 122% during the past 20 years. The prevention of suicide by adolescents and young adults is a priority for action.

A Department of Defense Dependents Schools DoDDS program to promote the positive emotional development of adolescents and young adults to prevent suicide is essential to address the continuing problem of youth suicide. The emotional development problems of youth often are compounded by other problems such as drug and alcohol abuse, child abuse and neglect, and school and family problems.

A suicide prevention program for the DoDDS students can best be accomplished by coordinating the educational programs at the ODS, regional, and local levels with appropriate community suicide prevention and crisis center agencies and community offices. It is intended that cooperation among these groups shall be a major component in this effort to achieve the successful prevention of youth suicide.

Crisis intervention and suicide prevention will center on better detection by students, teachers, and family members of the signs of emotional distress in an adolescent that might result in suicide; defined responsibilities for specified pupil personnel services personnel; timely referral of potential suicide victims to community professionals as needed; cooperation between schools and non-school professionals.

RECOMMENDATIONS

Working with other agencies, offices, and organizations, DoDDS will develop ways to inform and instruct all school personnel in the detection of conditions which indicate youth suicidal tendencies, and in the proper action that should be taken when there is reason to suspect that a student is contemplating suicide.

Working with other agencies, offices, and organizations, DoDDS will assist in the development of ways to inform and instruct parents and the general military community about the problem of youth suicide and ways to detect the warning signs that there is probable cause to suspect that a youth is contemplating suicide, and in the proper action that should be taken to prevent suicide.

Working with other agencies, and organizations, DoDDS will adopt curriculum materials to assist instructional personnel in providing instruction through a multi-disciplinary approach to the identification, intervention, and prevention of youth suicide. The curriculum materials shall be geared toward a program of instruction for grades 9-12. Strategies for requiring all DoDDS regions to utilize the curriculum are to be included in the prevention of youth suicide plan.

DoDDS will develop and acquire varied instructional materials relating to suicide prevention and positive emotional development, and shall ensure distribution to each region for required inservice training for all school personnel. DoDDS personnel will assist in the annual distribution of a suicide prevention awareness program.

DoDDS counselors, psychologists, social workers, and school nurses shall be certified in the ability to recognize signs of severe emotional distress in students and techniques of crisis intervention with emphasis on suicide prevention and positive emotional development.

THE ROLE OF CRISIS INTERVENTION CENTERS

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"'Next time it rings,' Paul said, 'you answer it, Sarah. They may have rung off because they want to talk to a woman.'

'I can take it,' Rachel said.

'Let Sarah. She's got to start sometime.'

Rachel looked at her doubtfully. 'I will if you like.'

'It's all right,' Sarah said, but after Rachel had gone out, she told Paul, 'I'm scared.'

'Suppose I don't know how to help? I haven't learned --'

'All you have to learn is just to listen.' The constant refrain. 'No instant salvation. Just humanity. Let it come through, Sarah,' he said gently, smiling, looking at her as if he liked her very much...

The telephone rang. Sarah jumped and was paralyzed, staring at it.

'Pick the damn thing up,' Paul said quite roughly. 'Do you want them to think no one cares?'

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When George came out of the station, he had asked the way and had been told, 'Turn left, turn right, take this or that number bus. Get off at the last gate of the football ground, you can't miss it.'

He had taken the wrong bus. The football ground never came. They never even went over a bridge. When the conductor came to the top deck, he laughed and told George he was miles away and going in the wrong direction....

He took another bus and it stopped in some wide square with new white buildings and announced that it would go no farther.

'You're supposed to go to the stadium.'

'Circus only, dear.' The conductress pointed to the sign above the back step.

'Why did you take my whole fare?'

'I didn't. Just as far as here. Don't you know what the fares are?'

'Look. I've never been in this cruddy town before...'

George's luck ...George's perishing luck that caused matchboxes to catch fire in his hand, strange towns to declare Early Closing Day as soon as he arrived, telephones to be always engaged, when they were not wrong numbers. Watch him get to the Exhibition Hall, if he ever did, and find the job had gone five minutes ago to someone else.

He growled down some steps in the middle of the road, expecting to find the Public Convenience out of order, flooded or full of queers.

'If you are in despair,' the notice said. Well, if that's what they want, here I am.

'Samaritans, can I help you?' A young girl's voice. Things are looking up.

'I'm in despair, darling.'

She made a sympathetic noise.

'I'm lost in this bloody city and I'm late and I'll probably lose that job and what the hell do you care?'

'What can I ...can I help you?'

'That's what I'm asking you,' George said patiently. 'How can I get to Exhibition Hall?'

"Where are you?'

'If I knew, I'd not be lost.'

She laughed then, and George laughed, and finally she said she would look at the map, and then she told him some street and

bus numbers, but he was not really listening. He had seen the clock in the bank window and realized how late it was.

'All right, now?'

'All right? I'm an hour late. I'll have to get a taxi.'

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Mrs. Latimer turned the telephone dial with a special gold gadget for turning telephone dials. She had a device for lifting sausages out of the frying pan and ejecting them onto a plate. She had a pair of tongs on a long extending handle to pick the dog's mess off the lawn, and another extending handle with a scoop at the end to get cans off the top shelf. She had brushes with disposable pads for cleaning toilets and baths, a little hook on a ribbon for pulling up zip fasteners at the back of dresses, and a button in her car which made the garage door go up and down. When a certain kind of plane flew over, the door went spookily up by itself in the middle of the night.

'Samaritans, can I help you?'

A young voice. She had expected someone cool and mature. A nice young voice, quick, and a little breathless, eager, like the voices of the daughters of the friends. Like someone she might know. It might even be someone she knew.

'This is Mrs. Charles Latimer,' she said, as if she were going to give an order at a store where she had an account. 'It's on behalf of my son. You do help people, don't you? Yes, oh, how nice...Well, he would, I think. He wanted me to ring you. He won't see his doctor anymore, but he said he might come to you.'

'Of course, he can run in anytime and talk to someone.'

The young voice was warm and interested. Not official. Perhaps they could make Gordie see that he did not need the gestures.

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I did it. It was easy. First that man, then Mrs. Latimer. I did it. I coped. I didn't panic. I was able to help them. They thought I was a Samaritan. Perhaps I am...

When the telephone rang again, she stretched out her hand without glancing at Paul, and picked it up quite confidently. Omnipotent Sarah. The saviour of the world."*

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One of the problems that plagues suicide prevention centers is that they have been expected to be saviours. Like Sarah, most centers and most crisis intervention workers come to their role of helper with ambitions to accomplish deeds far beyond the powers of mortal human beings. Suicide prevention workers are not saviours and they are not everybody's best friend. Sometimes people will call and the prevention worker will not understand the dilemma. Everybody can be helped by somebody, but that somebody may not be the person who will answer the phone at a crisis center.

It is a myth for those in the helping profession to think that all callers are loveable human beings. Callers are, like most of us, sometimes boring, annoying and occasionally obnoxious. If a phone worker finds himself hating a caller and he has ruled out the possibility that the caller is too much like his mother-in-law or his ex-wife, chances are that the caller is being hateful. Some callers have tried the patience of every agency in town. The center may not be able to help them. It is also a myth to think that all crisis workers are always unconditionally accepting and warm. Phone workers, like phone callers, are sometimes short-tempered and impatient or not clear-headed. They, too, may be having a bad day.

Suicide prevention centers cannot solve all problems. There are some problems with no solutions. At times the powers of empathy are put to the test when all the phone worker can do is to let the caller know that it is difficult to live with a question that has no answer or an illness that has no cure. Crisis intervention workers are not omnipotent. This is often a fantasy of both the phone worker and the caller. The caller wants help and the phone worker wants to give the caller the one bit of information which will change a life and transform the caller into a paragon of mental health. Forget it!

There are a number of researchers (e.g., Hendin, Holinger, Miller) who claim that suicide intervention workers do not prevent suicide. Miller's study states that the centers consistently reduce the suicide rates of only one group, young, White females. Miller estimates that only roughly 1,000 lives are saved a year by centers and perhaps 5,000

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* "The Listeners" by Monica Dickens. Pan Books Ltd, 1972, London, England, pp. 251-255.

attempts are prevented. This falls far short of the projections of other intervention methods such as restrictions on firearms which could save the lives of 3,000 to 6,000 teens a year; restrictions on prescription medications, which could save approximately 1,300 lives a year.

Suicide prevention centers have given help and comfort to an enormous number of people in distress. They have made us aware of the need for facilities for people with all sorts of emotional crises. They have also promoted the development of numerous peer counseling centers at high- schools and colleges across the country. The crisis centers are clinical facilities providing service to those in need. They are educational and training facilities. They are research groups. They are a catalyst for providing interest in suicide prevention. From this perspective, the suicide prevention centers are an outstanding success.

The Samaritans of Boston, for example, do not state that they seek to eliminate suicide. They do state that they seek to alleviate human misery, loneliness, despair and depression by listening and befriending those who feel that they have no one else to turn to. They provide a 24-hour telephone service every day of the year and a daily walk-in service from 8:00 a.m. to 8:00 p.m. The Samaritans is one of the select crisis centers in the U.S. accredited by the American Association of Suicidology. In 1984, the Samaritans received approximately 200 calls or visits each day; 5,300 people used the service for the first time; 40% were males and 60% were females.

Callers are encouraged to use the service as often as they wish, to come in, and with their permission, they are called back. The Samaritans also befriend those who prefer to make contact by writing letters. The total volume of calls and visits in 1984 was 71,802. In 1984, 2,163 callers were considering suicide the first time they called, 40% of the total number of new contacts. Of these, 754 callers had a method planned and 675 had made prior attempts, both high risk groups. People who were concerned about someone they knew who was suicidal placed 578 calls. The largest number of suicides in Massachusetts is in the 20 to 29-year-old-age group, which is also the age group that used the Samaritan service most frequently. Of these callers 653 were male and 740 were female. Callers aged 19 and under made 598 calls.

The Samaritans initiated a Youth Outreach Project aimed at reaching high school and college students and those working with them. Booklets and pamphlets discussing the signs of depression and suicide risk and where to go for help were printed and distributed to 1,500 schools and colleges in 1984. That same year, the Samaritans responded to 367 requests for

information on suicide from schools, students, parents and agencies. Trained Samaritan volunteers and staff led 340 discussion groups and presented workshops to high-schools, colleges, religious schools, social service agencies, hotlines, peer counseling groups, hospitals, clubs, health fairs and police groups. The Samaritans have also spoken at schools where there has been a suicide. It is estimated that education programs in our schools could save more lives than any other intervention, perhaps in excess of 5,000 a year.

During 1984, over 40 Samaritan volunteers met every Wednesday evening with inmates who are barred befrienders at the Charles Street Jail. Over 30 inmates participated in the process of seeking out, identifying and befriending the suicidal. The frequency of completed suicides has been reduced 88% since the Samaritan work at the jail began in 1978. Since the beginning of this program there have been six completed suicides at Charles Street, rather than the 56 that the National Institute of Justice statistics indicate normally happen in a county institution of its size. The National Institute of Justice study of county jails states that there are 2.5 suicides per 1,000 admissions. The Suffolk County Jail in Boston has 5,000 admissions, and therefore might expect 12.5 suicides per year or 25 in two years. Since the inception of the program there have been no suicides in 24 months. Officer training by the Samaritans in suicide prevention is now required by the State of Massachusetts. To date, 1,500 Department of Corrections employees out of a total of 20,000 have been trained. In three years half will have been trained.

Even if it could be shown that the suicide prevention and crisis intervention centers did not prevent a single solitary suicide by their phone service, in my opinion, they would still be worth their weight in gold because of all the other clinical, community, research and resource services they provide.

Maybe my original comment is wrong. Maybe the volunteers at these centers are saviours.

TEEN LINE - A MENTAL HEALTH DELIVERY SYSTEM FOR YOUTH

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Adolescence is a tumultuous and painful experience for many teenagers, regardless of their educational, psychological, economic, religious, or racial background. The dramatically increasing youth suicide rate is just one measure of our society's lack of recognition and response to the seriousness of the problem. Existing mental health delivery models are woefully inadequate in meeting the needs of this age group, even in those few geographic areas where these services exist.

The staff of the Center for the Study of Young People in Groups, an affiliate of the Cedars-Sinai Medical Center in Los Angeles, in an attempt to provide service to this population, has developed an innovative, cost-effective model with national implications that is based on psychodynamic, developmental and societal considerations.

Teen Line, a confidential telephone help-line for young people, is staffed by trained volunteer adolescent listeners and adult mental health professionals. The Teen Line has been in operation since April, 1980, and has over 15,000 completed caller-listener contacts. It is open every night from 6:00 p.m. to 10:00 p.m., and is staffed by three to five teen listeners and one resource associate each shift.

The resource associates are mental health professionals who, after going through a Teen Line orientation, volunteer for one evening shift a week. They are available to handle specific problems, but usually function as a supportive and clarifying presence. In addition, there is a senior staff person available by telephone for further coverage. Over 200 adolescents have gone through the nine week training program, which is currently being offered four times a year.

Calls that come in when the line is not operating are answered by machine, with a promise to return the call if a number is left. The bulk of calls come from Southern California, but with increasing national media coverage, we are getting many calls from out of state. We return calls to callers who are concerned about phone charges.

It is central to many theories of psychological knowledge that intervention close to the time of perceived need is most effective in preventing serious and irrevocable damage. Awareness and insights learned at this moment of crisis often serve to educate the individual in coping skills that can be drawn upon in the future. The average adolescent, however, is reticent to perceive himself as dependent on adult or parental caregivers, and on institutions associated with them.

The biological push and cultural pull toward separation from the relatively comfortable, secure, predictable past often makes for a psychologically precarious present. "Needing help" stimulates unresolved dependency issues that are common in adolescence and the resultant anxiety can inhibit "asking for help." Initiating contact with mental health services can, therefore, be an overwhelming prospect for the average adolescent. Factors such as filling out an application, transportation to a clinic or professional's office, being seen by someone he knows, financial matters, and dealing with the ambivalence surrounding the very issues he is concerned about, will most often lead the adolescent to avoid seeking help.

As a result, when average adolescents perceive personal concern, stress or confusion, they do not initially make contact with their local mental health professional. They rarely contact their school based counselor or clergy-person. A few will go to parents or a trusted adult, but these relationships, when they exist, are often characterized by the adolescent's previous developmental and intellectual level. In other words, the caring adult relates to the adolescent as he was yesterday, without a clear sense of where he is today.

The average adolescent does spend much of his time with peers, or wishing to be with peers. The telephone as a facilitator of that process is well established in his mind. It allows for the promise of immediate communication, catharsis and consolation, and, as such, assumes a central role in the lives of many young people. Even those adolescents who do not use the phone frequently are familiar with its potential for social contact and information transmittal. In addition, the telephone serves as an equalizer of the perceived discrepancies in the social, economic and cultural differences of the two parties speaking, to which adolescents are particularly sensitive. The anonymity it offers allows for incremental experimentation in personal exposure. The security that comes from the power to unilaterally terminate the call reassures the adolescent who feels overwhelmed, frightened and ashamed. And, of course, the phone is immediately available and affordable to most young people in the United States.

The preceding remarks provide part of the rationale for utilizing the telephone as an integral part of a system

addressing adolescent needs. However, the justification for using adolescents to answer calls, while appealing in terms of traditional peer-counseling models or intervention, was not, we felt, theoretically sound.

Adolescents are prone to intense and immediate reaction to many situations, especially to those situations whose emotional content overlaps their own conscious and unconscious issues. They are action-oriented, and their own omnipotent defenses naturally lead them to think in terms of quick solutions. Their identification with the caller and his discomfort and their wish to alleviate his anxiety, and theirs, encourages advice giving. The solutions and advice they tend to give their peers are usually based on their own limited experience and are colored by the various value systems to which they have been exposed.

It was, therefore, necessary to modify existing models so as to retain the advantage of the adolescents' empathy and credibility with his peers, while protecting the teen-caller and teen-listener from the excesses that are a function of their age and the potential intensity of the Teen Line relationship. We decided that the program model would emphasize the defining, focusing and clarifying potential of active listening by a caring, empathic and non-judgmental other. The program would have to have a structure and an ongoing sensitivity to the general and idiosyncratic needs of the adolescent listener. And of greatest importance, the program would have to be true to its advertised promise of teen-to-teen communication, while simultaneously providing the necessary professional training and supervision.

A detailed description of the training and operational aspects of Teen Line can be found in "The How and Why of Teen Line" by Leader, Lipton and Wisne. Briefly, the teens are selected for the training program on the basis of a telephone screening, written application, task-oriented group interview, and individual interview. Personality variables that are examined include emotional maturity, intellectual development, ability to understand others, tolerance for different value systems, and a willingness and capacity to commit the necessary time and energy. There is also a parent/teen meeting to inform the parents of the expectations of their youngsters, especially as they relate to punctuality, attendance and confidentiality, and to deal with any anxieties the parents might have about the program.

The formal training program lasts nine weeks, with two two-hour meetings each week. One session each week is focused on listening skills development, and the other on specific aspects of the adolescents' experience and world, family dynamics, value clarification, school experience, crisis intervention, self-destructive behaviors and suicidal ideations and threats, addictive behaviors, sexuality, and cultural differences. During the training program, the teens

are expected to observe the Teen Line in operation several times. Once they have graduated, they are expected to serve for at least one four-hour shift a week for a minimum of six months. They have formal group supervision with their 10 to 14 training group co-members to capitalize on the group process previously established. They have ongoing informal supervision by the resource associate, an adult mental health professional who is always present during the Teen Line operation. There is also a monthly staff meeting for teens and adults that is devoted to administrative matters and inservice training.

Teen Line plans to modify its structure to accommodate the increasing local and national demand for its services. Original planning to encourage replication of the program in other interested communities was not consistent with our criteria of cost-effectiveness. The most expensive part of our budget relates to the training program and administrative costs and salaries. These costs would remain relatively constant with an increased number of trainees and calls serviced. Another factor which limits the replication notion is that the program requires a large, metropolitan and psychologically sophisticated city to provide enough mental health professional volunteers for the position of resource associate. Also, in cities with smaller populations, there is a significantly greater probability of teen-caller and teen-listener meeting and/or knowing each other. It is for these reasons, and based on our experience with out-of-state calls that we are increasing our capacity to receive calls in anticipation of instituting an 800 number in the near future.

The Teen Line model in no way substitutes for or competes with a professional evaluation and intervention. It does offer immediate contact with a caring and concerned other, and the potential for issue clarification and resolution and referral. For the adolescent in pain, that can be life saving.

DYING FOR ATTENTION

Lynne F. Peterson
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The NBC documentary "Dying For Attention," dramatically brought the problem of youth suicide to the attention of our network. We interviewed kids who still call today when they get upset and need somebody to talk to. One girl called because she couldn't get through to her psychiatrist. They really are reaching out. In some respects, I thought it would be harder to talk with us; it was very public and they knew we were going to share their thoughts with the whole world.

The kids talked about many things with us, nuclear war, rock music. We asked them about suicide. They said when they feel suicidal, it involves intimate problems; problems with the family, love life, school, internal feelings. They are not able to cope with those problems at the time. If the psychiatrist, teacher, mental health professional, or parent says, "This is the way the world is," or, "It's the music you are listening to," the teens won't listen.

We know the suicide rate has gone up 300% in the last 25 years, and we wanted to know if it had become trendy, a fad. A young girl named Karen in Florida put it this way:

> "It is not trendy like blue jeans, but if I see so and so do it and it works for him, gets him the help he needs, things get better for him...well, then maybe I'll think about it for myself...maybe I don't really want to kill myself...maybe I'll think about attempting it because maybe it would work for me... and in that way it is trendy."

That is a very important point she is making. The attempt works because suddenly everyone is paying attention. We talked to high school students in Martin County, Florida.

The principal put together a group of six students who didn't have any reason to know about suicide. I wanted to interview them and didn't want them to know in advance what we were going to discuss.

I didn't get nice, mundane, middle of the road responses. A half hour into the interview one girl stopped me and asked, "Why haven't you asked any of us if we have attempted suicide?"

I said, "I didn't think I could directly ask anyone your age if they had ever attempted suicide. Have any of you ever attempted suicide?"

The girl said, "Yes, I did." She was the editor of the school newspaper.

Later, one of the boys said, "I haven't tried it, but I sure have been thinking about it." They all knew kids who had attempted it. They wanted to share. The girl who made an attempt hadn't told anyone. The school hadn't known it when they chose her to speak with me, but she was very forthcoming.

The students had some very strong messages. They believed, as you have heard before, that kids helping kids is the solution. We heard this everywhere we went, Oregon, Virginia, Florida. Kids helping kids is what they see as the answer, and they want to do it without adults. They feel they don't have a vehicle for having a dialogue with their parents. The students say that if they talk to adults, the adults will overreact and immediately rush them to a shrink, or a mental hospital. Listen to these comments:

Boy: "I can't really say, Mom and Dad I'm sick and tired of your fighting with me. I know you are going to get a divorce. I'm thinking of killing myself, can I seek help?"

Girl: "You can't always see the signs of someone who is suicidal from a teacher's point of view. A lot of students will act happy instead of showing their depression."

Girl: "The best way to help someone who is thinking about suicide or attempting it or thinking about attempting it...the best

thing is a best friend, a good friend, someone who is close, someone who can understand, someone who can listen."

They are saying they don't know how to go to their parents and ask for help.

We started looking at programs designed to help. In a Herndon, Virginia classroom, skits are performed in relationships classes. Students write a script, act it out for other classes. This is an example:

Kid: Hey, Rene, how are you, what's wrong?

Rene: Nothing.

Kid: Come on...

Rene: Leave me along, get off my back. My parents are on my back, my grades are going down...I don't know where my future is...just leave me alone.

Kid: Why? Did you have a fight with your parents?

Rene: I always have a fight with my parents. It is the normal way of life for me.

Kid: Things have to get better.

Rene: They won't. I just want to die.

Kid: Well, everyone feels like that sometimes.

Rene: I feel like that all the time. There is just no end. I just want to be alone.

After the skit, they discuss what should and shouldn't have been done. They are guided then into watching for the signs. They try to make it realistic to their own lives, sometimes that gets through.

There was a quiver in Rene's voice. We heard it and took her aside after the skit was over and talked to her. She admitted that it wasn't just that she was a good actress; she had been suicidal herself. That is one of the powerful points of the skit, and also one of its dangers. The skits do bring out emotions. The students do want to share and talk, and the skits provide a wonderful format for that. Experts told us that the group must be small, with enough

adults there to spot a girl or boy for whom a skit may bring out current or past troubled feelings and to take them aside and talk to them so they are not left more upset by the discussion than before. That is the key concern in this kind of program.

Our estimates indicate that a third to half the kids we talked to had had suicidal thoughts. Many of them thought that all of them did at some time. However, there is a big difference between thinking, "God, I wish I were dead, I just can't handle this any more," and thinking, "My mother has sleeping pills, maybe I should take them." Then there is the difference between that and actually going and getting the pills and taking them. There are different stages.

Professionals who conduct teacher in-service training say the important thing is to know the signs to watch for, what to be aware of, and say it in terms that everyone understands. Ask the kids, "Are you thinking about killing yourself? Are you thinking about suicide?" A lot of schools are starting programs to sensitize teachers to that message.

We found that most programs are aimed primarily at high school students. Some comments tell us we should be concerned at almost any age:

Pam: "When I was in first grade my Dad died and I remember having thoughts about killing myself when I was that young. I remember looking in the medicine cabinet for something and I remember my mother catching me. And I told her I had a headache and I was looking for aspirin. But she would never have guessed that I had suicidal feelings, not that young anyway."

Stacy: "Junior high I think should be the best place to start any kind of counseling... because just from personal experience. I started thinking these things when I was 12 to 13 years old, and that is about Junior high."

These 17 and 19-year-old girls are saying they would have talked about it when they were younger if someone had asked them.

Teachers and professors are concerned about certain restrictions in state laws. State laws don't prevent you from asking, "Are you upset?" If a student is upset, you don't have to get into why and how, you pass it on to someone who can. You pass it on to parents and professionals.

Some schools have developed peer counseling programs, in which students are taught to spot the warning signs and symptoms and how far they can go in counseling their friends. But there are two sides to it:

Stacy: "I told a couple of my friends that I was very depressed and just wanted to die. They took it as a joke, they didn't take it seriously at all. They said, 'Oh, you won't do it. You don't have enough guts to do it.'"

Ian: "If someone would have said to me, 'I felt that way last night or last year,' I wouldn't have felt so alone, like I was the only one."

Stacy: "None of us see there is something beyond this feeling here. If you kill yourself right now, there is nothing. If you don't kill yourself, you have all sorts of opportunities."

That is an awful lot of responsibility and burden to the students. Friends helping friends is important, but there are times when professionals or parents must be brought in. It is okay to tell. Your friend might be angry at you for a day, or a week, or a month, but in the long run, he or she will be grateful.

We talked to kids who had attempted suicide, who had been to psychiatric hospitals, and they had a uniform message to us. It was that friends are not enough, we need more.

Girl: "It's good to be able to talk to your friends about it, but they don't have enough skills really to help you get through it. But it is good to have them to help you also."

Boy: "It was somebody to talk to, someone to listen, somebody that would sympathize with me. But I still had the problems. They didn't help solve the problems."

No, they shouldn't run to adults every time kids talk about suicide. Yes, they can help, but they have to have in the back of their minds the question, "Is this a case where I should go to an adult?" Right now they are shutting out that option.

MEDIA: CORPORATE CONCERN

Thomas F. Leahy
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My role is to share with you some observations on corporate concern and corporate action, suggesting some ways in which we can help bring to bear the resources of corporate America on the problem of suicide prevention. I think especially of the human resources, the collection of knowledge and skills which the business community can tap into at the local level.

Corporate responsibility takes many forms. If it is true, as John Naisbett suggests in "Megatrends," that by the turn of the century 90 % of all jobs in this country will be in communications, then one experience of one segment of one communications company will be of greater relevance than might at first appear.

Communications is what brings us together here today. The painful and sometimes tragic difficulty in interpersonal communication lies at the very heart of the problem this conference addresses. The need to bring public communication, through all possible modes and media, to the task of "speaking about the unspeakable" is among the most important of the Youth Suicide National Center's charges.

What first focused my attention on the issue of youth suicide was the preparations for presenting the made-for-television-movie, "Silence of the Heart." It was broadcast on CBS Television Network on Tuesday, October 30, 1985. I am very pleased to report the film was exceptionally well received. Not only did it attract considerable favorable notices, it also attracted a sizable audience. It was the most watched program that evening, with a 35% audience share. It was the third highest rated made-for-television-movie on CBS last season.

I would like to address three questions: how did we come to do "Silence of the Heart"; what did we learn from it; and where can we go from here?

What impelled a commercial television network to do this important story? How did CBS come to present a prime time entertainment broadcast which deals with a family facing the

suicide of a teenage son and brother? In addressing those questions, I should like to say something about the nature of television to set my answers in context.

Television, almost anywhere in the world, performs at least two distinct roles. It is a disseminator of news and it is a source of entertainment. Many broadcasting systems throughout the world have also been assigned the role of conscious agents for the dissemination of official views on the national purpose.

That may work well enough within the context of totally different historical and philosophical traditions. But, it could never work and, indeed, should never be considered, within our tradition of Jeffersonian democracy. In our system, neither stations nor networks are conscious agents of national purpose. American broadcasting uniquely reflects our history and our beliefs. Congress established an allocation design and a regulatory system which foster our traditions of pluralism, federalism and private enterprise. The cornerstone is the encouragement of many diverse local voices.

The role of entertainment programming is to entertain. As long as it does that, as long as a program amuses, or diverts or engages the mind, as long as it attracts and holds an audience's attention, it has fulfilled its role.

If we want to talk about serious content with a message, "Silence of the Heart" did not stand alone. Indeed, one television critic described the season as characterized by, among other things, "gleaming, high-rated, serious T.V. specials and mini-series." The list would include CBS' "Kids Don't Tell," which dealt with the sexual abuse of children, and "Do You Remember Love," about the tragic onset of Alzheimer's Disease, NBC's "Burning Bed," which involved wife abuse, and "Adam," the story of a missing child.

The proliferation of such programming is a result of two major factors. First, the audience wants and expects long-form programming, and theatrical films are no longer a source which television can turn to for this purpose. Most motion pictures made for theatrical release are specifically targeted for audiences in the 12 to 24-year-old range, a very limited demographic group. The relatively few other theatrical films have exhausted their attractiveness to the networks by their earlier multiple exposures on pay cable.

To meet the public's desire for the regular availability of such programming, each of the networks currently schedules two nights of movies every week. That's six films a week, each week of the season, a total of nearly 150 original films. Producers must be constantly involved in a wide search for story sources. Inevitably, that search leads them to look at society and reflect its serious and often sensitive themes.

The creative community could not continue to make, and we could not broadcast, such made-for-television-movies unless they met the public's needs. Fortunately, today there is great acceptance for themes reflecting audience concerns, settings which are familiar or evocative, contexts which reflect real life. It appears that audiences will accept serious and sensitive programming, providing it is well done, and delicate and important themes are responsibly handled.

It is not television's role to set the national agenda. But once an issue has reached a level of public concern, the audience's response to its presentation on television can clearly show that an item has made it onto that agenda. Consider the numbers. Almost 30 million people watched "Silence of the Heart." Even more significantly, one teenager in every 10 in the United States saw it. That's 9.3% of all Americans between the ages of 12 and 24.

They also saw two important messages following the broadcast. The first told them about books on suicide available in their local libraries. This bibliography was prepared in cooperation with the Library of Congress. Such "Read More About It"* spots following certain significant broadcasts have been a trademark on CBS since 1979. The second announcement, a departure from previous practice, was a 30 second appeal* by Mariette Hartley, who performed so brilliantly in the film.

Public service announcements are nothing new on CBS. We have been scheduling thousands every year since broadcasters first came up with the idea in World War II. But never before had we developed one from the subject matter of an entertainment show, involved the show's starts, and offered it to our local affiliates for their inclusion in the closing 30 seconds of the broadcast.

The results were somewhat astonishing. In addition to running the announcements, some affiliates also ran special local discussion programs or segments that dealt with the issue in their local news broadcasts following the show. Literally thousands of calls were handled that night and on the following day. One call came to a Southern California crisis center from a girl who said that she had been contemplating suicide for some time and had decided that night would be the night when she actually killed herself. She had seen the show. She saw that others had feelings similar to hers. Seeing the public service announcement was the first time she realized that skilled and caring help was available. She called and was persuaded to come in for counseling the next day.

I'd like to share one other rewarding story with you. Henry Hove, President and General Manager of KTVF, Fairbanks,

*Videotapes of "Read More About It" and Hartley Public Service Announcement were shown at the Conference.

Alaska, wrote us to report the following: "After the program aired, 40 phone calls were recorded by the local crisis center having to do with suicide prevention. In addition, one of the calls was an apparent suicide in progress, and an ambulance and police were dispatched to the scene. The victim was transported to Fairbanks Memorial and was discharged after recovery six days later."

We have found three subsequent occasions when a similar public service announcement seemed appropriate: a broadcast dealing with child abuse; another on a particularly effective teenage drug treatment program; and the Joanne Woodward/ Richard Kiley film, "Do You Remember Love?" In every instance, the results have more than justified the effort.

"Silence of the Heart" will be rebroadcast. Many other opportunities to reach young people will come about as a result of the broadcast. Youth suicide is on the public's agenda. The Mariette Hartley PSA has found its way into the inventory of many stations and will be seen again and again. There will be other public service announcements. These are valuable for maintaining a level of public awareness of the existence of resources. A recent Roper study found that 61% of the American people find television their most important source of information about community organizations.

There will be local broadcasts. If there is one thing we have learned in broadcasting, it is that once the agenda is set and a problem is identified by the public, the community will want more information, and the local station will find fresh ways to revisit the story.

There will be other network broadcasts. SCHOOLBREAK, the highly acclaimed series of afternoon specials for young people, has presented "Hear Me Cry," a drama dealing with the suicide of a teenage boy. The Sunday after the broadcast of "Silence of the Heart," another CBS series, FOR OUR TIMES, presented a half hour entitled "Is Anyone Listening?"

We think these two broadcasts represent valuable opportunities to open discussion among young people, their parents and other adults. We have asked our Education and Community Services Department to prepare a set of suggestions for utilization, which are being made available to the Youth Suicide National Center together with videotape cassettes of the broadcasts. Should demand materialize, we will provide enough copies so that one can be available for distribution in each state. They might provide a way to mobilize other resources, not only schools, churches and synagogues, but also service clubs, fraternal institutions, and local chambers of commerce, which can provide ways to create alliances with partners in the business community.

I have shared with you how we came to do one broadcast about youth suicide on the CBS Television Network and what we

learned as a result, with the hope that it might shed some light on the larger picture, on the role of any corporate enterprise.

To be sure, at CBS we have unique ability to exercise corporate responsibility simply by doing what we do, albeit with care and skill and responsibility. But I believe that most business men and women in this country, who are also citizens and family members and parents, would welcome any opportunity to help in this singularly important task we have set for ourselves at this Conference. We have taken a tremendous step forward in the struggle. We have begun to find ways of speaking about the unspeakable. We have found that people can and will listen. I leave you with this one thought, perhaps our next step is the simple one of finding where to speak, and with whom. For I think you will agree, we know when to speak -- when we must speak. It is right now.

GETTING CORPORATE HELP

Barbara Wyatt
Director
Young Volunteers in ACTION
Washington, DC

I came into the Federal Government four years ago. My mission was to see if I could do something that would matter. At the time I joined ACTION, the Director, Mr. Thomas Parker, decided he wanted to create a youth volunteer program. He developed and implemented a program whereby 14 to 22-year-olds were involved in worthwhile volunteer activities on a non-stipend basis. The purpose was to help them develop job skills and learn about different job opportunities; to have them actively involved in their community and to help provide a feeling of self-worth. As you know, many children have low feelings of self-esteem. Many children who were involved in drugs, from broken homes, have been turned around with this program. Some of these children have come from very difficult circumstances and the volunteer experience has truly made a difference in their lives.

We need to involve our young people in worthwhile activities and perhaps we can reduce the number of problems that can be causes of suicide. However, in promoting this program, the Federal Government did provide model seed money for two years and then the program had to depend on the private sector. In order to do this, the project directors immediately had to involve the community and corporate leaders, thereby providing a commitment to future funding. If you're going to seek funding, you must find a reason for your existence and you must be filling that need. The public has to know you exist and that without you there will be a void in the community. In developing your program you must be concerned as to why you should be funded, then you must find the person who is going to be sympathetic to your cause.

Make a list of corporate people in your community. Many of them have in some way been touched by the issue of suicide and they know the impact it has on lives. Most of them have children and they have a sense of concern and commitment to the feelings that children have. They want to promote programs that have a positive image.

After putting together the youth volunteer program, I took the idea of developing a program dealing with missing children to the White House. I said that we could make a difference and I think you can see today, from the seeds planted in 1983, that we have made a difference. We worked with John Walsh on the movie, "Adam," a film about a missing boy. On the day the movie was to premiere in Washington, he came to see me in my office. He said, "All right, Barbara, I don't have much time today, but here are three questions -- what are your plans, what can you do and how much money do you have?"

I said, "John, that's very simple. I'll work backwards. I have no money, but here are the plans and here's what we can do." If you know there is a problem, get the seeds planted, say something can be done, go after it in a positive way, then there is no question but that you can make a difference. The issue of missing children is probably one of the most visible issues on the market today. Everyone is aware of it and the corporate sector is excited and anxious to get involved. In many instances it is called child safety, because the wording of the program is very important, especially when you are endeavoring to elicit financial support. Funders want a positive image. The negative program does not appeal to them. When you are putting your programs together, think about how you can present a positive approach to a negative problem.

The day before the premiere of "Silence of the Heart," I had been invited to meet with two Senate offices to discuss putting together a program on youth suicide. When I met Charlotte Ross at the premiere, I was introduced as the woman who put together the missing children program. Charlotte's response was, "I sure would like to have a program that successful."

My reply was, "You may get it. I just had discussions with the offices of Senators Denton and Spector and they would like to see something happen that would address the problem of youth suicide."

As you can see, it doesn't take a lot of people to make something happen, it only takes committed people. In fact, if you look at any organization, from church groups to civic groups, there are usually 25% who are the worker bees, then there are those who will find all the reasons that the program can't be done, and then you will find supporters. Don't wait for someone else to do it. If you see a need, fill that need. There are people out there who will take guidance, they aren't the leaders, but they have contacts and it may be just the contact you need. You must have a contact within a company. Everyone counts. There must be a personal approach. You have to be a salesman for your cause. You or your spokesperson must go in with enthusiasm, the right attitude and the right approach, if you are going to sell

someone on an idea. You must be committed in order to make a sale and you are talking sales when you are going to the corporate sector for help and involvement.

Anything is possible and it doesn't take many people to make a difference. I think that if you have a commitment, you are sincere about the issue, and you are secure in what you are saying, you will make a difference.

SUICIDE INFORMATION AND EDUCATION CENTRE

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A concern of society for the tragic loss of its youth through self-destruction is neither new nor unique. In the 19th century, continental Europe wanted to ban Goethe's "Sorrows of Young Werther," for the text was believed to have stimulated a rash of imitative suicides in young men. Early in the 20th century, there was a discussion about the "epidemic" of adolescent suicide during that era, with some of its origins attributed to the introduction of the comic book. Two features make the issue of youth suicide seem larger and more important in our present time. With a larger population, there are simply more suicides occurring even if the actual rate of suicide has not appreciably changed. In addition, the modern electronic and print media provide access for their viewers to a much larger pool of available information about suicide. The attention of an entire nation and continent can be focused on Plano, Texas; Loveland, Colorado; Westchester, New York; or Wind River, Wyoming to make us all more aware of the problems and terminal solutions of today's troubled youth.

This exposure to suicidal behaviors, whether experienced directly or through media awareness efforts, has generated both interest and concern. A commitment towards prevention activities has appeared not only in professionals and other caregivers, but also in those who were not previously sensitized to the problems of self-inflicted death in the young. These include: significant others to youth, especially parents, groups of gatekeepers and caregivers, legislators and planners who are responsible for the community's efforts to protect and support itself, and finally the young people who are themselves included in the at-risk population. These diverse groups need some means to translate awareness and concern into programs of effective action which will reduce the likelihood of suicidal behaviors in the nation's youth.

In one effort to address the entire issue of suicidal behavior, the Government of Alberta has supported a group of projects addressing research, information and education, and clinical and community activities (Tanney, Ramsay & Boldt, 1983). The underlying strategy linking these different areas involves the effective use of available information about suicide (Tanney & Ramsay, 1984). The approach includes and promotes interchange between the research and clinical areas. The Suicide Information and Education Centre (S.I.E.C.) is a focal point in this process of information interchange, acting as a clearing house for information, communication and education. Funded in 1982 as a project of the Canadian Mental Health Association, it is supported by the provincial government Advisory Committee which coordinates government initiatives in the area of suicide prevention.

Including this project as part of a strategy for suicide prevention implies that available information about suicide is not being used effectively. Surveys of the knowledge base of caregivers, mostly medical practitioners, indicated that errors, often of commission, were not uncommon (Rockwell & O'Brien, 1973; Reid & Smith, 1980). In 1981 the World Health Organization indicated that a first priority for suicide prevention activities was the provision of training in the detection and management of suicidal persons for helping persons. Caregivers themselves have clearly indicated a need to "know more" (Stoudemire, et al., 1982-83) and 50% of the caregivers involved in an Alberta pilot project for suicide education indicated that they had had no prior formal training in the topic area. These studies confirmed the need for an information source about suicidal behaviors that would be readily available to users with different levels of expertise. The S.I.E.C. meets this need in its primary goal of providing comprehensive and adequate information to any interested users.

COMPREHENSIVE INFORMATION

Some definitions of what is and is not appropriate in an information data base about suicide are needed. Relationships between violence and suicide, and the inclusion of materials involving indirect self-destructive behaviors are two important boundary considerations. Drug overdose and substance abuse are important topics in the area of youth suicidal behaviors. Limits on the collection of data in the vast area of drugs and toxicology to materials appropriate and relevant to suicidal activities have been established.

In its collection policy, the Suicide Information and Education Centre aims to make available all English language documents related to suicidal behaviors which have been produced since 1955. A number of printed bibliographies which summarize the literature of suicidal behaviors at a certain date are available. (Farberow, 1972; Prentice, 1974; Poteet & Santora, 1978). At the present time, a minimum of 30-40 new printed materials about suicide behaviors appear each month. In mid-1985, the collection at S.I.E.C. numbers more than 7,500 documents. Of the 1,270 documents which deal with issues of suicidal behaviors and the age cycle, almost 80% are focused on the issues of suicide in children, adolescents and youth (Figure 1).

In the information collection of the S.I.E.C., over 12 different types of documents have been identified, e.g., books, films, proceedings, articles, dissertations. This includes more than 25 audio-visual productions about adolescent suicide. These are mostly short, 12-25 minutes, produced since the mid-1970's, and designed to initiate or trigger a broader discussion of the topic. In the years 1980-85, at least six feature films on adolescent suicide were produced. As yet, no film has addressed itself to the group of young men 20-29, in whom the largest increase in the rate of suicide has been recorded over the past two decades.

In the effort to establish a comprehensive collection, one area has been excluded. The materials of EXIT and the Hemlock Society are not part of the information which can be accessed through S.I.E.C.

The information data base at the S.I.E.C. includes more than the formal scientific literature of citations and textbook references. S.I.E.C. also tries to collect the "ephemeral" literature, including lecture notes, pamphlets, promotional materials and educational programs. Solanto's (1984) contribution outlining "The Days After: A School's Response in the Aftermath of Sudden Adolescent Death" is a resource which shares an effective postvention strategy. As part of a concerned community's response to youth suicide, it is an example of the sharing of experiences which characterizes many of the program materials in the collection. Finally, S.I.E.C. is aware that human experiences are the largest source of information about suicide prevention efforts. One of the Centre's main objectives is to encourage and to facilitate networking between and among those who create and those who might use information about suicide and suicide prevention.

FIGURE 1

The Literature of Suicide and the Age Cycle

Age Group	No. Documents (May 1985)	
Aged	163	
Middle-Aged	12	
Adults	93	
College & University	164	
Adolescents	596	(79%)
Children	242	
	1,270	

FIGURE 2

Major Headings in the Hierarchical Classification of Suicidal Behaviors

The Personal Condition — Epidemiology — The Societal Condition

Classification — Demography

Natural History	Caregiving Processes Assessment Intervention Postvention	Theoretical Perspectives	Aspects of Suicide

AVAILABLE INFORMATION

If information is to be used effectively in planning and promoting suicide prevention activities, it must be rapidly accessible and meet the user's specific needs. This requires some framework for organizing the mass of information within the topic area. A controlled list of subject terms is used to describe each item of information in the collection. A Thesaurus defines and offers synonyms and linking terms for each of these subject terms. The breadth and diversity of the information which is available about suicide behaviors is emphasized by the need for over 660 terms to fully describe the subject area. The grouping of these terms in a nested Hierarchy (Figure 2) offers a plan for studying the entire field. This map of suicidal behavior broadens the perspectives of S.I.E.C. users by encouraging a survey of all areas involved. As well, it permits users to make more specific requests for the aspect of suicidal behavior which is of particular interest to them.

Organizing the field of suicidal behaviors through this descriptive mapping is only one aspect of availability. Another function involves the access, retrieval and distribution of the information itself. S.I.E.C. operates as a special library in the content area of suicidal behaviors. Instant access to information in its collection is available through an online catalogue which describes every document in the collection with an individual entry (Figure 3). The catalogue is computerized for rapid access from anywhere in the Americas, Australia or Europe by any computer terminal with a modem telephone connection. Registered users are provided with a password, a user's manual, and a copy of the Hierarchy and Thesaurus of Subject Terms along with suggestions for search within the system. The catalogue of documents can be computer searched in nine different fields, along with free text searching for specific words in both the title and abstract. In searching the content field, up to 20 subject terms can be combined to narrow the focus of information which is being requested. This means that a user could request all documents con-
children and adolescents and family problems, or those discussing family problems in adolescents and not children, or those discussing family problems in children and not adolescents, along with up to 17 other specifying criteria.

In addition to their inclusion in the catalogue, documents may also be organized into special collections as part of S.I.E.C.'s clearing-house function. These include curricula of educational programs, pamphlets, posters, and public service announcements about suicidal behaviors. A recent project developed a computerized inventory of all Albertans

FIGURE 3

Description of a Document in the S.I.E.C. Catalogue

Accession Number	:	831248
Author	:	Maris, R.W.
Title	:	Suicide in Chicago: an Examination of Emile Durkheim's Theory of Suicide (Microfilm HV 6548 V52C43 1965)
Date	:	1965
Source	:	Thesis (Phd) - University of Illinois, p 243
Location	:	ACU (Alberta Calgary University)
Subject Term(s)	:	Demography Social Integration Ecological Studies Socioeconomic Status Time of Suicide United States. Illinois
Document Type	:	Thes
Abstract	:	

who are interested and involved in suicidal behaviors. S.I.E.C. holds a copy of each document within its collection, and makes these available through a document delivery service. It is not economically feasible to make the full text of each document available online.

ADEQUATE INFORMATION

Present English language information available about suicidal behaviors is simply not sufficient to answer all inquiries concerning suicidal behaviors. For the information that is available, the Centre offers open access to all users, and encourages computer-assisted access. There is no restriction of materials in the collection based on either assumed level of user expertise or type and content of the document. A full time Information Officer is available to facilitate requests for information. At present an average of five information requests per day are received from the Alberta population of 2.3 million potential users. By monitoring user requests, a number of specific information services have been developed:

1) A calendar of suicide prevention related events, local, national and international, is maintained online, as a bulletin board function.

2) A monthly Newspaper Clipping Service is available by subscription.

3) Current issues and information in the area of suicide behaviors are included in the "Current Awareness Bulletin," a quarterly newspaper.

4) Although essential documents are highlighted and summarized in the "Current Awareness Bulletin," full-text copies are made available for widespread distribution. One of the most popular is "The Youthful Suicide Epidemic," a presentation in the Public Affairs Report Series from Berkeley, California (Seiden, 1984). Another is a University of Minnesota pamphlet, "The Issue of Suicide" (Rickgarn, 1983) concerning suicidal behaviors and their aftermath in the college and university population.

5) A catalogue of audio-visual materials is in final draft prior to publication.

6) Collections of documents, with a specific topic and audience focus are made available as kits. A kit includes an introduction and summary, three to five

of the most useful and effective documents in a content area, and a supplementary reading list with S.I.E.C. catalogue access numbers included. The first of these kits has been developed in the content area of adolescent suicide. A special guidance counselor's version is presently available, with both student and parent packages also planned.

7) There has been a recent explosion in the number of public information materials which are available concerning adolescent and youth suicides. There is much repetition in these materials, especially in the area of facts and myths about suicide. S.I.E.C holds an extensive collection of these materials with the intention of developing an updated and comprehensive series of public education materials in this area.

These specialized information services and products have been developed in response to user requests and interests. The main work of S.I.E.C. continues to be ensuring rapid access to information about suicidal behaviors through focused, specific and computer-assisted searches.

SUMMARY

S.I.E.C. exists as a link in the chain of those who create, manage and use information about suicidal behaviors. To be successful, it requires a willingness to interact among its many types of users. The Centre does not generate new information about suicidal behaviors, but facilitates the use of information by different types of users with different needs and requests. Because there is always more information being produced, S.I.E.C. has ongoing and evolving functions. The sheer maintenance of this clearinghouse function is not a small project. The expertise of multiple disciplines is required, including specialists in suicidal behaviors content, library function and design, computer software development and maintenance, community consultation, and public relations and marketing.

As the prototype of an information clearinghouse in the area of suicidal behaviors, S.I.E.C. could support the development of similar activities in other systems. Because any computer in North America can access the information collection of S.I.E.C., it is more effective to involve these other systems in an active information network than to reinvent the suicide information and clearinghouse function in a variety of other settings.

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School Programs

"HOW DO YOU EAT AN ELEPHANT?? ONE BITE AT A TIME!"

Peter Alsop, Ph.D.
Educational Psychologist
Topanga, CA

I write humorous songs. I don't have any about suicide. I don't think it's a very funny topic. It is possible, however, for music and the other arts to get people's attention, and then to educate them about some of these relevant issues.

Educating about this subject is a big task. Did you ever hear that old joke "How do you eat an elephant?" It's a question I ask myself whenever I'm facing a seemingly overwhelming task. The answer is, "One bite at a time."

There are many different influences in our culture and in our upbringing that conspire to make us goal oriented. As adults, we've learned to interact with the world around us while we concentrate on other tasks. We think about future possibilities or reflect on past occurrences. We spend a lot of time living in our concepts. We're not really there a lot of the time, because of "how" we've learned to live. We need to be more aware of our process.

In our schools, we teach an idea that no one comes out and says directly. It is that "Every question has a right answer." That message is implied in every test we take. There's an emphasis on "coming up with an answer." Our school systems, our families and our churches can sometimes turn us out with attitudes that I consider to be "static." When we are faced with a problem or a question, we feel an overwhelming need to reach a "stasis" or a balance before we can go on. We need to feel comfortable, so we grab for the simple answer.

When we expect simple answers, a lot of hidden things go on in our heads that can create social ills. We stereotype other people. "Why is this person upsetting me? Oh! Because he's a JERK!" or "That's just the TEACHER," or "He's a RED-NECK!" or "This kid's EMOTIONALLY DISTURBED." Categorizing doesn't allow other people to be more than what we expect them to be, to be all they could be, to us or themselves.

Where do we get these attitudes? School is just one place.

Another major contributor of hidden messages and attitudes is the television, "the simple answer box." There are some very important things about television you may be missing.

(Song) Ya Get a Little Extra When Ya Watch T.V.*

Peter Alsop

Chorus:

You get a little extra when you watch T.V.
Ain't that ducky! Well you're lucky if you see that
You get a little extra when you watch T.V.!

You sit too close and you get a big surprise
Lots of radiation in your body and your eyes
And your eardrums hum when someone turns it up too high,
When you watch T.V.!

We learn lots about our bodies and our aches and pains,
Headaches, hemorrhoids, heartburn, diarrhea, denture stains,
Gotta buy more drugs t'stop our stresses and our strains
When we watch T.V.!

Chorus

When someone in an advertisement tells me lies
I jump up and switch the channels, so I get some exercise
And my body's getting healthy while my mind is getting wise
When I watch T.V.!

Daddies only love the Mommies when the dirt's all gone
From their shirts and shiny floors, the coffee has t'be right on
I'm so glad my Dad's not fussy, cause he'd leave my Mom,
If he watched T.V.!

Chorus

In real life it never works when people go
And hit and kick and punch and smash each other's heads and toes
But it always solves the problems on the cartoon shows
When you watch T.V.!

Last night on the highway when our car got stalled
We saw a bloody accident with bodies that were mauled
Though my folks got sick, it didn't bother me at all.
Cause I watch T.V.!

Ya Get a Little Extra When Ya Watch T.V. (Continued)

Chorus

If you think that I am lazy, don't you call me names
I have learned important skills from playing video games
If a spaceship should attack us, I could shoot'em
down in flames,
Cause I watch T.V.!

Yeah, a big T.V. can really give you quite a rest
If you get one near your bed, you've got no reason to
get dressed
You never have to talk to anyone, your life is a success
When you watch T.V.!

Chorus

On television, if you don't feel well, you take a pill. When you come home from a hard day at work, a hard day at elementary school, "It's Miller time!" We find many suicides are drug or alcohol related.

The question is, "How do I get to feel better?" The simple answer is, "Take a pill!" If that doesn't work, try something stronger. Being alive in the world is more complex than that. We need to be able to live with saying, "I don't have a simple answer to this, but eventually something will come up. It will work out."

Understanding this is not just essential for kids, but also for health care providers, teachers, parents and other adults. We all do the same thing! We all want an easy answer. We've been trained in the same ways.

We have many wonderful educators in our schools, but I don't think that our school systems are really "educational" systems. "Educate" comes from the Latin word "educare," which means "to draw out, to nourish." Most often we find ourselves instructing. Instruction teaches people what to think instead of how to think. This happens because teachers are expected to have students at a certain level of proficiency by the end of the year. There's the goal, and we feel obliged to achieve that goal. As a result, we often focus on the goal and not on how we get there.

We should be aware that we have these goal oriented pressures on ourselves when we're working with young people, and we should notice when we're passing the pressures along to them. How do the kids feel? A lot of times they feel, "I'm not gonna make it. I'll never measure up," even though many of the young people who commit suicide are "A" students.

The arts are incredibly process oriented. Would you raise your hand if you started playing an instrument in school and

you're no longer playing that instrument? (About half of the audience raise their hands.) Why did you stop playing? I used to play the trumpet, but not anymore. My guess is that we quit because we thought, "There's no way I can really use this skill. Sure, I enjoy it, but I've got a lot of other things to attend to." If we don't see a goal, a reason, a simple answer, we stop pursuing the question. When we do this, we give up that valuable process of working to learn another song, of finally getting that melody we couldn't quite get, and feeling terrific and proud of ourselves when we got it! These small victories build self-esteem.

We can never dance the perfect dance. We can never sing the perfect song. We can only get better at it and see our own improvement in small ways. When Pablo Casals, the great cellist, was 76 years old, an interviewer asked him, "Well, Pablo, how does it feel to have mastered the cello?" He replied in Spanish, "Mastered it?! Why, I've just learned how to play the damn thing!"

We've learned to avoid investigating questions when we can't see what the answers might be. We use stereotypes that limit ourselves and others. Simple answers may make us feel a little safer, but it's an unhealthy sense of security. We force our limited concept of what we think will happen onto what is really happening because we're unsure of ourselves. We lock ourselves into specific, predictable patterns.

Here's a story about two frogs that fell into a cream barrel. They paddled around and around and around looking for a way out. The walls were too slippery, so they couldn't climb out, and after a while the first frog turned to the second frog and said: "I don't think I can make it! I'm exhausted! I'm gonna go under!"

The second frog said, "No! No, you can't do that! We've gotta keep trying!" But the first frog was totally discouraged.

"No," it said, "I can't make it! You'll have to go on without me." The second frog was alone.

"Oh no! What am I gonna do now?! My friend is gone and I'm never gonna get out of here!" All of a sudden, the frog felt something solid with the tip of its tce.

"What? What's that?" and it kicked and stretched and was just able to set its toes down for a second so it could rest and catch its breath.

"I've got to keep trying, even though it seems hopeless!" So it paddled and kicked and swam around some more, and paddled

and kicked and paddled, until suddenly the cream turned to butter. The little frog climbed right out!

If we can just keep working on the question, sooner or later an answer will come up! We stop ourselves.

There's an economic poverty in parts of this country, but there's another kind of poverty as well, a "poverty of heart." It's a spiritual poverty that happens when we don't really connect with each other. We've forgotten how to care about each other. People feel alone.

The range of the essential aspects of being human, the range of our emotions and feelings, has been pared down and narrowed by the choices we've made in the way we live our lives. Many of us live and work in environments designed for maximum efficiency and bottom line financial cost. We watch soap operas to get our emotional exercise while we don't take the time to really listen to our breakfast companions.

Helping people to ease their loneliness, to find some fulfillment in their lives, is complicated by the fact that there is a cultural bias in our country about the arts. Poetry, dance, theatre, music, literature, the very activities which nourish and sustain those emotionally rich parts of being human, are considered the most expendable when budgets are cut. Many of our teenagers leave poems as suicide notes. Perhaps we need to reevaluate our attitude about the arts in light of our immense loneliness. Our priorities need revising.

It is a popular theory that our human "left brain" functions differently than our "right brain." The left brain is supposedly analytical, cognitive and linear, our verbal hemisphere. The right side of our brain functions in a more intuitive, holistic and inspirationally creative manner. Our school system and our society as a whole values those skills which are predominantly centered in the left brain; reading, writing, arithmetic and science.

It makes sense to bring the arts back into our education, because it gives us a totality, a sense of completeness that we desperately need. We plan something, make it ourselves, and then get to use it when it is done. When you have created something or accomplished something, no matter how small or insignificant the end product, it was the process that was important.

Games that encourage skill building are offered to us in our childhood, at a time when we are expected to make mistakes and to learn by doing. When we try to blow a bubble or blow up a balloon, to spin a top or pump ourselves on a swing, to ride a bike without training wheels or to jump rope, we are facing the small risk that we might fail. As we keep trying, we succeed. We feel good and self-confident about ourselves. We become less afraid of failure and more willing and able to reach out for learning.

Juggling is wonderful because it forces you to rely on your right brain. When you begin, each step seems simple and your left brain comprehends, then suddenly, when you're throwing three balls at the same time, there's a mental leap. Your left brain short circuits and screams, "Egad!! I've got all these balls in the air! What do I do now?!" It wants a logical linear progression of commands so it can comprehends what is going on. When this happens, your right brain kicks in and does the juggling. It's clumsy at first, but there is an experience of "juggling" that comes to you and you just do it! It's that right brain insight. It's that step where we say, "Wow! I never saw it this way before!" I want kids who are at risk to make that step and say, "Wow! I never saw my life this way before!" That's what the arts can foster so incredibly well.

When something awful happens to you, there is one major question that comes up, "Why did this happen to me?" The most common answer we come up with is, "There must be something wrong with me. I must be no good. I'm a bad person." When you think and feel you're a bad person and other people aren't seeing you as a bad person and punishing you, then you do it to yourself. When you think of yourself negatively, low down, or as a victim, you're much more likely to let yourself be victimized again. Even when things are going well, we become uncomfortable with the unbalanced situation of knowing we are no good and knowing that we don't really deserve to have any good things happen to us. When the discomfort gets too great, we create more problems for ourselves.

Hundreds of thousands of kids see themselves as victims. They have a low, negative self-image and little or no self-esteem, and they need help changing. It's not only the kids, many adults have the same difficulty.

It seemed like a good idea to use humor and music to build self-esteem and to educate about grief and loss. Grief and loss, conflict resolution, loving and human sexuality are all sensitive areas that are difficult to open up and talk about. When young people become involved in these areas, they often have no preparation or frame of reference to cope with the experiences. They have no idea where to go for support or guidance. They simply can't cope, and sometimes life no longer seems worth living.

Here's an example of a song I use to break the ice in talking about death. Many times childhood losses seem insignificant to adults, and we pass up valuable opportunities to help educate our kids when they are most involved.

(Song) My Brother Threw Up On My Stuffed Toy Bunny*

Barry Louis Polisar

Chorus:

My brother threw up on my stuffed toy bunny
You better not laugh cause it really isn't funny
It was lying in my bed while I was sound asleep
But it could have been worse, yeah, it could have
been me!

My bunny's name was Bill and he was pink and white
His eyes were purple and they glowed at night
His ears were ragged and his nose was red
He was soft as my pillow from his paws to his head
And then,

Chorus

Well, Dad tried to help when I started to scream
He threw my bunny in the washing machine
But my bunny Bill still smells so bad
And I lost the best friend that a kid ever had
Because,

Chorus

My bunny now sits on my shelf at home
Next to my smelly toy telephone
And the dirty old bear with the stains and the spots
Cause my little brother throws up a lot! Yeah,

Chorus

Death is often a subject that adults have trouble talking with children about. It helps to be able to play a funny song like this, and then talk about some serious things. By using music and humor, the issue becomes less threatening, and being able to talk about it alleviates much of the tension that gets built up around the general issue and the personal events themselves.

One of the benefits of humor is that it can reframe the way we see the world. Spontaneous humor is appropriate to the moment and requires a non-static approach to whatever difficulties or problems come up. A "dynamic" attitude and approach to life is called for.

Some comics will throw a barrage of static simple one-liners at an audience, hoping something will get a laugh. A good comedian, on the other hand, works dynamically, inserting just the

right one-liner into a situation, lifting it out of the ordinary, giving us a crisp right-brain insight and making us laugh.

As we grow out of childhood, we learn to use language and symbols to explain our thoughts and our experiences. We also learn to take our concepts of reality as reality itself. Each of us has eaten with friends or relatives and been miles away, thinking of something else at the same time. We were not really there experiencing the meal at all. Ashley Montague says, "When we take the concepts we use for reality as reality itself, it's like walking into a restaurant and eating the menu!" It's time to examine the menus we've been eating and then find ways to reframe those ideas we've swallowed that are unhealthy for us.

(Song) No One Knows For Sure*

Peter Alsop

There's a camel in the desert who could really use a drink
Her hump is all dried up and her name's Irene, I think
If she doesn't get some water, or some juice or soda soon
I don't think she'll last much longer,
I don't think she'll last till noon
And the sun is burning brightly, and the desert sand's so hot
And Irene's so awfully thirsty, she might die right on the spot!

Chorus:

But no one knows for sure, something might come along
That could save the day and help her out
And fix whatever's wrong.
Cause no one knows for sure, we've still got time to hope
And Irene might see a giant milkshake over the next slope!!
Well, she might if she keeps walking!
Cause no one knows for sure, no one knows for sure!

There's a monkey named McCaffree who's lived a long, long time
And he's got a broken tail that makes it pretty hard to climb,
So he's careful in the jungle when he climbs where monkeys go
But he missed a vine and fell into the river down below!
And the crocodiles surround him, and McCaffree, he can't swim
And he's driftin' toward the waterfall,
Guess that's the last we'll see of him!

*Copyright 1983, Moose Stool Music (BMI). Lyrics used by permission.

Chorus:

But no one knows for sure, something might come along
That could save the day and help him out
And fix whatever's wrong.
Cause no one knows for sure, we've still got time to hope
And McCaffree might see Wonder Woman and she might have her rope!
Cause she usually carries one with her, doesn't she!
And no one knows for sure, no one knows for sure!

There's a kid I know named Evelyn, one of my fav'rite friends
And they put her in the hospital, for testing once again
And the Doctors and the grown-ups,
Well they were sad when they were through
They told her she was very sick, no one knew what to do
To make her feel better, so she could run and play
And Evelyn knew that she might die, but she'd look at me and say!

Chorus:

But no one knows for sure, something might come along
That could save the day and help me out
And fix whatever's wrong.
Cause no one knows for sure, we've still got time to hope
And maybe Dr. Seuss and me'll invent a Super-Dooper kind of soap!
And I'd wash behind my ears even, cause no one knows for sure,
No one knows for sure, no one knows for sure!

We must learn where people are coming from, how they see the world before we decide what's best for them. We should omit no options for opening communications, whether it's tribal dance or stories or mime, humor, music, theatre, poetry or rock and roll. The arts are a vital key to unlocking people's terrible isolation.

I think it would be great to have the kids at a school write and put together a play about suicide in order to help communicate to their parents how they and other kids are feeling. Once the teachers and health care providers are aware of the problems and signs, then the parents and their children can begin to talk about some of the issues. The goal, of course, is to stop the fatalities, and the growth value comes from the process of putting on the play as an educational community event.

Our work is to raise public awareness about the importance of the arts in our lives. We need to do it for ourselves, to

examine and redefine our own cultural biases, and more importantly, we need to do it to enrich the existence of those young people who are still vibrant and alive, still asking the questions to which there are no easy answers. We can dine on "the elephant" together, one bite at a time.

CALIFORNIA YOUTH SUICIDE PREVENTION SCHOOL PROGRAM

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In 1979, I was asked by some parents in the local PTA in Los Angeles to come to one of their schools and do a program for the students. I'd been doing programs for years for teachers and parents, but not in the classroom for the students. I accepted the challenge. Borrowing from Charlotte Ross in Northern California and from my own experience, we put together a program for a high-school in Los Angeles.

The first question I asked the class was, "How many of you 15-year-olds have ever, recently, or at any time, have had told to you or communicated to you by a friend, that they have been thinking of suicide?" One-third of the class raised their hands.

I said, "It must have been just one student. One person talked to all of you." They told their stories. Not only wasn't it one student, but when I asked them,"What did you do when the friend told you?", the responses I heard were terrifying.

Some students said, "Go ahead and do it. See if I care." One said, "I thought I psyched him out." Others went home and stayed home for a week because they were afraid that if they returned to school, they would find their friend missing, perhaps dead. Others couldn't sleep. Some were afraid to tell anyone because their friend had told them to keep it a secret. I was very impressed at the enormity of the problem.

We began doing the program at other schools. We went to inner city schools. The figures were about the same, 30-40%. We went to rural schools, suburban schools. Again, the figure was about the same; 30-40% of these students were constantly inundated by suicidal friends. At one time, I calculated that in Los Angeles County, if you're talking about secondary school students, you're talking about 250,000 students a year who are receiving suicidal communications. More recently,

I've encountered 12-, 13-, and 14-year-olds at two junior high-schools where there have been 12 suicide attempts since the school year began; in another, there were 22 suicide attempts in the same period. Many of them occurred on or around campus.

In 1980 the California State Legislature held hearings on youth suicide. A committee was formed and out of the committee there came legislation, Senate Bill 947, the California Youth School Suicide Prevention Program, designed to develop a curriculum and implement the curriculum in the schools in the State of California.

We began in 1984 by reviewing other work that had been done and trying to put together a series of programs that would meet the needs of the students. Who wanted these programs in the schools? The parents and students were in the forefront. Everywhere we went, the parents said to us, "We want you to come into our schools and help our students. We don't know what to do."

The students said to us, "We need it. We have to have something like that in the schools." We weren't dealing with the traditional mental health bureaucracy, nor the traditional educational bureaucracy, which don't ordinarily take active, powerful stances on issues such as this.

It's the parents and children who are hurting, who took the powerful advocate stances, saying, "We want this program for us. We need it."

The curriculum is designed in the following way: a series of five classroom sessions for students; a teacher training education; and a parent awareness session. The curriculum can be taught in any classroom, e.g., health education or social studies, depending upon the teacher's training and desire to become involved in teaching about suicide. There is special training for the teachers.

The focus in the classroom is simple, to help the students begin to understand themselves and the stresses they live with. We want to help them understand depression. We want them to know how to cope with everyday depressive feelings and with clinically depressive feelings. We want them to understand this important message, "Suicidal feelings pass. No matter how bad the pain, it passes. Suicide is a permanent solution for a temporary problem." This point is repeated throughout the curriculum.

Students, when they become suicidal, usually don't go to their parents, teachers, school psychologist or administrator for help. They don't go to their clergymen or family doctors. They go to their friends, the people who are least prepared to do anything about it. We want to teach these friends, these peers, how to listen, how to express concern, how to

understand that they mustn't promise to keep it a secret. Their primary responsibility is to get that person to adult help as soon as possible, and we want to teach them how to do it.

The teacher training/education component of the curriculum is designed to teach educators how to recognize suicidal clues and how to appropriately respond by getting the person to help. An element stressed in the parent awareness training is: "Don't be defensive. It's not your fault. The important thing is to recognize it, be open and to get that youngster some help. We will provide you with the resources. Don't be guarded. Don't be defensive." That message has to be gotten across to parents and is more important than any other single message. We want to be able to teach schools, as a whole, how to be able to respond to an emergency, how to set up a crisis program, how to become involved when a suicide does occur, and how to educate staff and students on how to respond.

The final aspect of this program is an evaluation component. When we are finished running the pilot programs and when the schools have offered the curriculum in their own way, we want to be able to tell if the students were helped by it. Ultimately, we hope a program such as this one adopted in the California schools will perhaps be utilized nationally, thereby impacting and lowering the youth suicide rate.

A TRAINING MODEL FOR SCHOOL PERSONNEL

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Years ago youth were dying from contagious diseases. Today they are dying sudden, violent deaths, most of which are self-inflicted. Although no single theory can account for all suicides and no single measure can prevent all of them, experts agree that suicide can be reduced through organized preventative programs.

Since schools provide such a critical social/educational experience for most adolescents and maintain such constant contact with youth, schools have become the focal site of most preventative efforts. Most programs across the country have concentrated on delivering awareness training and student curriculum. The awareness training usually consists of a two to three hour session offered to school staff, parents, and other interested community members. The goal of most programs is to sensitize staff to the warning signs of suicidal youngsters. The student curriculum has similar goals with the added task of breaking through adolescent loyalty codes, in efforts to get peers to turn to adults when they know of a suicidal friend.

Although these programs have been noted for their effectiveness, concern has been raised about the ability of schools to manage suicidal crises once consciousness has been raised. Institutions, like individuals, are reactive to suicidal behavior. At times, this reactivity can lead to mismanagement. Schools need to know what to do and how to respond when at-risk students are identified. Concrete policies, organizational strategies, and skilled internal resources need to exist within a school to maximize prevention efforts.

It was this philosophy that motivated the Suicide Prevention Project of the University of Medicine and Dentistry of New Jersey-Community Mental Health Center of Rutgers Medical School, to develop a prevention program that specifically focused on training those school staff who are the key

internal resources. A program was developed for the special service staff, school psychologists, social workers, nurses and guidance counselors, to train them in assessment and crisis intervention. Three guiding principles influenced the design of our program:

(1) A strong belief in the need to address both the cognitive and affective aspects in teaching suicide prevention. It is not enough to know about the warning signs or to know how to intervene with suicidal youth. One also has to be in touch with and in charge of one's feelings. Anxiety and fear of managing a suicidal crisis can immobilize professionals and lead them to over or under react, regardless of their knowledge base. As such, our program gives equal weight to the cognitive and affective components involved in the learning process and structures course material to facilitate both.

(2) If school staff are to be effective in preventing suicide, then they need to be taught in a way that would maximize the learning process and ensure the transfer of knowledge to their work setting. Therefore, our course was designed as a "how to" course, to build concrete skills. A variety of teaching devices are used throughout the course and exercises are created to give staff "hands on" experiences.

(3) If suicide prevention is to become a contrived effort once the "experts" leave the field, then a course must address system issues which impact on the management of suicidal behavior. Thus, emphasis is placed on helping schools to devise internal support networks, to develop linkages with outside agencies, and to evaluate policies and strategies for the management of suicidal behavior.

With these underlying biases, we developed an intensive crisis intervention training program for special service staff. The program consists of a two hour, eight week course which is delivered on-site. This model has also been adapted into a two day intensive workshop, as an alternative format. All sessions follow a pattern of combining didactic presentations with an experiential component. From the beginning, participants are assigned to small groups in which they remain for the length of the course. Most sessions begin in the large group with a guest or staff lecturer presenting on a designated topic. Lectures are approximately one hour long and incorporate different audio-visual materials to demonstrate points and to stimulate thoughts and feelings. Following the presentation of cognitive information, members meet in their small groups and are given tasks directed by trained group facilitators, to practice skills and to explore further specific personal/professional concerns. Topics covered in the course include: overview of adolescent suicide; youth suicide and society; assessment of suicidal risk; crisis

intervention; enlisting family support; mobilizing the peer system; and organizational strategies for suicide prevention.

In offering this training to a variety of schools over the last two years, we have learned much about delivering prevention programs. There are several key factors that need to be considered in creating effective school based programs:

(1) It is important that training focus on demystifying the intervention process. School staff have shared that one of the most valuable aspects of the course was seeing various "experts" role play different situations, e.g., role play interviewing a suicidal student. Furthermore, it was also helpful to have other professionals share their own anxieties and concerns around intervening. As school staff began to view assessment and intervention as a skill which could be acquired, they became more confident in their own ability to be effective.

(2) It has been our experience that schools should make the course voluntary, not mandatory. It is critical to stress that not everyone is comfortable with the topic of suicide. Throughout the course, we strongly advocate the "second opinion model," that is, the importance of calling a colleague when one is unsure of their judgment on a particular case. Participants have reported that this philosophy was instrumental in helping them to overcome the overwhelming sense of responsibility that is often attached to intervening with suicidal youngsters.

(3) When possible, we have found the eight week on-site course to be more beneficial than the two day workshop. Eight weeks allows participants to assimilate the information more thoroughly and to try out their skills and bring back to the group any concerns they had. An added benefit of the eight week course is the development of an internal supportive network within the school. In general, programs have to consider the feasibility of schools being able to offer such intensive training. To date, schools in our area have been willing to invest in such training. Administrators have recognized that the skills special service staff acquire ultimately will facilitate their work with all troubled youth, not just suicidal ones.

(4) In offering the course, we have found that two topics in particular consistently raise the most anxiety in school staff. Overwhelmingly, school personnel feel the most anxiety over contacting and working with families of suicidal youth. It should be emphasized that the course does not attempt to make school staff into therapists. However, school staff need to be able to approach family members when they are concerned about a student and facilitate a referral. The second factor which

consistently raises anxiety is talking with students and learning to directly ask students if they are suicidal.

(5) As a result of working with schools, there is a dramatic increase in at-risk students being identified and referred for therapeutic services. Therefore, in offering prevention programs, it is critical that a strong collaborative relationship be developed between the local mental health agency and the school.

(6) The last factor that is critical to remember in delivering such programs is the high probability that several participants will be depressed and suicidal. Every time we have offered our course, we have intervened directly with staff who were suicidal. Therefore, trainers need to be sensitive to the impact of materials on participants and need to be prepared for crisis within the course.

School based prevention programs can make a difference. As programs are developed, however, we have a responsibility to begin evaluating them and examining both the possible benefits and harms inherent in our efforts. Unless we critically evaluate our programs, we run the risk of adding to, not solving, a problem.

THE SCHOOL AND YOUTH SUICIDE

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A little over 5,000 of the 20,000,000 teenagers in America have been committing suicide each year for the past several years. The percentage is double what it was 25 years ago. Why would a teenager, who has the good fortune to grow up in the greatest country in the world, take his own life?

Long ago a poet boasted, "I care not who writes my country's laws so long as I can write its songs." A look at our nation's songs can tell pretty well what is in the hearts of those who sing them. When I was a teenager in the Big Band era of the 1940's, the popular songs had lyrics expressing happiness, the joy of living, optimism in the future, and sex only in terms of romance and enduring love.

If you listen to today's rock music, the big question really is, why do we have so few teenage suicides? Rock music lyrics are filled with talk of suicide, death, depression, loneliness, sex and drugs. It's pretty clear that anyone who cares about preventing teenage suicide must, first of all, address the problem of rock music.

This generation's music tells young people there's no future, no hope. The music expresses paranoia, depression, anxiety, despair, escape through drugs, and a negative attitude toward life. The lyrics say, "What's the use?", "Have fun now, for tomorrow we die." Rock themes are persistently and perniciously nihilistic.

Pink Floyd, a successful punk rock group, sold 12 million copies of its album, "The Wall," featuring the theme of suicide, despair and death. One title, "Goodbye Cruel World," was on the top-selling lists for 17 weeks in 1980. Two 15-year-old Leominster, Massachusetts girls left suicide notes that quoted lyrics from "The Wall." They wrote, "Goodbye cruel world, I'm leaving you now ..."

Melissa was another tragic case. The album on the family stereo when Melissa committed suicide, Aerosmith's "Rocks," contained a song entitled "Sick as a Dog."

Blue Oyster Cult has a record called "Don't Fear the Reaper." It convincingly entices teenagers to join in a romantic suicide pact.

The Cars, a new wave group, has a song called "Since You're Gone." The lyric goes, "Since you're gone, I'm throwing it all away. I can't help it. Ev'rything's a mess." The recurring theme is that life is not worth living after a loved one has gone.

Black Sabbath song titles include "Electric Funeral," "Hand of Doom," and "Nativity in Black." A White Cross lyric asks "How much more can I take, before I make my last mistake?"

Prince has an album called "1999." He sings, "War is all around us. My mind says prepare to fight. So if I gotta die, I'm gonna listen to my body tonight." Oral sex, masturbation and incest are themes in other songs on this album.

Ozzy Osbourne's lyrics are all graphically pornographic and suicidal. His song called "Suicide Solution" ends "Where to hide? Suicide is the only way out."

Led Zeppelin is obsessed with the occult. Judas Priest has graphic sado-masochistic themes. The Rolling Stones are openly satanic and encourage perversion.

Unfortunately, some schools even glorify these rock stars in textbooks. The state of Florida has a textbook approved for remedial reading, grades seven to twelve, called "Superstars of Rock." It glorifies rock stars and takes the child through exercises designed to have him learn in detail about the rock stars and their songs. In some areas, schools have played rock videos in the cafeteria during lunch or rock music on the school bus, and parents have had a terrible time getting it stopped.

The Hearings conducted by the U.S. Department of Education across the country in seven cities in March 1984 offer a fertile field for investigation of how classroom curricula contribute to teenage depression, despair, lack of hope in the future, and even suicide. At these Hearings, several hundred parents gave witness to their first-hand experiences with classroom courses that depressed and alienated their children. The preoccupation of classroom courses with suicide, death, dying and similar morbid subjects would be hard for an adult to take, but is devastating to teenagers.

Witness Anne Pfizenmaier told how her child was given an eighth grade English textbook which instructed the students to "write a suicide note." The book gave the following sample for the student to copy from. "I am finally going to do it. Unemployment drives me crazy. Inflation makes me angry. The cost of living turns my stomach. Big business raises the cost of candy and gum. Teachers expect too much. School takes

away my freedom. I can't communicate with my parents. My parents don't understand me. I have said my goodbyes. I fought a good fight, but I have met defeat."

Cris Shardelman was one of many witnesses who told how her children were subjected to numerous requirements concerning death-related subjects, including having to write their own epitaph. She said that at least one suicide was the result of teaching a section on suicide in the mental health course.

Witness Doris D'Antoni told how first-graders were required to make their own coffins out of shoeboxes.

Witness William Dean Seaman told how his children were taught that death is an ultimate end, glorious in itself. He stated his belief that the attitudes pressed and impressed on students have promoted suicide, as well as teenage pregnancies and abortions.

Gail Bjork testified that her seventh grade daughter was given a questionnaire in Health class which required the child to give her views about life after death. She was asked, "What reasons would motivate you to commit suicide?" Five reasons were listed from which she was required to choose. Her child was then given a list of ten ways of dying, including violent death, and required to list them in order of "most to least preferred." The child was asked what should be done to her if she were terminally ill. Two of the five choices on this questionnaire were euthanasia.

Witness Flora Rettig told that, after her son committed suicide, she went through his papers and found proof of the depressing, despair-producing materials he had been taught in high school. Her son's school notes included references to psychic experiences, ESP, psychokinesis, astral projection, dream analysis, suicide, and drugs. She found proof that the drug education course he had taken in high school did not tell him that drugs were wrong, but on the contrary, taught about drugs and told the student to make his own choice in using them. Mrs. Rettig then went through the books her daughter was using in the same school and found one that was a "how to" manual to the occult world, transcendental meditation, and yoga. She came to the conclusion that the classroom was being used like a clinic for the mentally ill, with teachers acting as unlicensed psychiatrists.

Many other witnesses told how their children had been alienated from their parents, divested of their religious faith and morals, deprived of all respect for authority, and left psychologically rudderless without standards to cling to. Many parents described the suicides of their children as a result of the psychological abuse they received in classroom courses.

Witness Dr. Lawrence Dunegan told how his child in Health class was given what was called a "mental health index" and told that anybody scoring above a certain score had a serious mental health problem and needed psychiatric care. He described how this had a traumatic emotional impact on the students that lasted for days, especially as a result of the questions about suicide.

Witness Myrtle Kelly told how the psychological techniques used in her children's school were so harmful that there were four known suicide attempts, plus two children who are now under permanent psychiatric care in clinics away from home, plus numerous other behavior problems, all the result of the attempts to engage in unlicensed group psychiatry in the classroom.

Witness Joan Lauterbach told how the school set up a program for children to counsel other children who are supposedly considering suicide. The age of these kiddie counselors is shocking. They were eight to twelve years old.

Witness Jayne Schindler told how her seventh grade child was inflicted with Death Education. In the course manual, 73 out of 80 stories concerned death, dying, killing, murder, suicide, and what you want written on your tombstone. One of the children who was given this course, a ninth grader, blew her brains out after writing a note telling what she wanted on her tombstone and pinning it to her front door.

Witness Shirley Mapes told how a Massachusetts school gave a course for fourth to sixth graders called Anti-Parent Pressure. The only reason she found out about it was because her son brought it home by mistake. Students in that school had a very high teenage suicide rate.

Many parents, too numerous to mention, told about the violent anti-life lessons which desensitize children to the notion of taking a human life. These include the lifeboat game and fallout shelter game in which the child is required to "eliminate" or kill five persons, the film called "The Lottery" in which a mother is stoned to death in front of her son, and other stories which include role-playing of killing and suicide.

Witness Delores Brown described how a Death Education course was concealed in a drug curriculum. Again, the children were required to write their own epitaph or obituaries. She testified that she is convinced this is a cause of teenage suicide.

Witness Snookie Dellinger told how her fourth grader was required to take Death Education. He had to write an essay on the recent death of his pet, draw a picture of the pet, and read his report out loud to the class. She told what a traumatic experience this was for her child.

Witness Archie Brooks told how an 11-year-old child was forced to stand up in front of her class and tell her "feelings" when she found her father dead. He told how the child was subsequently hassled and teased by her classmates.

Witness Robert Griggs told how "Dungeons and Dragons" is played as part of the school curriculum. Witness Cris Shardelman told that it is taught as part of the Talented and Gifted classes, and that she believes it has been responsible for several suicides. The National Coalition on Television Violence thinks that "Dungeons and Dragons" has been a major factor in causing nine suicides and murders.

Several witnesses told how nuclear war courses have scared and depressed children. Witness Jim Hopkins told how even second, third and fourth grade children were put through nuclear war classes so depressing that one nine-year-old said she was so scared that she felt "like I should just cut my head off."

Another witness quoted directly from journals written by pupils to illustrate the depressing effect that nuclear war courses have on children. Here are a few samples: "These days, I just try not to think about my future, because I have a hard time seeing one. I want to do something with my life, but who cares about me? Besides, we're all going to get blown up anyway. Some of the discussions we had got 'pretty heavy,' and it was hard to handle! It's hard to spend 45 minutes a day talking about dying, and it's depressing! It's hard for me to seriously think of the future. It is overwhelming to me, as it must be to you, that every human being on this planet must live each day to its fullest, because the next day may never come."

The ABC docudrama, "Surviving," dramatized the tragic effect that nuclear war courses can have. The last words the two teenagers said to each other before they turned on the carbon monoxide were, "It doesn't matter what we do. The whole world's going to blow up soon anyway." It was clear from the docudrama those pathetic teenagers didn't get that notion from their parents. However, they could easily have gotten that notion from any of the several nuclear war curricula or other depressing materials so widely used in public schools today.

Anyone who reads the Hearings conducted by the U.S. Department of Education in March 1984, now available in my book called "Child Abuse in the Classroom," would know why the rate of teenage suicides has doubled in the last 25 years. Added to these outright psychological abuses and morbid preoccupation with death is a heavy diet of assignments and supplementary reading with depressing themes, degenerate characters, filthy language, and overt attacks on the American system.

Every suicide probably has a mix of contributory causes. These causes surely include the widespread use of drugs and

alcohol, and the emotional trauma caused by teenage promiscuity which is so contrary to traditional moral standards and so frequently results in pregnancy, abortion, or venereal disease.

I believe it is clear that any real attempt to prevent teenage suicide must start with an expose of the suicide-promoting materials they are given in class and the rock music lyrics they listen to. If 30-and 60-second television commercials can influence our actions to buy certain products, certainly the hours which teenagers spend on despair-promoting literature and music must have a major influence on their behavior.

Teenage suicide shows clearly why the 1978 Pupil Protection Amendment and its 1984 Regulations are absolutely necessary. It is clear that the psychological death and suicide courses described in the Hearings were given to children without prior parental consent. Teachers must be prohibited from playing amateur psychologist or psychiatrist or therapist without a license while imposing experimental treatment on normal, healthy children.

The suggestion has been made in the press that one way of addressing the problem of teenage suicide would be to mandate suicide courses in the high schools. This would be the worst thing that could happen, as the U.S. Department of Education Hearings prove. Many parents who have been through the suicide experience believe the classroom courses which discuss suicide are the cause of teenage suicide, and therefore they cannot be preventive.

Many psychiatrists believe that open discussion of suicide can tend to make it matter-of-fact, to give it respectability, and to encourage teenagers to turn inward on their problems and to maximize them. Some psychiatrists believe that the outbreak of suicide in New York's Westchester County area could have been partially caused by its highly-developed preventive approach and open discussion of suicide. Suicide is not and should not be treated as a group problem.

It is essential that the Pupil Protection Amendment be strictly obeyed and enforced so that students are not given any experimental psychological treatment or classroom courses pertaining to suicide without prior parental consent.

It is also essential that parents, who obviously care the most about the life and welfare of their children, be alerted immediately if the school detects any suicidal tendencies in an individual child.

OUR CHILDREN, OUR CASUALTIES?

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Twenty years ago, we were congratulating ourselves for creating a "Great Society" and for ascending into a new "Age of Aquarius." In abandoning the past, we assured ourselves we were liberating society for a new consciousness of love and compassion. Since the heady days of the 1960's, youth suicide has grown to epidemic proportions according to the World Health Organization. Today, one-tenth of the young people in this country so despair of life they attempt to snuff it out before their 19th birthday. Adolescents kill themselves, we are told, because of depression, loss of parent, alienation from family, drugs, alcohol, and increased mobility. These explanations are true, but not sufficient. They're too limited.

The "Washington Post" recently carried a column by William Raspberry about some of the records that are very popular with teenagers today. One, a platinum record, is called "Eat Me Alive." It's about oral sex at gunpoint. Another is "Bitch, Be My Slave." "It's impossible," Raspberry writes, "to listen to most of the rock stations, or watch the televised videos, without being exposed to kinky sex, torture or even killing. Because we as adults in our pseudo-sophistication, refuse to acknowledge shock, the effect is to legitimize and popularize things that ought to have us screaming bloody murder."

Kinky sex, torture, killing, and adult passivity; the everyday stream of consciousness of many young people. What is happening in our society to not only produce these pathological disorders, but also to make the adult population passive onlookers to the socialization of their children by these forces?

The theme of one of the most popular TV shows, which was also a movie, was titled "Suicide is Painless." Popular songs have titles such as "Think I'm Gonna Kill Myself." Groups have names like "The Grateful Dead." Suicides of famous

people, such as John Belushi and Jim Morrison, have cult followings.

Forty-five years ago, as Hitler stormed across Europe, Walter Lippmann said that Western civilization was being destroyed in classrooms which emancipate students from their cultural heritage. "The emancipated democracies have renounced the idea that the purpose of education is to transmit the Western culture. Thus, there is a cultural vacuum, and this cultural vacuum was bound to produce, in fact it has produced, progressive disorder." The effect on the individual student, Lippmann wrote, is devastating. "The school cannot train the pupil to look upon himself an inviolable human person because he is made in the image of God. These very words, though they are the noblest words in our language, now sound archaic." The title of his essay was, appropriately, "Education vs. Western Civilization."

A few years later, C.S. Lewis, in a reflection on the teaching of literature in high school, said that man was being "abolished." Lippmann and Lewis were right. They were right to mourn what was happening to young people a generation or two ago. Today, the perhaps most influential education psychologist in America hails the abolition of what he derides as "the man defended by the literatures of freedom and dignity." He wrote, "This abolition has long been overdue. To man qua man we readily say good riddance." He enjoins us in the name of progress to abandon the notions of "freedom" and "dignity." In short, he would have us dispense with the notions that were at the core of the culture which we inherited. It is no surprise that we seem to be only poorly passing on that culture to our young people.

Critics have pointed out that our contemporary arts are drenched with what one of them calls a "death-oriented hopelessness" which conveys fantasies of instant gratification, narcissism, nihilism, sadism and meaninglessness. Is it really a wonder that some of our young people get the message? When we, as parents, make our children expendable; when we pass on to them only pragmatic skills, and even then, without much enthusiasm; when we allow our children to spend more time watching TV by the time they're six than they spend talking with their fathers for the rest of their lives: should we be surprised they feel they have nothing to live for?

We have become so "sophisticated" that we don't even know we are fighting a battle for our individual and collective souls. There is evidence we are losing it. We are seeing the casualties in our classrooms, in our families, on the inscriptions of our tombstones. Christopher Dawson, the cultural historian, put his finger on it in 1947. He said, "The recovery of moral control and the return of spiritual order have now become the indispensable conditions of human survival."

Government bureaucrats can't define how that "moral control" and "spiritual order" are to be reestablished. Those of us in government, particularly in education, should examine where we've impeded the recovery of moral control and spiritual order. All of us, as concerned Americans, had better recognize these things must be restored for the survival, in the most literal sense of the word, of our young people. It's a life and death matter.

This problem is too big for any government program to solve. Programs may help, but at best they only touch the edges of hopelessness and despair. We need to marshall resources to attack the problem. The resources that count are not dollars, they are people: you and me; our neighborhoods; our families; our churches. We must nurture and re-empower these mediating institutions upon which people depend in times of stress.

This is not just a therapeutic problem. It's not just a question of how we can cure people or make them healthy. It's not just a pedagogic question either; it's more than how we teach. It's a moral issue. Kids need to be told that suicide is not just unhealthy, it's wrong. As Chesterton said, "The man who kills a man kills a man, a man who kills himself kills all men. As far as he is concerned, he wipes out the world."

We must re-strengthen and re-empower parents in particular. Parents must get more involved with their children. We know from research that mothers spend only between four and seven minutes a day on education activities with their children. If those of us who are fathers think that is bad, we spend between zero and one minute a day with our children on educational activities.

Above all else we must transmit what we have inherited, what we are trustees of, what we are seemingly neglecting to pass on: a heritage that is very precious, a heritage that we are given as a gift by our parents, a heritage that holds out hope, meaning, love, and an identity that transcends the individual performance of the individual child.

Parents must show their children tough love. On the Bill Cosby show, Bill Cosby says this to his son, Theo: "You won't use drugs in this house. When you're 18 and out on your own, you won't use drugs. When you're 75 and I'm dead, you still won't use drugs." The parent is showing tough love. That parent is talking about a partnership for live.

Oscar Wilde, on his first trip to Niagara Falls, looked at the river flowing over the precipice and said, "It's impressive, but it would be much more impressive if it flowed the other way." Our task is to somehow make that river of hopelessness flow in the other direction.

STUDENTS AGAINST SUICIDE

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Students Against Suicide (SAS) is an organization created by teenagers. They designed the purpose and intention of the program, wrote the guide book, made the tee shirts and the buttons.

The purpose of SAS is to provide a forum for people to communicate and work together to make a difference. Students work in their schools and community. They learn the warning signs of suicide, what to say, and how to respond in a crisis. They have an opportunity to share their commitment to life with others. They speak at junior high and elementary schools, sharing their experiences. They have a petition whose signers declare their support for ending suicide and pledge their commitment to life.

In the guide book, the students agreed to be real with each other, be open and close to each other. In school after school, kids have joined SAS and it gives them a reason to be with each other, to support each other.

The students have developed fundraising ideas and projects. One is to start a SAS group at the West Wind Reservation in Wyoming where last October nine young men hanged themselves. They want to start SAS programs in the Youth Detention Centers and Juvenile Halls where the suicide rate is so high.

Young people are ready and willing to step out of the hopelessness. What they ask of adults is to care. We have to support them: teachers, principals, parents, and professionals. Kids from Wisconsin, Indian Reservations, upper-middle-class schools and prisons can network together and take a stand against suicide.

It is a big task these kids have taken on. What's so great about youth is they believe anything's possible. The generation that's bringing about an end to world hunger, actively taking a stand on drinking and driving and saying no to drugs, just may be the generation to put an end to the ultimate act of self-destruction of human beings. In all the darkness, this is a glimmer of hope. I ask that you support the children in your life or in your school and offer them the opportunity to participate.

Youth Panel

YOUTH PANEL INTRODUCTION
Learning From Youth

Charlotte P. Ross
President and Executive Director
Youth Suicide National Center
Washington, DC

Conferences on depression and suicide among the young are infrequent; inviting young people to speak for themselves, to discuss their views on these matters, is an even rarer event. Yet, in a field that many would find depressing, a gratifying experience and one which engenders optimism for the future is listening to young people as they talk about the problem which has brought us all here.

Youth suicide is real and immediate for them. They see and hear peers talking about it more often than adults. They bring insights not borne of research or controlled studies. They express, instead, the emotions and feelings of teenagers who are personally and deeply involved. Their participation adds a special quality to this conference.

In their testimony of concern, they lay aside the bromide that high-school-age men and women are too busily engaged in their own lives to be touched by the problems of others. The corollary that only one or two children in any school are potential victims of suicide, so "don't let's talk about it and trouble the rest of the students with the notion" is just as invalid.

These young people who are appearing at this Conference are not a "representative sample" of anything. They are simply five teenagers who speak out of their own experiences. What distinguishes them is their interest in others and their attempts to reach out when they were needed. They are part of a solution.

Each of us needs to reach out for help at sometime in our life. Each of us can, at other times, reach out to offer it. These youngsters are examples of youth who have had

experience with pain, are sensitive to it, and are creatively seeking to help others deal with it. One of the renewable and beautiful resources of this planet are those who are natural helpers. These helpers are here to explain their particular interest or association with the issue of youth suicide. What they have to say is expressed in quite different ways.

Music has been said to be the common language of teenagers. For Mark Elliott, a folk singer, it is his way of dealing with the feelings. Mark has been a student at McLean High School in Virginia. During the past year, four of his schoolmates attempted suicide. Mark tried to understand what was happening, and then, six weeks ago, a young girl at his school took her life. Mark wrote about her and her suicide in a moving and perceptive song. I believe his words and his music can help us all better understand the world of young people, those who consider suicide, and those left behind to mourn.

Judy Pshak was editor of her high school newspaper at Mountain View High School in Mesa, Arizona. Concerned by what she had seen and read about teenage suicide, Judy used her skills as a writer to produce a prize winning research paper on the topic. She offered her insights in "Teen Suicide, An Overlooked and Pressing Problem."

A'Lee Jones is a senior at St. Bernard High School in Los Angeles, California. When she was still a sophomore, the lack of support and help available to youngsters her age gave her great concern. She discovered "Teen Line," a telephone helpline provided by teenagers for teenagers.

Fred Wyatt is a 15-year old who will be a senior next year at Valley Forge Military Academy in Virginia. He reached out, literally, to a friend on a bridge and saved his life. Intervention for Fred is not a rarified concept, but something instinctive for him, in this case, instructive for us.

At Central High School in Flemington, New Jersey, there is a 15-member organization called "Health Occupation Students of America." One of its leaders and organizers is Robin Cox, who, with her colleagues, developed material about depression and coping strategies to which her peers could relate. For those of us who have struggled to produce similar material, the results are impressive.

HEALTH OCCUPATION STUDENTS OF AMERICA

Robin Cox
Central High School
Flemington, NJ

Each year the Health Occupation Students of America have the opportunity to conduct a community awareness project. This year we worked on teenage suicide. It sparked interest in every member of the classroom. When we took a poll of our students, not just one or two knew someone who had thought about suicide or had committed suicide, but everyone of us had been personally touched. That hurts because we always hear that the high school years are the best years of your life.

We produced a brochure for the friend of a suicidal person because statistics say that 92% of suicidal teenagers will tell a friend before they go to a parent, teacher or authoritarian figure. Sometimes a friend is the least able to be of real assistance, so the pamphlet contains information about where students can go for professional help, and some "do's and don'ts" on trying to get a person through crisis. That was the main thrust of our project, to get suicidal students to people who could help them through the crisis so they could see there was a light at the end of the tunnel.

This project has been dear to all of us. We didn't expect to know for sure if anybody had been helped, but to our delight we found out that two people are receiving therapy as a direct result of information in our pamphlet. They walked in with friends and our pamphlet in their hands, and now they're in counseling. It makes us feel good that our efforts have paid off. If you find any of this information helpful, take it, copy it, turn it into sources that can help.

ONE YOUNG GIRL'S PAIN

Mark Elliott
McLean High School
Falls Church, VA

I'm so glad I got the chance to sing my song and talk to you, because I have a lot to say. I have my own feelings, like everyone, and I am interested in sharing them with you. Given the opportunity, I think people could go on forever about how they feel. My message to you is that it is important to give students the opportunity to express their feelings and thoughts.

In my school, there have been several attempts at suicide. At first, things were kept under the rug, partly due to the parents' wishes, I suppose. The students had a hard time finding out exactly what was going on in their own school. It was a long time before we found out what happened, and it turned out to be people we all knew. You couldn't get anyone to talk. You didn't hear anything about discussion groups, even though there might have been some.

Around May or the end of April, a 10th grader jumped off a nine-story building and killed herself. I didn't know her personally, but she was one of those people you see in the hall every day. One day you saw her walking down the hall, then all of a sudden the principal is on the loudspeaker saying that she took her own life. Then we had discussion groups and counselors wanting to know if students needed to talk about it. Students will talk about it, and given the chance to talk to professionals and other people in the field, kids will get a lot off their minds. I took advantage of talking with guidance counselors and friends. It helped me.

While watching the movement of increased awareness, I wrote a song. It's by no means a happy song, but it has something to say. I wrote it, keeping in mind all the attempts, television shows and then the one success, or should I say completion, of the girl's suicide. If you listen to the words, maybe you can get an idea of how I feel. This is called, "One Young Girl's Pain."

One Young Girl's Pain*

She was a young girl, anticipating
No more sunshine, no more life
There was a mother not understanding
All the pain she felt inside.
There was a scream one April morning
a lot of questions, not much to tell
A mother cried out in holy terror
As her only daughter fell.

There was a note left on the table
Her mother read aloud, in a somber tone
It said oh God, I am so tired
and so very much alone.
I am frightened and I am trembling
I can't believe it's true.
All the trouble life has brought me
And what sorrow has made me do.

Her picture lies upon the mantle
A little dust rests on the frame
It's been a long time since that morning
But the memory still remains.
On a chilly autumn evening
A mother crying all alone.
One simple rose lay on a tombstone
But the final Dove, has flown.

TEEN LINE CARES

A'lee Jones
Saint Bernard High School
Los Angeles, CA

Teen Line Cares is a program at Cedars-Sinai Medical Center in Los Angeles which provides a special opportunity for young people. It allows troubled teenagers to speak over the telephone with other teenagers who are trained as "listeners." Teen Line was started on the basic premise that when teenagers are in trouble, they are most likely to go to their peers, rather than to adults for help, and speaking from my own experience as a high-school senior, I have found this to be true. Teenagers want to speak to someone who they feel understands them, knows where they are, and is less likely to judge them.

Teen Line receives calls dealing with many subjects, ranging from an argument with a friend, to drug abuse, pregnancy, and suicide. The latter is perhaps the most difficult to deal with. The Teen Line listeners always have the support of an adult mental health professional behind them.

The calls dealing with suicide can be broken down into three basic types of situations. The first one is when a person calls in concerned about a friend who is having suicidal feelings. The way this type of call is usually handled is by first talking to the person on the line about their own feelings. Then we help the caller to start dealing with the suicidal friend and to encourage the friend to seek help from a parent, relative, or some other adult.

The second type of call dealing with suicide is when a listener is on the line, and during the conversation he or she hears either outright talk of suicide or suicidal undertones. It is then important to find out if the caller is thinking of suicide now, and if he has attempted suicide before, and if he has a definite plan of action. It is a more serious situation if the caller knows where the gun or pills are and has set a date for using them, as opposed to a situation in which suicide has just crossed the person's mind.

The third, and most serious type of suicidal call, is when a person calls the Line and has already taken some kind of substance. When this happens, the adult supervisor plays a

big role, either by counseling the teen listener, talking to the person directly, or finding some way to get immediate help to the person on the other end of the line.

The Teen Line Cares program strives to not only provide help dealing with immediate problems like suicide, but also to provide intervention before serious problems do occur. For these reasons, benefits are there for the caller as well as the listener.

ANY TOWN

Judy Pshak
Mountain View High School
Mesa, AZ

In Arizona, Phoenix has the highest rate of teen suicide; Arizona is the second leading state, and their rate is twice the national average. People in Arizona don't realize this. I wrote an essay to draw attention to this problem and to propose solutions. One of my suggestions was Any Town.

Any Town is a program sponsored by the National Conference of Christians and Jews. It is a human relations and leadership camp for teenagers. They teach you self-image and how to get along in society. Society is constantly changing. Youth are faced with more and more pressures, more and more problems, and they don't know where to turn. Any Town deals with these problems on a one-on-one and group basis. The camp includes adult advisors, college counselors, and about 100 high school students. It's a week-long camp, where you can discuss anything and everything.

I've been to Any Town and it's a great experience, but not enough teens can go because it's privately funded. One of the things I proposed in my essay is that the government put up funds so we could have more of these camps, and more teenagers could be helped. More teenagers are touched at these camps and can then reach out to other teens. I have had several experiences with people where just talking helped them. I know two of these people had been thinking about suicide, but after they went to Any Town, or after they talked to someone and found out they could be helped, their lives turned around.

Any Town helps to open up your feelings. You learn to open up to anybody. If somebody is in need, you learn to ask if they want help and direct them. I knew someone at my camp who came with suicidal thoughts and he left loving everybody, loving the world. He was totally changed. He cried himself to sleep the first couple of nights, and then at the end, he knew he had so many friends and so much to live for.

Since Any Town started in Arizona it's become very popular and camps are now starting here in the East. A camp in Boston opens in August and one is being developed in Kentucky. Any Town is a good solution because it's a place where teens help teens. When I went there, everybody was so open, and when I came back, I felt I could talk to anybody. Like Debby Boone said, the people you met up there were "friends for life."

TEENS HELPING TEENS

Frederic T. Wyatt
Valley Forge Military Academy
Arlington, VA

Several months ago a friend at school withdrew from his friends. At lunch he would stay back in the corner. I went over to him and he said, "I don't want to talk." Later I was at my friend's house, he was with me and we were talking with his girlfriend. Suddenly he disappeared and went outside. He did not seem to be in very good shape.

I found him standing on the Calvert Street Bridge. I came up behind him and grabbed the back of his belt and said, "Let's talk."

"No," he replied, "there's nothing to talk about. I shouldn't be here."

I said, "Yes, you should. Why were you put here if you shouldn't be here?"

He said, "No one loves me, no one cares for me. It's very simple. I shouldn't be here. There is no reason for me to stay alive. My parents don't care. My grades are going down. I just hate it. I even lost my BMX because of an injury. Everything is going wrong for me."

I said, "You know it's life that's important. A lot of people care for you."

At that moment, a passerby asked, "Is he OK?"

I said, "Yes, he will be all right." Then I turned to my friend and said, "See, people who don't know you care. You don't even know how many people care for you. You just can't see it. Your girl friend's back at the house worried sick about where you are. Everyone cares for you. I wouldn't be out here on this bridge if I didn't care."

He said, "You know, life seems to be over. There seems to be no reason for me to keep on living."

I said, "You have to think of life as a race of hurdles. Sometimes the hurdles are high and sometimes they are low. Just because you trip over one doesn't mean you can't get up and keep running."

He said, "I don't have any friends and I don't feel like I should be here."

I said," You know you can always talk to any of us. We are all your friends and we want to listen. We really do care about you."

A friend can help another friend in a lot of situations. It's on the level of a teenager talking to a teenager talking to a teenager. They can establish and relate on a common level because they have the same concerns. Someone cares. Everyone cares.

Legal and Ethical Issues

YOUTH SUICIDE: LEGAL AND ETHICAL ISSUES

Howard A. Davidson
Director, National Legal Resource Center
for Child Advocacy & Protection
American Bar Association
Washington, DC

LEGAL ISSUES

I co-direct a program of the American Bar Association called The National Legal Resource Center for Child Advocacy and Protection. Although I have worked with children's legal issues for ten years, not much is known about the legal issues related to youth suicide. I will give an overview of where the law is now, and the direction it may be going relating to youth suicide.

I will start by discussing two cases from my own experience. The first case is about Bryan, a nine-year-old boy who was physically abused by his mother on a number of occasions. Bryan ran away from home and went to a former boyfriend of his mother's. The boyfriend took Bryan to the police station where police saw his injuries. He had black and blue marks on his face and marks on his back that indicated he had been hit with an extension cord. At this point, Child Protective Services intervened. Bryan said that he did not want to go home to his mother and if he was forced to go home, he would kill himself. The Child Protective Service Agency took Bryan to a psychologist who concluded that Bryan was seriously depressed and should be considered a suicide risk. Bryan was nine years old. The court ultimately placed Bryan in a foster home because of his emotional vulnerability.

The case of Bryan Mill was a fictitious case we invented to teach people how a child abuse case worked in the court system. The mock trial was conducted by our Center in 1981. We brought together a police officer, a psychologist, and a social worker, gave them the facts of the case and acted out a trial. Of all the comments we received from that case and the mock trial, the one I remember best was that everything was realistic except for one thing, nine-year-old boys don't make threats of suicide and can't be considered serious suicide risks. Recent conversations about Child Protective Service work, and cases involving children of Bryan's age, convinced me that in 1985 it

would not be unrealistic to consider Bryan Mills a risk. We were ahead of our time in 1981. We made suicide an issue in a child abuse case involving a nine-year-old boy and everybody thought we were being unrealistic.

The second case is real. Patty, 14, had been sexually abused by her stepfather. I was appointed by the court to represent her in 1976. At that time there weren't many child sexual abuse cases that came into the court system. While we often represented children in juvenile court, we never considered whether they had any problems as a result of being sexually abused. In this case the abuser was out of the home, but Patty was out of control. Her mother could not handle her at home. A decision was made to place Patty in a residential facility for evaluation. Within a matter of days, Patty set fire to her legs. I was told that that was not uncommon behavior for sexual abuse victims.

Since that time, I have represented a number of cases where it was common for children in custodial settings, psychiatric facilities, juvenile dentention centers or residential treatment facilities, to make what were called suicide gestures, calls for attention, or manipulative acts. It concerned me that these attempts, or gestures, were not given adequate attention. Fortunately, none of the children I actually represented committed suicide; however, after my experience with Patty and a number of other cases, I read that sexually abused children exhibit self-destructive behavior and are often considered suicide risks.

I am convinced that the legal system does not adequately appreciate the potential for suicide in many of the children who come before the courts, whether as abused children, status offenders, or in need of supervision or services. It is critical that judges, lawyers and probation officers, as well as social workers, be trained in the identification of at-risk children.

We need to raise the consciousness of people in the legal process to the suicide risk, how to appropriately handle such a situation, and how to identify those children in the justice system, juvenile justice system, or family court system who are in need of services. Unfortunately, the thought of suicide makes people so uncomfortable that a lot of them, particularly judges and lawyers, don't want to deal with it.

There are both criminal and civil laws in this country which directly and indirectly address suicide. I will talk about statutory law, laws that are passed by state legislatures, as distinguished from case law that is made by judges.

In olden days, suicide was a crime, a criminal offense. English common law punished the crime of suicide by requiring that the person be buried at a crossroads with a stake impaling the body, a stone placed over the face and the amputation of

the hand that committed the act. The King also was permitted to confiscate the suicide victim's property.

Today in the United States, no state treats suicide as a crime. Attempted suicide is a crime in two states, Oklahoma and Texas. However, I doubt anyone is ever criminally prosecuted for attempting suicide.

A more serious issue of concern among youth are those who aid, abet or advise someone to commit suicide, or enter into a suicide pact. Twenty-two states have criminal penalties for aiding, advising, abetting, or entering into a suicide pact. If someone enters into a suicide pact, and one person kills himself while the other survives, theoretically the survivor could be prosecuted in those states that have such a law.

Another area where criminal law speaks to the issue of suicide has to do with what happens to those who try to stop someone from trying to commit suicide. If you try to stop someone from committing suicide, you could find yourself charged with assault and battery. You have no legal right to interfere with another person's act unless they threaten your own life or you are acting in self defense. Eleven states have laws which say that the use of force to prevent suicide is a specific defense to an assault and battery charge.

The civil laws are non-criminal laws dealing with suicide in a number of ways. One area has to do with the ability of minors to consent to their own health care. Many at-risk young people, under the age of 18, may be reluctant to seek psychiatric care because many states require parental notification and consent. Most states allow that in an emergency, children may be treated without parental consent or notification because they don't want their parents to know that they are getting treatment. States are beginning to pass what are called mature minor laws which allow the minor to consent to his or her own psychiatric care and treatment without parental notification or consent. California Civil Code Section 25.9 has contained this particular exception for the last five or six years. Also, there are 35 states that specifically provide for a minor to consent to his or her own treatment for alcohol or drug problems.

Life insurance is another area affected by civil laws relating to suicide. Historically, life insurance policies have been written to deny payment in the case of death by suicide. Sixteen states have passed laws which in some way limit the ability of insurance companies to write policies which deny payments to suicide survivors.

Workers' Compensation insurance, which is government mandated, basically covers you for job related injuries. Seven states have specific laws which allow that Workers' Compensation payments include situations where the work-related injury precipitated the suicide. These states seek to recognize that there are cases where suicide might not have occurred were it

not for a debilitating work-related injury that the person suffered. Also, there have been a number of court decisions which have allowed a Workers' Compensation claim to be paid to a survivor in a suicide case. The conflict in all this, of course, is that in suicide you have a choice of whether you live or die. The Workers' Compensation laws or the wrongful death laws might certainly apply for those who die a natural death as a result of a work-related injury. The traditional legal view has been that suicide is an intervening act within your own control and, therefore, no one else should be held responsible for it.

Another area which directly affects teenagers are the laws that deal with the serving and selling of alcoholic beverages. These are called dram shop laws. They render the person who sells or serves alcoholic beverages legally responsible for any consequent injuries or accidents. Seventeen states have general liability statutes, dram shop statutes, which say that, whether in the case of adults or minors, if someone goes to a tavern, drinks too much and, as a result, kills somebody, the survivors can sue the tavern owner. Fourteen states have specific dram shop statutes that apply to the serving of minors. Seven states, by court decision, have extended liability onto the servers of minors. In July, 1985 the American Bar Association will be considering a policy resolution that calls upon all states to enact dram shop laws. While dram shop laws generally apply to commercial establishments, there is also a concept known as host liability where a number of the dram shop laws apply.

A number of states have enacted legislation to establish teen suicide prevention programs. They provide for education and training programs in the schools, mental health agencies, and crisis intervention and hotline services, targeted at the suicide issue. There are three states with legislation in this area: California Senate Bill 947, enacted in 1983, Florida State Bill 529, and New Jersey Assembly Bill 2286.

The court cases that deal with the suicide issue generally involve the imposition of civil liability for money damages in which somebody is sued for a cash amount, and in which suits are brought against either an individual or an institution that is alleged to be responsible for a person's suicide. The suits are usually brought by the surviving parents. This is not a new area of litigation. There are cases that go back to the 19th century. As a rule, the courts will not hold one person legally responsible for the suicide of another because, as I mentioned earlier, suicide is considered a deliberate, intentional, intervening act. However, there are exceptions to this general rule.

The first major exception is where a person causes a mental condition which results in another person's uncontrollable impulse to commit suicide. An example would be where someone

intentionally inflicts severe physical or emotional injury or maliciously torments someone into a suicidal state.

The second area is where a person violates a law which prohibits the sale of liquor. The dram shop laws are a major exception to the general rule of no liability.

The third area is where a person or institution breaches a legal duty to provide care to prevent suicide. Here we are specifically talking about those who provide custodial care in jails, psychiatric hospitals and juvenile reform schools. A 15-year-old runaway in a juvenile type cottage program committed suicide, and the court of New York held that there would be liability. A recent federal court case involved someone who committed suicide in jail. People in the jail should have known that this person was a suicide risk. They didn't watch the person and the person committed suicide. The court held that there could be liability. There was another case in which the staff and administration of a health care facility were held liable.

Another area is where the individual is a specialist or mental health professional who has the precise duty, or a special relationship and control necessary to care for a patient's well-being, and, therefore, to prevent the person's suicide. Generally, the cases say that the physician or mental health professional only has the duty when the patient is hospitalized, again, a custodial setting.

There are some situations where courts have held there is no liability. One that has been getting a lot of attention is the clergy malpractice case in California in which the survivors of a suicide have sued the Grace Community Church and its ministers. That case, the Nally case, just ended with a trial judge dismissing the case on First Amendment grounds. There is a 1984 court of appeals opinion on this case in which two of the three members of the California Court of Appeals suggested that, in some circumstances, clergy might be liable for malpractice, for negligence, or for intentional infliction of emotional distress.

In the 1960 Wisconsin Bogust case, a suit was brought against a school guidance counselor who was not a doctor or certified psychologist. The counselor had recommended termination of therapy or counseling sessions for someone who subsequently committed suicide. The court held no liability because the counselor had no special training, no duty and no control in that case.

An attorney was sued for malpractice by the survivors of a client who was sentenced to prison and committed suicide. The court did not rule for the survivors.

In a suit brought by the parents of a child who committed suicide, the courts did not hold liable a psychiatrist who

failed to notify the parents of the child's condition. However, this followed a case in California where a psychiatrist had been held liable based on the fact that he had a duty to warn others if his client presented a danger.

The dram shop acts allow that liquor servers or sellers can be held liable but the general rule of the courts has been not to hold liable the pharmacists who dispense a lawful prescription for medicine or drugs used by a minor to commit suicide. I think the outcome might be different in suits against those who unlawfully sell or give medicine or drugs used in a suicide but we are not able to find any cases that deal with this issue. We will have to see how the law evolves.

Another area where again there hasn't been a case might be a suit against a parent or other adults whose abuse of the child leads to the child's suicide. It could be sexual, physical or psychological abuse. I suggest that we will begin to see these kinds of cases emerge as these issues become better known. We are certainly a litigious society. We are seeing more negligence suits being brought against doctors, lawyers, psychiatrists and psychologists. I suspect that if I gave this presentation a year from now, I am sure I would have a much longer list of interesting cases to relate.

YOUTH SUICIDE: LEGAL AND ETHICAL ISSUES

James Childress, Ph.D.
Woodrow Wilson Center
Washington, DC

ETHICAL ISSUES

My field is religious ethics and I am especially interested in the relation of ethics to public policies and health care. Now, ethical issues don't simply exist in the world like mud puddles we step into or walls we bump into. Rather, they are created by the principles and values we affirm as a society or as individuals. The character in Tom Stockard's play, "Professional Fouls," said that there would be no moral dilemmas if moral principles worked in straight lines and never crossed each other. It is the crossing of moral principles and values that gives rise to ethical issues, to ethical problems and to ethical dilemmas. What moral or ethical issues are raised by youth suicide and by community responses towards suicide? The community responses to youth suicide include the responses of professionals, family members, and the society through legislation or judicial decisions.

Several principles and values are widely approved in our society and we can talk about how they might apply to the area of youth suicide. A fundamental principle in our society, in professional codes and the codes of medical ethics, is first of all to do no harm to another person. That widely recognized principle has already been invoked in some of the cases described, such as the duty not to torment people and lead them to suicidal actions. When we are driving an automobile, the duty is not to impose undue risk of harm to others. Here the law and morality would substantially overlap.

A second ethical principle is acting to benefit others. The law requires less in this area, but we recognize our general duty to benefit others at our discretion. However, in ethics there are certain special relationships, parent-child, teacher-student, lawyer-client, physician-patient, in which there exist ethical and legal duties of one individual to benefit another, to act in a person's best interest.

Third, we recognize that this is a terribly messy world in which we live and that it is impossible to avoid harming others, and simply to benefit them. Often we have to balance benefits and harm, or balance the probability of harm against the probabiltiy of benefit. Trying to act on someone's behalf involves risk.

A fourth consideration is that it is not enough to look at the balance of benefits and harms in the world at large. We have to ask who will bear the benefits, gain the benefits, or who will bear or endure the harms. This is a principle of justice, distributing benefits and harms. Thus, we would need to know whether certain of our policies, for example, pose an undue burden on the elderly or the young, leading to increased suicidal actions in those groups.

Another consideration is the principle of respect for persons, their autonomy, their right to make choices. Sometimes we might want to benefit a person and feel that our actions would be in that person's best interest, and yet that person may not want our actions on his or her behalf. Let's suppose the Good Samaritan had encountered a victim who pulled out his wallet and showed his living will that said, "If I am ever attacked by robbers on the road, let me lie where I have fallen." That situation would create a conflict between the principle of benefitting a person and the individual choice of a person not to be benefitted.

These are the five major principles: do not harm others, do benefit others, balance benefits and harms, justly and fairly distribute benefits and harms, and respect persons and their autonomy. Truthfulness, promise-keeping, and confidentiality are derivatives of these five major principles. We have to look at these principles in relation to different kinds of cases. These principles and values shape and structure community, professional and individual responses to the problem of youth suicide. It is necessary to balance and hold these principles in some tension to each other because if we go too far one way or the other, we will end up losing a lot that is morally significant.

When we talk about suicide attempts, we are talking about a person at risk of harm committed by himself or herself. If the harm the person is at risk of undergoing is death, an irreversible harm, then that weighs very heavily in assessing the situation. Another problem is that of the probability of risk. This leads into the prediction of dangerousness, a difficult matter in law and psychiatry. There has to be some occurrence of the probability of danger to oneself before we can intervene. Then we would have to balance the probable benefit of the intervention against the probable harm of the intervention, as well as the probable harm of non-intervention. It becomes very complex because the intervention itself may well create problems. It requires a judgment on the part of a friend or a family member.

The means of action is another consideration. We have to consider whether the means would be effective or not, whether we have chosen the least restrictive, least humiliating and least insulting in regard to the respect of the person involved. In maintaining respect for persons and their autonomy, it may be difficult to interpret what they are saying, what their wishes really are. Suicide attempts or gestures are cries for help. When a person is competent, informed and acting voluntarily, and confides that he or she is thinking about suicide, I think it should be taken as a request for assistance. If you get a young person through a suicide attempt, will that young person look back and thank you six months from now?

There are other problem areas; one has to do with how we deal with family autonomy, especially parental relations with children, and the autonomy of the children. A youth may seek help from a health care professional without notifying the parents. Some statutes recognize that by allowing youth autonomy in this matter, in the long run the benefits will outweigh the harms.

In the area of confidentiality, how does one use information obtained in psychological testing in high school or college that may indicate a person is suicidal? Who has a right to disclose it to whom? Do you tell the young person who may well than make the prophecy self-fulfilling?

There are also problems about education and discussion of suicide issues, how much, and in what context. Finally, there is the question of allocation of resources for prevention, rescue intervention and the area of reduction of the number of suicides. Six thousand young people a year commit suicide. This is a major cause for concern.

The law is likely to address itself to minors rather than adults in the issue of suicide. An adult will always be legally free not to seek medical attention because of religious reasons. However, the law is clear that parents cannot impose those decisions on children. State and federal statutes and court decisions will most likely deal with protection of the minors and paternalism in the sense that the responsibilities, controls and ultimate respect of the parent's authority over the child is valid where it is viewed as a way of getting a child help.

A good example of this is a 1979 Supreme Court decision in the Parham case which had to do with voluntary commitment of children to mental institutions. Essentially, it was voluntary on the part of the parent, but involuntary on the part of the child. The question: was the child entitled to a hearing with the same legal rights as an adult? The Supreme Court said no, and held to recognize parental authority on the basis that parents generally seek the best for their children and that the law should respect that. This was largely seen as a setback in

terms of children's rights issues, but in response many states have changed their laws to provide for tighter restrictions in the process of involuntary commitment.

Another question is do we as a society and a culture think that perhaps we have failed or that the suicide of a young person is almost by definition irrational, apart from certain considerations such as terminal illness? There are cases in which young people, 15-year-olds, have been permitted to refuse life-saving treatment. This kind of a situation is viewed as hopeless, a waste to the society, whereas if you are talking about an older person, there is a willingness to grant the presumption of competence.

Mature minor laws are cropping up in the areas of hospitalization, abortion, treatment for venereal disease, treatment for prevention of pregnancy. These laws are commonly accepted; however, they do vary. Some are written in such a way that parents are supposed to be notified or informed, and an attempt should be made to get consent. Some of the laws incorporate the parental autonomy theory, but allow exceptions in those cases where it is deemed by the professional that parental notification or consent should not be sought because it might jeopardize the child receiving services.

This society draws a distinction between an act of suicide and the right to refuse life-saving treatment. It is a value judgment. Even though suicide has been decriminalized, it is still considered morally wrong, especially by those adhering to the fundamentals of religion. Mandatory reporting laws for potential suicide risk may evolve as they did in the 1960's concerning battered and abused children and just as we have had for doctors to report gunshot wounds to the police. If any police officer, social worker or doctor has any reason to believe that a child has been physically or sexually abused, or seriously neglected, there is an obligation in every state to report. You have to be fully informed to be able to report a potential suicide risk. The issue is not as concrete as a child with bruises or burns on his body.

Needs and Strategies

GETTING HELP WHERE HELP IS NEEDED: A NETWORK OF CARE

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It is truly heartening that at last our nation is beginning to confront the extensive and disturbing problem of teenage suicide. It has been compellingly pointed out that the 15-24 age group is the only one in our country to experience an increasing death rate over the last two decades. In view of the national efforts to sustain life in people who are older, people who are facing illnesses such as heart disease, stroke and cancer, it is especially disturbing that we have not been doing as well by our teenage and young adult population.

There may be any number of factors involved in the increase in teenage suicide. There is too much we do not know, and we must be careful to avoid the serious dangers inherent in premature closure or assumption of knowledge. There are also, of course, many ways in which we must do better. Some things we do know are: (1) suicide is one of the leading causes of death for people in their late teens and young adults, and it has been increasing; (2) this increase is particularly great in the 20-24 age group where it is double the increase seen in the 15-19 age group in the last 25 years; (3) women make more attempts than men; (4) the most substantial increase in completed suicides has been in the White male population; (5) it is almost impossible to identify the individual who is likely to commit suicide; and (6) there are an array of sociodemographic factors which correlate with higher risk.

For instance, the importance of geography, i.e., rural versus urban settings, is well known. Also, about 40% of youth suicides have made a previous attempt. About 50% of youth suicides have previously consulted a mental health professional. We estimate that 75% of children who make a suicide attempt are treated medically and given referral for mental health care, but do not return for treatment. We know that 10% of boys admitted to inpatient services for suicide attempts will nevertheless go on to commit suicide. We know that hotlines, which are being used in many places around the country, are not necessarily effective in preventing suicides.

While we do know this much about suicide, much remains for us to learn. A recent literature search revealed only one study of completed teenage suicides. So as we try to go about the business of getting the right services to where they are needed, the best we can do is to base our planning on whatever data we now have. This current information does allow some general strategies. First, there obviously must be a special effort aimed at older teenagers and young adults. This means not only high-schools, not only colleges, but wherever one finds teenagers and young adults, e.g., in the work place, in prisons, and in military populations.

Second, we know that health professionals and others who have contact with such young people must be alert at least to the general risk factors. They must know how to elicit information, and this is no small order. The capacity to elicit very sensitive information from somebody who is in pain is a skill that must be well taught and learned. Communication is a very complicated process, and there are many patients who walk in to see many, many health professionals and go out again never having spoken of the issues of greatest concern to them. Further, we know that we must develop a suitable network, so that if a young person is identified as being at risk, he or she can be appropriately referred. The nature of the referral itself is important. The adult making the referral must talk with the younger person about it, try to elicit emotional responses to it, get a sense of whether he or she will actually go. There is an appalling gap between the numbers of referrals made and appointments kept.

In addition, we must try to ensure that identifying this particular psychiatric diagnosis is within the repertoire of general health professionals as well as mental health professionals. Data collected by the National Institute of Mental Health a few years ago showed that up to 30% of people walking into a general health practitioner's office are suffering from an underlying psychological or psychiatric problem, but one that manifests itself in physical symptoms such as sleep difficulties, pain, or eating disorders. Of those 30%, approximately 90% are missed by the primary care physician. General health practitioners must be sensitized to this problem, and they must develop the ability to make at least a general psychiatric diagnosis. Their role is particularly crucial because, while a number of suicides are attempted or completed in the context of a psychiatric illness, there are also many suicide attempts and some completions outside the context of diagnosed psychiatric illness. Our whole society, educators, ministers, and others who interact with students and young adults generally, must be educated and must participate.

It is also important that we evaluate our various services. It is no help, and it may even be dangerous, to initiate programs without a proper evaluation component. We need to

accumulate solid, systematic data about exactly what makes a suicide intervention program work.

There are a number of questions that call for formal investigation: (1) is there a genetic factor operative in suicide, and if so, to what extent is it significant; (2) can we develop any tests that would reveal a person who is at risk; (3) how many children die in epidemics each year; (4) what starts an epidemic; (5) how can we treat suicide attempters in order to ensure that they do not later become completed suicides; (6) what is the role of the media; (7) what should the role of the media be; (8) how important are drug and alcohol abuse; (9) what is the breakdown between individuals with and without diagnosable psychiatric disorders?

In my view, the dispute about whether or not to focus primarily on psychiatric issues in dealing with this problem be set aside. What we need to do is examine the problem closely and then carefully consider the data that emerge. How can we rank order the importance of various risk factors? How can we evaluate intervention programs to determine which are helpful, and which of the specific features makes them helpful? One of the most formidable challenges in treatment research is identifying the therapeutically powerful factor. How can we learn why there are fewer suicides in some cultures than in others, and why?

To deliver the right services, sensitive, sophisticated and effective, to the right people, we must foster constant interchange, a flow of up-to-date information going both ways between investigators and people in the front line of activity. People who see kids in trouble should let investigators know what kinds of questions need answers; this is just as vital as the need for investigators to return their findings to clinicians. Such an information flow entails a major program in technology transfer and ongoing communication among different components, both of the health professional community, and of the concerned citizen. It also, ultimately, entails adequate and stable funding at the national level. Public enthusiasm, task forces, conferences, inquiries and the like are all very well and good. But there must be sustained and committed interest on the part of lawmakers if these programs are really going to be effective.

I would like to reiterate that we must approach this entire field with some humility, both as to what we know and as to what we can do to help. Our efforts must be well informed and carefully considered in advance. In addition, we must prepare for evaluation efforts to learn what parts of the programs we initiate are truly effective. We should also review existing programs and try to get some clinical sense of how well they are working. It is vital that we convert the momentum we are generating into programs that succeed.

I would add that our present impetus must not become a transient event, with transient media coverage, but rather must grow into a system of public and private programs for kids who are potentially at risk for suicide. To achieve this goal, we would do well to moderate some of the extreme positions, e.g., the argument against educational programs, the argument against biological factors. This is a complex problem with many individual variations, and it does not lend itself to extreme positions or quick generalizations. Finally, we must put this item on the agenda of our country and see that it stays there.

I am delighted to see people like Charlotte Ross and her colleagues bring this issue to the nation. I am also delighted that Secretary Heckler has set up a Task Force coordinating the government efforts in this regard. It is reassuring that broad segments of the population are finally coming to grips with this troubling problem.

THE ROLE OF GOVERNMENT IN YOUTH SUICIDE PREVENTION

Dodie Truman Livingston
Commissioner
Administration for Children, Youth and Families
Department of Health and Human Services
Washington, DC

The Executive branch and the Congressional side of our government care about youth suicide. We want to help. Secretary Margaret Heckler has established a Task Force on Youth Suicide. We have the participation of many other agencies in the government. The military services are developing a tremendous family services program. ACTION and the Department of Justice are here in full force.

You've heard about our research at the National Institute of Mental Health, the Alcohol, Drug Abuse and Mental Health Administration, and the Administration for Children, Youth and Families. We participate in a grants program which includes our agency and the other allied agencies in the Office of Human Development Services. In this past year, we have given seven grants to our runaway and youth shelters to provide training for center personnel in issues related to youth suicide. Shelter personnel are saying, "We are getting a lot of depressed and troubled kids who are, perhaps, close to an attempted suicide. Some of them have already made attempts." In response, we have given grants for them to figure out, working in their local community, what they can do. They will share their models with us as part of the grant arrangement. We will have that material back in eight or ten months. You can be sure we will share it. Part of our emphasis in ACYF is to help across the country at the grass roots level. The ACTION agency can be very helpful in pulling together volunteers. I am sure many of you already have an active volunteer force working with you and for you.

We get into other issues, and while they are not directly involved with youth suicide, they are concerned with the strength of families. Strong families give us one leg up in dealing with the issue. Some of these other areas are the whole field of child welfare: foster children, foster families, adoption, special needs adoption, child abuse and neglect, child sexual abuse and related areas. We fund or help to fund 265 runaway and homeless youth shelters around

the country. We anticipate that we will be adding 15 or 20 more to that list this year. Our funding is not total. They have a great deal of community involvement also. The youth shelters are making a big difference with kids, mostly in their home towns. We have a strong emphasis on strengthening the family, and we have done some grant work in that area regarding step-families, regular families and single-parent families.

Of course, the biggest program we have is Head Start, a $1 billion dollar program, and one of the key elements is parent involvement. We are trying to give kids, most of whom come from impoverished situations, a head start on life. We have formed a task force to rework our parent involvement component, because we feel if the parents are more involved, they can be a stronger influence in the lives of their children.

In the future, we need to work more closely with other agencies and departments across the government. There are billions of dollars being spent in a lot of different departments that have tremendous responsibilities. While we have been planning the conference, we have also been doing a number of other things at the same time; we are a busy agency. We will reach out to other departments and talk more about how we can work together and collaborate to help our youngsters.

We are very pleased to make new friends with the international youth here. We have an interagency task force that has been working since the beginning of the year and we have talked about continuing the task force after International Youth Year on an informal basis.

We have started to access existing youth networks and we need to go further. We are connecting with an organization called the National Youth Collaboration, representing 25 million youth, through Boy's Clubs and a number of other organizations, to see how we can work more closely. Once you develop partnerships, you get into specific issues like youth suicide.

We need to provide more leadership based on what we are learning from community based strategies. The problems are where you are and you know what you need to be doing. As you share your good ideas with us, we can help spread the word, just as you're doing through your networks. We have a continuing challenge. We've made good progress, but we feel we have a long way to go. We always welcome your ideas, your successes and your problems as we work together to solve the problem of youth suicide.

THE YOUTH SUICIDE NATIONAL CENTER

Charlotte P. Ross
President and Executive Director
Youth Suicide National Center
Washington, DC

A few months ago the Youth Suicide National Center was a vision and a dream of a group of people from varying backgrounds and different parts of the country. Their common bond was a concern for the epidemic problem of youth suicide.

The Center's first major undertaking, this National Conference on Youth Suicide, accomplished several things. It brought together more than 500 people concerned about the problem of youth suicide. It created a forum for an exchange of information about research and programs among different professional disciplines. It involved families who have found ways to deal with the aftereffects of a child's suicide. It provided an opportunity for teenagers to talk about their experiences and their views.

It was a cooperative effort of public and private sectors, of individuals and associations, of local, state and federal institutions. It has succeeded beyond our highest expectations because of the participants who have come from all over the country and from every sector of society. You have inspired each other and you have inspired us. You have sent word through a hundred different community grapevines that this nation is ready, is committed, is in fact, already hard at work to develop and implement effective programs for the prevention of youth suicide.

We also understand that the communication cannot stop here. The exchange of information, inspiration and support we gain from being together and hearing about each other's work and progress toward our common goal must continue if we are to be successful. Those who worked to organize this conference were determined that this not be just another meeting that passed, was applauded, and then written up in a report to be placed on a shelf. We wanted it to be a beginning, not an ending.

It was this same feeling, this desire to find a means through which people could find help and consultation easily and quickly, that resulted in the establishment of the Youth Suicide National Center. The Center was created to serve as a central source of information, guidance and leadership that will support, encourage and improve existing prevention efforts and facilitate an effective national mobilization to prevent youth suicide. It will undertake to lead a national awareness campaign. Although numerous television programs, newspaper articles, magazine and radio specials have dealt with this subject recently, the problem of youth suicide has been, at times, sensationalized or inaccurately portrayed. A public awareness campaign that is focused, accurate, forceful and consistent must be developed.

Participants in this conference have emphasized the pressing need for a national clearinghouse for information on youth suicide. Too many families are struggling alone; too many organizations are trying to develop programs in isolation. Beginning with the collection, development and distribution of materials, and including the creation and computerization of a data base, a central clearinghouse would provide information to suicide prevention centers, crisis intervention agencies, college mental health centers and other public and private agencies as well as individuals. In addition, a comprehensive prevention strategy must include the education and training of specific groups who have primary contact with youth. The Youth Suicide National Center is dedicated to increasing skills in recognizing and assessing suicide danger signals among students, parents, educators and professionals in health fields.

While many people and institutions are currently pursuing important research projects, the Center can encourage the promotion and funding of research which would target components of youth suicide as part of current research programs in mental health, drug abuse and alcoholism. It can encourage formal evaluation of current prevention strategies.

A national strategy for the Youth Suicide National Center includes support for the formation of self-help groups at the local and regional levels and the support of autonomous national networks that could be instrumental in the provision of needed preventive treatment and rehabilitative services. The Center will seek to help families who have suffered the loss of a loved one through suicide and who carry unusual burdens in their bereavement. Survivors are themselves a valuable resource for the prevention of youth suicide and the Center will encourage their involvement.

Based in Washington, D.C., the Youth Suicide National Center will work with government on various levels. It will focus on Congress to guarantee an accurate overview and continuing concern. It will provide information to individual government agency representatives who wish to respond to requests for data and guidance on youth suicide. It will distribute model state legislation in appropriate ways. While governments can do much, the private sector can make an immense and continuing contribution to youth suicide prevention efforts by contributing talent, leadership and funds to various groups and individuals. The Center has the opportunity to do this across the nation to the benefit of local groups as well as regional and national ones.

Parents, friends, children and youth at risk need someone to talk to at a time of crisis. While 24-hour a day local hotlines are increasing, too many people in need remain unserved. They need to talk to someone who is knowledgeable, willing to listen and able to help. The Youth Suicide National Center wants to supply that missing link.

These are our plans. They are not an impossible dream. Young people at risk need us and we intend to be there. This conference has taught us a great deal about local and state activities, and we hope they have encouraged you to think of us as a new and responsive resource.

A description of our board will show you that we are a new institution with years of experience, a passionate desire to reach out and help, and perseverance in dealing with complicated problems. We intend to be your Friends For Life.

I am the President and Executive Director. Dr. Seymour Perlin, Professor of Psychiatry and Behavioral Sciences at the George Washington University Medical Center is Chairman of the Board. He is a former president of the American Association of Suicidology, and recipient of the Louis I. Dublin award for contributions in the field of suicide prevention. Dr. Perlin is also co-editor of Ethical Issues in Death and Dying.

Ursula Meese, Vice Chairman, the wife of Attorney General Edwin Meese, III, is a voluntary Commissioner to UNESCO and a delegate to the Status of Women in the United Nations. Mrs. Meese brings to the Board not only her long involvement in a multitude of civic organizations, but six years of experience as a Suicide Prevention Counselor in Sacramento, California.

Arthur H. Bredenbeck, Secretary, is a partner in the regional law firm of Carr, McLellan, Ingersoll, Thompson and Horn, a firm specializing in business and tax planning with significant involvement in health care law.

Lee Katz, Treasurer, is a California real estate investor, an economist and an educator. Always active in community and political affairs, she has served as chairperson and member of the boards of directors of numerous community and human relations organizations. Four years ago Lee and Martin Katz lost their son to suicide.

Dr. Norman L. Farberow is Clinical Professor of Psychiatry at the University of Southern California School of Medicine and the Co-Director of the Institute for Studies of Self-Destructive Behaviors and the Los Angeles Suicide Prevention Center. A pioneer and pre-eminent leader in the field, he has published extensively and has received numerous honors and awards for his outstanding contributions to suicide prevention.

Mariette Hartley, an esteemed actress, dedicated mother and involved citizen, brought new national awareness to the subject of youth suicide through her role in "Silence of the Heart," a CBS TV special in which she played the mother of a teenager who commits suicide. Ms. Hartley's personal concern for the issue and her sensitive and perceptive understanding of the subject, has made her an effective spokesperson.

Tom Leahy, Executive Vice-President of the CBS/Broadcast Group, has been recognized on many occasions for his outstanding leadership in the broadcast and business communities. Mr. Leahy is a past President of the International Council of the National Academy of Television Arts and Sciences and has served on the Board of Directors of the International Radio and Television Society.

Dr. Herbert Pardes is the former Director of the National Institute of Mental Health and the Chairman of the Department of Psychiatry at Columbia University. He also serves as Director of the New York State Psychiatric Institute and is well known nationally and internationally for his leadership and advocacy for support of research on mental health and mental illness.

We look forward to working with you in the challenging times ahead.

SUMMARY AND CONCLUSIONS OF THE NATIONAL CONFERENCE ON YOUTH SUICIDE

SUMMARY AND CONCLUSIONS OF THE NATIONAL CONFERENCE ON YOUTH SUICIDE

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Introduction

The high rate of suicide among our youth is everyone's concern. This concern and the desire to do something about it came to focus in these Proceedings of the Youth Suicide National Conference. The co-sponsors describe the Conference as an opportunity for 500 people with a common interest to exchange information about research and programs. It is a bountiful feast at a banquet table of information, issues, problems and questions voiced by some of the most prominent experts in suicide and its prevention, as well as government officials, entertainment figures, business and industry representatives, academia greats and adolescents representing the focal group, and the general public. The 61 presentations make rich reading. Each should be read in its entirety. This summary chapter offers only a taste of their offerings.

SIGNIFICANCE OF THE PROBLEM

NATIONAL AND INTERNATIONAL TRENDS

The significance of the problem of youth suicide is documented, as well as mentioned, by a number of the presenters (Farberow, Frazier, Hardy, Heckler, Lettieri, O'Connor, Pardes, Shaffer). Suicide in the age group 15-24 has increased by 119% between 1965 and 1978 (Farberow); a young person commits suicide every 90 minutes; about 6,000 adolescents and young adults end their own lives in one year; suicide is the third leading cause of death in this age group. The most telling point is the statement that the 15-24 age group is the only age group in our country to have experienced an increasing death rate over the last two decades (Pardes). It is also noted that the most substantial increases in completed suicides have been in the White male population and that suicide is the number one killer in the Native American population (Bryant). However, suicide rates among minorities, especially Blacks, have also shown similar, if not so marked, increases (Stubbs). The rate for Black males peaks between ages 25-34 and between the ages 20-29 is almost the same as the rate for White males (Stubbs, Mitchell). No data are available for an adequate evaluation of suicide trends among Hispanic youth (Sanchez).

Significantly, the surge in suicide rates in the past three decades has not been limited to the United States only (Farberow). Canada has reported an even larger increase in the suicide rates of their young males (mostly White),as have a number of countries in Europe. These include Finland, Austria and West Germany, with Finland showing the greatest increase in its younger males, more than tripling to 211%. France's youth suicide rates have climbed steadily since 1965 and the rates for Sweden peaked in the mid-1970's before coming back down to their original level. On the other hand, England and Wales have shown opposite trends, with a rate for their youth that has remained relatively stable over the last two decades. In the Far East, the youth suicide rate in Japan rose markedly in the 1970's and then showed a considerable drop. The rates for both males and females in the younger age group in Australia rose markedly in the late 1970's and then began to drop slightly.

Native American Youth: Some sub-groups among American youth merit special investigation. For example, the suicide rate among the Native American youth is several times the national average (Bryant). Van Winkle and May verify this with an exhaustive report on the suicides of Apache, Navajo and Pueblo Indians in New Mexico, covering the period from 1975 through 1979. The youth suicide rates are similar to or greater than that of the U.S. population, with the Apache ranking highest,

followed by the Pueblo and the Navajo. The impact of social and economic conditions has had its greatest effect on the young males, as indicated by the ratio of from seven to ten males to one female in the committed suicide statistics. Problems in social integration and acculturation continue to play a significant role in the suicide rates of Native Americans. Bryant feels that the number of suicides would be considerably lowered if the Federal Government were less involved in the lives of the tribes and individual Indians, a change that would significantly help the economic conditions on the reservations.

Black Youth: Both Mitchell and Stubbs note that the rate of suicide among Black youth is generally increasing and that between the ages of 20 and 35 the suicide rate of Black youth in New York City (and probably in many other large urban centers) has exceeded that of the White youth in the same age range. The pressures on Black youth in Washington, DC, are alarming when the fact emerges that no less than 50% of all the suicides up through age 30 in the last three-and-a-half years have been involved with drugs or alcohol. Of all the drugs, phencyclidine, or PCP, which has apparently become the drug of choice among young people today, has also become the drug of choice for committing suicide among the Blacks of Washington, DC. There might be something to the effects of PCP, especially the psychotic behavior which PCP easily brings on, that may play a prominent role in those suicides. Some dynamic causes may be in weakening of communal and filial ties, alienation from traditional institutions and/or closer-knit rural communities and unmet monetary and social expectations.

Hispanic Youth: The extended family, a characteristic of Hispanic society, has been a bulwark against suicide in Hispanic youth. Where this has broken down, the result has been a lack of effective role models and a decrease in self-value for the young (Sanchez). Church-related functions and activities play a strong role in suicide prevention among Hispanic youth and need to be supported.

Incarcerated Youth: A higher potentiality for suicide among juveniles in adult jails and lockups is confirmed in a study reported by Brown. Given the fact that there are close to half a million persons below the age of 18 who are in an adult jail or lockup for any length of time in any one year, it is obvious that this population can produce a considerable number of suicides. When compared with the suicide rate for young people between ages 12 and 17 in the general population, it was found that the rate of suicide among juveniles in adult jails was 4.6 times higher. The rate of suicide among

juveniles in adult lockups was more than three times higher. Interestingly and unexpectedly, the suicide rate among children in juvenile detention facilities was even less than the rate in the general population. There are interesting reasons for the differences in the rates for the juveniles in the adult jails and lockups versus the juvenile detention homes. Brown points out the findings have strong policy implications for not incarcerating children in adult jails or lockups. The higher rate of suicides in jails and lockups becomes even more poignant when it is seen that half of the juveniles had not committed a felony and actually posed little threat to their communities.

College Students: Berendzen feels that college students have one of the highest rates of suicide of all the population groups in American society. Approximately 10,000 students in college attempt suicide each year, with anywhere from 500 to 1,000 successful. There may also be a number of suicides masked as automobile accidents. Some studies seem to indicate that college students are more likely to commit suicide than non-college peers.

CLINICAL FEATURES

ETIOLOGY AND PSYCHODYNAMICS

Etiology, psychodynamics and treatment aspects of youth suicide are discussed by a number of the presenters (Farberow, Frazier, Shaffer, Voth). Shaffer indicates that the most solid information that we have about youth suicide comes from death certificate data. Some generalizations include: males commit suicide more often than females; suicide is rare before puberty, but becomes increasingly common with each advancing year in the teens and early 20's; the rate is higher for Whites than it is for Blacks (this may be reversed for young Blacks in high density urban centers, says Stubbs); and there has been an increase in the proportion of youth suicide deaths due to firearms. Blacks seem to use jumping as their primary method of suicide (Stubbs).

Shaffer's current study on youth suicide in New Jersey, Connecticut, New York State and New York City has yielded four tentative, but useful, categories among the deceased children. These are: teenagers who have had many problems in their lives, including trouble at school, with impulsive, aggressive behavior and feelings of depression; well-behaved, non-troublesome but perfectionistic, anxious, rigid youngsters

who constantly misperceived their abilities; primarily girls with most of the classical features of depression; and a small group with manic depressive psychosis.

MAJOR FACTORS

Frazier outlines the major factors as psychosocial, biological, family history and genetic and psychiatric predictors. Among the psychosocial factors, a disturbed family life looms large, especially when there is a family history of suicide--an event that increases the risk factor sixfold. The breakdown of the traditional family unit through disharmony, divorce or frequent relocation deprives youngsters of the sense of safety, support and unconditional love they need to flourish (Hardy). Parental neglect, as well as physical, sexual and emotional abuse, are found in the history of the runaway population (Guthrie).

If there is alcoholism, violence and other disturbed behavior in the family, the risk increases further (Farberow). Violence and suicide are especially closely related among Black youth (Stubbs). The developmental process and the handicap with which a teenager faces adolescence, with its accompanying physiological turmoil and the psychological process of separation and independence from the family, is described by psychoanalyst Voth. The desirable growth experiences are ordinarily provided by mothers and fathers in a home life that fosters the capacity to trust others and the security to handle challenges of life. Trust and a secure feeling of self are necessary in meeting the stresses of a society that has seen "the breakup of homelife, a soaring divorce rate, broken homes, partial homes and a near dissolution of family life." Peterson found that problems causing suicidal feelings in the young dealt with the intimate aspects of family, love, school, feelings, not the broader aspects such as the potential for nuclear war.

College Students: Berendzen notes that special stresses plague college students aside from the usual important developmental phases involving independence, definition of self, intimacy of peers. The specific stresses are loss or lack of a peer-love relationship, culture shock, homesickness and loneliness, academic pressures, a dramatic decrease in the status of a student in college compared to what the student had enjoyed before, dread of returning to the home country (if foreign), dread of the real world after graduation and anxiety about the real world of work after leaving the university. Family conflicts are immensely important. A survey indicated that one of the most dominant concerns, not only from suicidal

youth, but from all college students interviewed, was the stability of their parents' home and marriage.

Disabled or Handicapped: Another subgroup with high risk is the disabled or handicapped (Heilig). Everyone goes through crisis, episodes of trauma, loss, illness and severe family problems. While most of us get along, we all need help to get through the especially difficult times. Disabled people, however, may need a bit more. Heilig points out particular times when suicide possibilities may be higher among the disabled: the onset of a disability; exacerbation or worsening of a disability or pain; and discouragement of the treatment team. When patients feel that the doctor is losing interest, they also tend to give up on themselves. Chronic pain is also difficult for anyone to endure and may cause severe depression. The withdrawal of services leaves people who depend on them in desperate straits.

Substance Abuse and Youth Suicide: The role of substance abuse in youth suicide has been noted often in the literature, according to a number of presenters (Hendin, Hertzman, Lettieri, Litman, Meeks, Mitchell, Pardes, Stubbs). However, although the relationship between substance abuse and suicide clearly exists, the nature of the relationship continues to be poorly understood (Hertzman). It may be causative by releasing aggressive impulses; facilitating, as with automobile accidents; or incidental, that is, simply occur from the widespread experimentation with drugs among teenagers. Litman points out the too easy availability of alcohol and street drugs which contributes to the vulnerability factor in suicide. Most importantly, alcohol and drug abuse are closely related to youth suicide. As a result, Litman sees drug abuse medicine and counseling services as essential elements of an overall suicide prevention program, especially for the older teens, 16-19, the ages where alcohol and drug abuse is most often first introduced and also the ages in which the greatest increase in youth suicide occurs. Berendzen goes so far as to say that the most common suicidal condition among college students is that they are under the influence of alcohol.

Biochemical Factors in Depression: Recent advances in biochemical studies may now be offering the most promise for aiding the detection of suicide (depression), as well as for treatment. Still, the most powerful predictor of suicide in young people is the presence of a mental disorder, with clinical depression both the most common and most significant. As Frazier points out, the suicide rate for people with serious depression is 25 times greater than in the general population. Add to this the fact that one out of ten

Americans seems destined to have a major depression in his lifetime, and it is then possible to anticipate the source of a significant loss of human life. What is most unhappy about this situation is that effective treatments are known, effective and inexpensive. Yet, most people suffering from clinical depression do not seek treatment, and when they do, many of those treating are not familiar with the excellent treatments available (Frazier).

TREATMENT CONSIDERATIONS

Evaluation of Risk: An important aspect of treatment of suicidal adolescents is evaluation of the suicide risk. Motto points out that most clinicians tend to use essentially the same criteria for evaluating adolescents as for adults because there have not been any specific measuring instruments developed for the young age group. The important criteria continue to be the presenting clinical picture, especially if depression or psychosis are present, accompanied by feelings of hopelessness, suicidal thoughts, a suicide plan and the available means. High stress life circumstances involving serious loss, absent or inadequate support system, and abuse of alcohol or drugs, are significant features in this category that need to be evaluated. The psychosocial factors contributing to high risk are mostly concerned with family, especially the broken or stressful home setting, a suicide or emotional disorder in the family, chronic alienation from family and others, and a history of unstable, impulsive behavior (Berendzen, Motto). Motto reports the results of a number of other investigators as well as those of his own prospective study of 335 suicidal adolescents, aged 10-19. One of the most important conclusions was the fact that suicidal behavior in adolescent males was not always an impulsive act that comes as a complete surprise to others. He also found that very specific depressive systems were frequently present, adequate sleep and financial resources were not cause for reassurance, and that poor communication and a negative attitude toward being interviewed by a potential helper were significant causes for concern.

Lettieri summarizes the clues to consider in identifying child and adolescent suicide. It is important to understand what death means to the suicidal child, for death means something very different to the various age groups (e.g., the young child does not think of death as permanent), and it is probably not until latency that the concept of death is generally, if not fully, understood as universal and as the permanent cessation of all bodily activities. Motivations of the suicidal youngsters will vary also according to age and

elements of punishment of self, expiation of guilt, and identification with a suicidal parent may be found. For girls, the motivation seems most often to be interpersonal and to stem from rejection. School failures are often because of high expectations by the student that have been incorporated from the parent. The most common feelings noted are hopelessness, depression and feeling different. Behavioral, social, familial, physical, environmental, and emotional changes along with depressive clues are noted in his two tables, with the depressive clues categorized by age groups.

Meeks adds as an important factor in evaluating risk, the patient's stated wish to die. In treatment, the attitude of the therapist is also significant. He feels the fact of suicide risk must be forcefully expressed to the patient and the therapist must take an active position against the suicidal wish and thoughts. Establishing a contract (i.e., an agreement between the patient and therapist that all suicidal feelings be openly discussed and not acted upon) with the patient he has found to be useful, and mobilization of the family for close monitoring and supervision at home is necessary in order to insure safety. Treatment of the depression or underlying psychiatric illnesses usually involves a combination of medication and supportive psychotherapy. Conduct disorders require active involvement of the therapist with control or direction to help the youngster to develop appropriate responses. Both Meeks and Litman note that treatment of suicidal youngsters is complex, takes a long period of time, involves major elements of re-education and personality growth, requires limit setting, the development of a trusting transference, re-educational techniques and involvement of the family. If the young person presents a combination of both drug abuse and suicide attempts, one can assume multiple problems encased in a complex package of misery (Litman). Usually this requires prolonged and expensive treatment.

Treatment of Suicidal Children and Survivors: In the therapy of suicidal children, Pfeffer and Weiner caution that the first goal is to protect the children and then to proceed with the evaluation of risk, which would include noting depression, suicidal behavior of significant others, and death preoccupation. In proceeding with the evaluation, it is important to obtain an adequate and appropriate diagnosis to learn the stress factors pertinent in the child's situation and to discover the meaning of suicide and the child's concept of death. In treating the child, it is important to work within the system, especially with the family. Medication will be considered and group therapy is often a possibility.

The basic aim is to build protective barriers for the child, so that suicidal behavior does not recur.

An important clinical sub-group too long ignored, but certainly a significant one in terms of pain, suffering and increased suicide potential, are the survivors of youth suicides. As Heckler points out, the impact on parents is often overwhelming. Programs of prevention among youth suicide may actually be "double prevention," in that they would also prevent the increased likelihood of the subsequent suicide of the parent. Two persons report on programs for survivors. Iris Bolton, in a poignant recounting of her own experiences after the suicide death of her son, indicates the stages of feeling, the continual search for the answer to "why?", the struggle with the difficult feelings of guilt and anger and the need of friends and family for a support system. In addition to helping others face the tragedy through lectures and seminars, she has helped to establish support groups throughout the country, the Compassionate Friends and Survivors of Suicide.

Zinner also describes her experiences in conducting suicide survivor groups. While there are, at this point, no controlled experiments indicating effectiveness, there is much clinical evidence. The survivors group provides mutuality over and above the fact of death. It is around suicide that the members are able to relate to each other. The groups are also not stigmatized, that is, not identified as mental health, nor as psychology. The sessions are not considered therapy, but rather opportunities for sharing the benefit of mutual support. The theme stems from "a joy shared is a joy increased; a burden shared is a burden lessened." There is considerable empathy and understanding among participants with members sharing almost anything that is expressed as feelings or experiences. The groups also provide models of surviving to those newly bereaved in indicating that it is possible, eventually, to overcome the pain. A number of helpful, practical suggestions are made on how to start a group.

Problems in Treatment of Black Youths: The psychosocial aspect is seen as highly important by Hendin. His studies of young suicidal Blacks have impressed him with how their experiences in the ghetto have flooded their consciousness with angry homicidal impulses, complicated with feelings of being overwhelmed by the loss of control. He makes two intriguing points: (1) that earlier formulations about a supposed inverse relation between suicide and homicide need to be revised as a result of his studies: and (2) that there is now convincing evidence that one source of stress among the young, over the past three decades, lies in the increase in

the percentage of young people in the population. This increases the competition for desirable adult options. Young people face different odds in competing with each other when there is a limited number of new and challenging positions. Perhaps the fact that the suicide rate of the young is no longer increasing and may even have begun to drop is related to the fact that the baby boom has now passed and the percentage of young among the population has begun to decrease.

SUICIDE CLUSTERS

One characteristic of the current suicide problem is identified by several of the papers (Frazier, Rosenberg, Kahn, Shaffer). This is the "suicide cluster" where one suicide appears to trigger a number of other suicides in a group, usually a school or a community. Clusters such as these have been identified in the past two years in Plano, Texas; Westchester County, New York; Houston, Texas; Clearlake, Texas; and Minnesota. The question of why and how such clusters occur is a problem urgently requiring investigation. Shaffer wonders whether imitation might be the mechanism through which suicide clusters occur in a high school district or a geographical area. Factors needing investigation of this phenomenon include whether or not fictional stories of suicide on television or in movies can influence imitative suicide, and whether imitation affects attempted suicides. Also, we do not yet know what proportion of teen suicides occur in clusters. Peterson of NBC News interviewed school youth and asked if suicide had become a trend, a fad. One girl's response was that it was not trendy like blue jeans, but if she sees someone attempt suicide and that succeeds in getting the help needed so that things get better, then she thinks maybe it would work for her too.

PROGRAMS

YOUTH SUICIDE NATIONAL CENTER

A number of programs, current, operating and planned, are described by various presenters. The Youth Suicide National Center has been established in Washington, DC, with Charlotte Ross as its President and Executive Director and Seymour Perlin, M.D., as its Chairman. Its purpose will be to serve as a central source of information, guidance, and leadership that will support, encourage, and improve existing prevention efforts and facilitate effective national programs to prevent

youth suicide. Plans are to develop a public awareness campaign; a national clearinghouse for information on youth suicide; to collect, develop, and distribute materials on youth suicide through a central clearinghouse; to create and computerize a data base; to provide a comprehensive prevention strategy that includes the education and training of sub-populations in primary contact with youth to increase skills in recognizing and assessing suicide danger signals among students, parents, educators, and professionals in the health field; it will also encourage research funds, including evaluation of current prevention strategies and help in the formation of self-help groups at local and regional levels. The Center will help families and individuals who are bereaved through suicide and encourage them to become a resource in the prevention of further youth suicide. The Center was established to facilitate the interface between government and the private sector, encouraging both federal and state legislation, business and industrial and corporate support, and encouraging local autonomous programs involved in youth suicide prevention.

HEALTH AND HUMAN SERVICES TASK FORCE ON YOUTH SUICIDE

One indication of significant government concern and involvement is the establishment of a high level task force on youth suicide by HHS Secretary Heckler. This group is chaired by Dr. Frazier and is made up of senior officials of the National Institute on Drug Abuse, National Institute of Alcohol Abuse and Alcoholism, Centers for Disease Control, Office of Human Development Services and the Administration for Children, Youth and Families. The collaboration and coordination of other agencies of the Federal Government, as well as Congress and state and local governments, will be sought. The aim of the task force will be to assess and consolidate information that now exists and to recommend activities that will reduce the youth suicide phenomenon. Regional forums will be held to promote communication among health and mental health professionals in all levels of the community. In addition, the Centers for Disease Control in Atlanta will concentrate on the problem of improving the reporting of youth suicide to provide better data on frequency and trends.

RUNAWAY AND HOMELESS YOUTH PROGRAM

Consistent with the problems of the disturbed family, there has been a marked increase in runaways and homeless youth. This problem has been addressed by funds from the Federal Government for the establishment of over 265 shelters across

the nation and recently awarded grants to organizations for the development of effective techniques for intervention and provision of emergency services to the depressed and suicidal youth who use the shelters (Hardy). The program is described in detail by June Bucy, Executive Director of the National Network of Runaway and Youth Services. The data indicate that 82% of the shelter users present significant psychiatric disabilities; 33% of the girls and 15% of the boys have contemplated or threatened suicide. A pressing need is for runaway centers to be properly informed and trained in identifying and assessing suicidal potential among the youth (Bucy, Guthrie). Training programs have been initiated and training materials have been disseminated. Guthrie describes a training package and a youth workbook on teen suicide that the Suicide Prevention and Crisis Center of San Mateo, California is developing. The method combines didactic presentations with an experiential approach. The major objective is to give the participants a clearer understanding of their own depressive behavior and feelings and to help them to understand and recognize signs of depression in the youth that they are trying to help. A self-help workbook on coping with depression and suicide is being developed. The contents will illustrate the feelings experienced by a youth when a peer threatens suicide and at the same time refuses intervention or swears the listener to secrecy. Information on possible methods of intervention as well as the right to receive medical attention will be offered. The workbook will be addressed toward reducing the feelings of fear, shame and guilt that young people experience along with suicidal thoughts and that prevent them from asking for help. Bucy feels that the runaway Centers are probably the most effective and responsive nationwide system for addressing the crisis needs of youth in America.

DEPRESSION PROJECT

Frazier reports that as a result of the awareness of the significance of depression, not only among suicides and suicidal youth, but also among the public in general, a major campaign is planned. The purpose of the campaign is to increase the awareness of clinical depression among the general public, general health care providers and mental health specialists, and to heighten knowledge of the effectiveness of treatment and its availability.

STATE PROGRAMS

California: Several states have developed long-range overall plans for addressing the problem of youth suicide. One of these is California, described by Dr. Michael O'Connor, Director of the California Department of Mental Health. The first-program is a major piece of legislation, SB-947, passed by the State Legislature in 1983. This is a three-year pilot project evaluating the effectiveness of teaching suicide prevention to students, teachers and parents. (The program is described in more detail in Peck's paper.) A second project is a five-year Youth Suicide Prevention Program that will involve a variety of public and private resources and will aim toward gathering exact information on the youth suicide problem--completed, attempted, threatened, substance abuse and other indirect manifestations. The program will use the first year for a comprehensive evaluation of the problem through information obtained from young adults themselves on the kinds of pressure that they face; the second year envisions materials and program development; the third year will be used for program implementation and initiation of training programs around the state utilizing local resources; the fourth year will continue with ongoing implementation of programs; and the fifth year will use the data obtained for a comprehensive evaluation for effectiveness, community involvement, local flexibility, mobilization of local resources and partnership between private and public sectors.

Florida: George McKinney of the Department of Health and Rehabilitative Services in Florida describes the development of a state plan for youth suicide. The result has been Florida Senate Bill 529, which mandates that the DHRS work closely with the Department of Education and collaborate with all other departments related to children, youth and families. The plan devised by the DHRS required the 11 health districts of Florida to set up their own individual task forces to study the problem on a local basis and to make recommendations to the state task force. The Department of Law Enforcement was involved to find ways to train law enforcement people who were concerned with the problem. A public awareness campaign was planned and curriculum materials were to be developed. The districts also were asked to evaluate current programs, their cost effectiveness and impact. Each district was to come up with a model of services continuum, procedures for implementing it, possible barriers and possibilities for implementation with or without funding. One glaring omission was to survey the contribution of private providers. The basic philosophy of the program was that suicide was part of the bigger problem of children in crisis and that it needed many people from many areas working in cooperation. The model of services continuum included prevention, public awareness, peer counseling, school

personnel, parent education and training. Intervention efforts included crisis hotlines, crisis counseling, runaway shelters, crisis centers and mobile response units. Treatment services included emergency rooms, crisis stabilization units, inpatient treatment and hospitalization. Funding was made available for a campaign in public awareness training, a 24-hour toll-free crisis line service into rural areas, two crisis centers, evaluation, and the development of a uniform state-wide recording system. The act has not yet been signed into law.

New Jersey: New Jersey has also signed a Suicide Prevention Bill into law, Senate Bill No. 2005, as of June 1985. The State Department of Human Services will establish a program to develop classroom instruction, with materials aimed specifically at students and teachers to make them more aware and to identify suicidal persons, to inform them about available community services and to increase information about the relationship between adolescent suicide and substance abuse. In addition, community based agencies would set up crisis telephone service lines, staffed by professional counselors, to provide not only crisis intervention, but also post-intervention services, with parent education programs and programs for the families of suicide victims. An assessment and evaluation component is included and Youth Suicide Prevention Advisory Council has been formed. The Council will have responsibility for compiling information, disseminating the materials, assessing the most effective methods and assessing the costs for providing the programs. In addition, three suicide prevention projects will be established in the northern, central and southern regions of the state to implement the various recommendations.

ACTION, NATIONAL VOLUNTEER ASSOCIATION

The importance and usefulness of volunteers as a readily available and eager resource for addressing significant community problems is emphasized by Donna Alvarado, Director of ACTION, the national volunteer association. Volunteers contribute most by helping to build public awareness of a problem and by taking action when specific problems are identified. With over 370,000 retired volunteers, it is apparent they are a prime resource for educating Americans about youth suicide and for reaching out to young people who are considering suicide. The National Center for Citizen Involvement of VOLUNTEER will help with the networking among the volunteer action centers which, in turn, would mobilize local volunteers. Barbara Wyatt, of ACTION, also emphasizes the usefulness of involving teenagers as volunteers and how

this gives them a strong feeling of self-worth. She also stresses the importance of belief and commitment in your program that depends on raising funds, whether from the public, governmental or business sectors.

UNION OF AMERICAN HEBREW CONGREGATIONS

Another example of a community program, this one emanating from the religious sector, is described by Rabbi Arian of the Union of American Hebrew Congregations. The program is aimed at peers, parents and professionals who work with youth with the main objective being education and awareness of the problem of youth suicide. The program uses published materials, media films, information sessions for interested parents, group discussions and a kit of materials for professionals. The program is implemented through the various congregations in the Union.

PARENT TEACHERS ASSOCIATION

In a similar fashion, the Parent Teachers Association (PTA) has thrown its vast resources into the struggle against youth suicide in a number of ways, according to Ann Kahn, its current President. Primarily through information and communications in their journal and newsletter, and supportive activities for programs in their local areas, interest and awareness is being stimulated through all of their chapters. In addition, the PTA lent its support to legislative programs and has been active in initiating programs in various communities, especially those where cluster suicides have occurred.

CALIFORNIA MEDICAL ASSOCIATION AUXILIARY

Helen Karlsberg reports a program initiated by the California Medical Association Auxiliary, an organization made up of physicians' spouses. This Auxiliary has developed regional and county seminars for professional school administrators, teachers, physicians, nurses, counselors, coaches, clergy, social workers, law enforcement agencies, parents and students. The goals have been to educate, increase the awareness about the problem of suicide through emphasizing recognition, identification, effective intervention, and appropriate referral. The seminars have used an experimental approach, films, and published materials. The program has been supported by the National Auxiliary and other states have initiated similar activities. Insofar as possible,

organizations already existing in the community are coordinated and integrated into the program.

NATIONAL FUNERAL DIRECTORS ASSOCIATION

A unique but obviously important role at the time a suicide death occurs is that of the funeral director. Recognizing the opportunity to be influential in the prevention of subsequent suicides, the National Funeral Directors Association has distributed a program to its members, informing and educating about the emotional problems involved with suicide, and providing suggestions for helping the survivors (Conley, Hagin). Help is also extended to friends and classmates of a youth who has killed himself, usually through group meetings led by trained counselors familiar with suicide and with suicide grief. The program focuses on suicide education for youth and parents as well as for educators and caregivers.

ARMY

The Army, made up of youth in their older teens and young adults (when the suicide rate jumps high), and subject to a new and strange life, separated from their family, and subjected to a number of unknown stresses, would seem like a segment of the population automatically characterized by high suicide risk. It is interesting therefore to note from Thomas' description of the Army suicide prevention program that the total suicide rate in 1982 is lower than the total U.S. rate and that males 20-24 have less than half the rate of the same group in the general population in 1981 (13.5% versus 26.8%). The Army's suicide prevention program is based on a caring leadership and early involvement of the chain of command. Its main thrust is education, awareness and training, and it facilitates this by establishing a suicide prevention task force at each installation. The purpose of the task force is to coordinate the suicide prevention activities of the command and evaluate the needs of the installation. The program has produced a videotape on suicide prevention, published an Army guide on prevention of suicide, established a 24-hour help line on all Army posts, provided additional training in mental health, improved the reporting of suicides, conducts formal psychological autopsies on all soldier suicides and also conducts a major research project to study suicide and its prevention.

DEPARTMENT OF DEFENSE SCHOOL FOR DEPENDENTS

The Department of Defense also conducts dependents' schools in foreign countries for members of its troops stationed in countries outside the U.S. (Gray). A program has been established for these schools emphasizing detection, defining responsibilities of personnel, and developing referrals to community and professionals. The program will focus on instructing school personnel, informing parents, developing curriculum materials for grades 9-12 that would be distributed for in-service training. All health personnel will be certified that they have been trained to recognize suicide potential signs.

SUICIDE PREVENTION CENTERS

Suicide prevention centers and crisis lines have existed in the U.S. since 1958. Cantor answers the contention that SPCs actually do not prevent suicide except within one group--young, White females--pointing out that the SPCs and crisis intervention centers do prevent suicides and are also valuable for all the clinical, community, research, and resource services they provide. Not only have they given help and comfort to a number of people in distress, they have prompted the development of numerous peer counseling centers at high schools and colleges across the country. The Centers are providing clinical facilities and also serving as educational and training centers. They are serving as research centers and have been the starting point for the necessary interest in suicide prevention. She points out that many of the criticisms of SPCs are unreasonable. They cannot solve all problems for there are many for which there are no solutions. Also, suicide prevention and crisis intervention workers are human, and should not be expected to be saviors, all-loving and unconditionally accepting of everyone. They may not always have the best solution. Despite these unreasonable expectations, the provision of opportunity and place where human misery, loneliness, despair, and depression can be alleviated in those who feel they have no one else, or no place to turn to, more than justifies their continued role in their communities.

TEEN LINE

The advantage in using young people to respond to the distress of a suicidal adolescent is described by Lipton and Leader and one of their adolescent counselors A'Lee Jones. By means of the telephone, instant direct contact is made with distressed adolescents, providing immediate communication, catharsis and consolation. The advantage of the telephone is that it is an

equalizer and allows anonymity. The adolescent counselors are given extended training and close supervision in order to attain the program of teen to teen communication with active listening by a caring, non-judgmental other who has been trained and supervised by a professional. To some degree, the feasibility and practicality of such a program is limited by geography, for the program is not seen as useful in a small community. It requires a large metropolitan and psychologically sophisticated city, large enough to provide mental health professional volunteers and to eliminate the probability that the teen call and teen listener would meet or know each other.

SUICIDE AND THE MEDIA

Although Peterson of NBC News does not describe a program to be used in school or in the community, her report of her experiences in talking to young students in schools throughout the country is included here because it emphasizes and substantiates the point made by Lipton and Leader. She found that the youth strongly felt that "kids helping kids" is the only solution. They do not want to have adults involved for they fear overreaction, a rush to a "shrink," or a hospital, or else disbelief. She also found that the young people were eager to share and held back very little when given the opportunity to talk about their own feelings. In some of the schools where peer counseling programs were available, skits constructed by the students were helpful. Sometimes, however, the skits opened up the youngsters so it was necessary to have adults present to watch for those who were troubled and to provide the needed counsel. One strong recommendation that emerged from her discussions with the young people was that it was necessary to initiate programs in junior high school and even into some elementary schools, not just to limit programs for counseling and awareness education to the senior high schools

BUSINESS AND INDUSTRY

There is still another important area of the community which while it may not be organized per se against suicide, nevertheless offers as yet mostly unexplored opportunities to play a significant role in its prevention. This is illustrated by the remarks by Thomas F. Leahy, Executive Vice President of CBS Broadcast Group, who describes the production of "Silence of the Heart," a film portraying survivors' grief over an adolescent suicide, and by Peterson, a producer for NBC News, that produced a documentary, "Dying for Attention."

Leahy points out that in terms of the potential for education and awareness, the system can reach the largest audience at any one time better than any other approach. The broadcasting systems are aware of and are willing to play a role in disseminating information and education, both in the form of entertainment and through follow-up discussions, dissemination of educational material, bibliographies, and announcements. In addition, broadcasting systems are committed to presentations of public service announcements which serve the purpose of heightening and maintaining awareness of the problem in the general public. CBS represents one portion of the corporate world, and the implication by both Leahy and Wyatt obviously is for efforts to be made to involve other segments of the business world, industrial and organizational. This, too, would contribute to the avowed aim of Secretary Heckler to arouse a national unity and awareness in the attack on this problem.

It is of interest to note that Motto, in his study of suicidal adolescents, found that the ability to communicate well with others was a significant factor in differentiating between those who subsequently suicided and those who did not. None of those subjects who were rated as able to communicate with the interviewer subsequently committed suicide. To Motto this gave credence to the frequent observation that communication difficulties or breakdown are involved in an adolescent suicide. Communicating through television and videotapes is increasingly available, and may be one way in which current high-tech capabilities can be used to an advantage.

SUICIDE INFORMATION AND EDUCATION CENTRE

The best example of suicide prevention through communication is the Suicide Information and Education Centre (SIEC) established in Calgary, Alberta, as a focal point for information, communication, and education (Tanney). The program is a project of the Canadian Mental Health Association and is also supported by the Provincial Government of Alberta. The SIEC serves as a resource for all English language articles on suicidal behaviors produced since 1955. About 80% of its 1,270 documents dealing with suicidal behaviors and the age cycle are on suicide in children, adolescents, and youth. The SIEC even collects ephemeral literature such as lecture notes, pamphlets, promotional materials, and educational programs.

The SIEC has developed a list of subject terms to organize the entire area of suicidal behaviors. Instant access is available to the abstracts and to all the documents concerning

any problem area subject for investigation. The SIEC has also developed a "bulletin board" to serve as a calendar of suicide prevention related events; it provides a newspaper clipping service; publishes a quarterly "Current Awareness Bulletin"; publishes a catalog of audiovisual materials; and has developed kits with related materials in specific content areas. Any computer in North America, Australia, or Europe can access the catalog with a computer terminal and a modem telephone connection.

THE ROLE OF SCHOOLS IN SUICIDE PREVENTION

Another avenue for widespread dissemination of information and education is the school system in which our youth spend the major portion of their days. One would suppose this would be readily welcomed as an effective means of reaching most of our youth under well controlled conditions. While some programs have been developed, the path has frequently been rocky and beset with considerable difficulties.

Pilot Program in California: Two programs are described at length by participants as examples of school programs currently in operation or in development. Guthrie, O'Connor and Peck describe the program in California now in progress under a mandate by the State Legislature through AB 947 to conduct a pilot program in the schools of two areas of the State, Los Angeles and San Mateo counties: the development of a suicide prevention program and its evaluation. A State Advisory Committee on Youth Suicide Prevention considered the problem and recommended to State Senator Robert Presley a three year, many pronged approach with one part of the program aimed at students, another at teachers and school personnel, and a third at parents. The basis for inclusion of students was the discovery that not only were a significant 30% to 40% of the students experiencing suicidal impulses, but the people they were most likely to confide in and turn to for help were their peers. The major problem among the peers was that they did not know what to do with the information, and worse, were frequently committed to silence about the information on the basis of their intra group code of silence. The curriculum has been designed as a series of four classroom sessions for the students, with the primary aim of helping them to understand something about the stresses they live with and to know what depression feels like. They are also taught that such feelings are temporary and will always pass. In terms of what to do with the information when someone else tells them about feeling suicidal, they are taught their primary responsibility is to get the person to adult help as soon as possible, a point also emphasized by Peterson. The teachers

are taught how to recognize depression and suicidal feelings, how to approach it non-judgmentally, and how to obtain appropriate, adequate and professional help. The parents are likewise informed about the program so that they can collaborate and be supportive of referrals when and if they should occur. The evaluation component, with before and after data and planned follow-up data, is a crucial part of the program. The program was designed to allow school districts maximum flexibility and to utilize fully community resources.

University of Rutgers Medical School Program for Public Schools: Heiman and her colleagues from the University of Rutgers Medical School have developed a suicide prevention project that is directed at the special service staff in schools, that is, the school psychologist, social worker, nurse and guidance counselor, to train them in assessment in crisis intervention. The program addresses both the cognitive and affective aspects of suicide prevention, adopts a "how to" approach to build concrete skills, and places emphasis on helping the schools to devise their own internal support networks, develop linkages with outside agencies, and to evaluate policies and strategies for the management of suicidal behavior. The program is offered either as an eight-week on-site course, or a full two-day workshop. The most anxiety aroused in the school staff was related to contacting and working with families of suicidal youth, and talking with the students and learning to ask directly whether they were suicidal. As a result of working with the schools, there was a dramatic increase in at-risk students being identified and referred for therapeutic services. The program has also emphasized the significance of a strong collaborative relationship between the school and the local mental health agencies.

American University Program: Berendzen describes a hotline that has been set up in American University and supports the oft-repeated comment that prevention and early identification are best carried out by student-peers. He feels the most effective preventive strategy in a college is a campus that works with a sense of community and a diverse support structure. He has found that resident advisors are especially important in a university setting. These persons have control and responsibility for a floor in a dormitory. They play an important role in early identification of suicidal persons because they get to know the students living on their floor very well. He feels that the perception that there is at least one person on the campus who understands and cares dramatically decreases the risk of suicide. A training program for students and all staff working in dormitories as well as in student counseling produces well-informed trained

peer counselors. The University Center for Psychological and Counseling Services has been identified as available 24 hours a day.

Pros and Cons of the School Prevention Program: As indicated earlier, the development of school projects on suicide prevention has not been smooth. Concern has been voiced by some professionals and direct opposition has been raised by some members of the general public. Voth, a psychoanalyst at Menninger's, is very much concerned with the teaching of such materials in the schools where he feels it only serves to add to an already existing sense of instability, stress and sense of despair and hopelessness about the future. He is even more concerned about discussing the cases of suicide in too much depth because of the danger that inexperienced people will be in over their heads in their efforts to respond. He does accept the fact that the teachers should be provided with information so that they can recognize when despair and distress are present, but emphasizes that teachers should be referring the child to someone (a competent professional) who knows how to handle troubled children. Peterson also found that teachers did not want to get involved, that they were afraid of legalities. However, they should learn the signs, not be afraid to ask, and then refer to appropriate help, whether parents, professionals or both.

Schlafly goes still further in condemning the whole practice of teaching anything about suicide, or its prevention, or even death, in the school system. She refers to hearings conducted by the U.S. Department of Education in seven cities in March 1984 as an indication of how classroom curricula contributed to teenage depression, despair, lack of hope in the future, and even suicide. She also quotes a number of parents and teenagers from these hearings who stated that such subjects promoted distress and may even have produced suicidal behavior among the students. Schlafly terms these experiences as "psychological abuse" received in classroom courses and equates it with violent "anti-life" lessons which desensitize children to the notion of taking a human life. She feels this is the basis of the rate of teenage suicides doubling over the last 25 years. "The children are acting out what they have been taught in class. Added to these outright psychological abuses and morbid preoccupation with death, is a heavy diet of assignments and supplementary reading with depressing themes, degenerate characters, filthy language and overt attacks on the American system." Schlafly also feels that any real attempt to prevent teenage suicide must start with an expose of the suicide promoting materials that are given in class and rock music lyrics they play. In her view, the 1978 Pupil Protection Amendment and its 1984 regulations are necessary

because the school courses were given to children without prior parental consent. She does agree that parents should be alerted immediately if the school detects any suicidal tendencies in any individual child, but offers no suggestions how the training for detection should occur.

On a different level, John Klenk, Director of Planning and Evaluation Services, Office of Planning, Budget and Evaluation in the U.S. Department of Education, deplores the feeling of negativity, sense of hopelessness, and lack of ideals that permeates our society and seems as well to be taught in our schools today. Like Schlafly, Klenk deplores the rock songs, their titles and the names of the groups that sing and play, and wonders whether it reflects a deterioration in the morality and ethics of our society today. His own concern is reflected in the feelings that Walter Lippman expressed that "emancipated democracies have renounced the idea that the purpose of education is to transmit western culture." This cultural vacuum has produced progressive disorder. The problem seems too big for any government program. What is needed is to marshal resources, especially people, and aim toward restrengthening and re-empowering parents in particular. We need to transmit hope, meaning and love derived from our heritage, and join in a collaborative effort to reduce the sense of hopelessness that seems to have developed in our society.

Pros: Directly opposed to Schlafly's opinions are the statements of the teenagers presenting at the Conference. One example of the impact of an adolescent suicide upon the rest of the students in his school is illustrated by Mark Elliott and his song about the pain of a girl. Representing the feelings of most other students from his school, he stresses the importance of giving the students an opportunity to express their feelings and thoughts about suicide, especially when a suicide death or attempt occurs. It is contrary to good mental health to suppress or not discuss what is distressing everyone in the school.

Ross, in introducing the members of the teenagers panel, states that they provide us with examples of youth who have had experience with pain, are sensitive to it, and are creating settings to help others deal with it. Teenagers Cox, Pshak and Wyatt talk about experiences and programs they are connected with that have dealt with suicidal feelings among their fellow students. Wyatt reports talking to a friend who had become suicidal and convincing him that everyone was concerned and that people did care if he did not feel good about himself to the degree of wanting to kill himself. Pshak describes a camp in Arizona called "Anytown" where young

people could attend for a week and discuss anything, especially their feelings. The major objective is to build self-image. The camp was experienced as especially useful and a plea was made to establish similar camps throughout the country. Cox reports the activity of the Health Occupation Students of America which sponsors community awareness projects, and writes pamphlets on suicide to help students know what to do if a peer should become suicidal. A major objective of the instruction is to get the person to professional help.

Students Against Suicide: Students Against Suicide is described by Molly Hardy as an organization created by teenagers and developing out of their own needs and a desire to prevent the tragedy of suicide occurring among their friends. The basic principle upon which they are organized is that the teenagers agree to be "real" with each other and willing to be with each other in a way that will discourage other teenagers from wanting to commit suicide. The organization is seen as providing a forum for people to communicate and to educate the community by letting people know about the need to make the kind of commitment that will make a difference. Training is given on how to respond during the crisis. Referral resources are also included. The organization is based on the familiar principle of teen helping another teen that is described by Lipton and Leader, but functions in a much less formal manner and without the professional supervision Lipton and Leader feel is so important.

LEGAL ASPECTS OF SUICIDE PREVENTION

Davidson's paper on the legal aspects of prevention of suicide among youth is a fascinating exposition of the problems and questions encountered by the law in this area. In a review of state and federal court cases and of the state statutes, it becomes apparent that the court system does not adequately appreciate the potential for suicide in many of the children who come before the court. It is therefore critical that judges, lawyers, probation offices and social workers be trained in the identification of children at risk. In a review of criminal laws, Davidson notes that suicide is no longer a crime in any state; attempted suicide is a crime only in Oklahoma and Texas; 22 states have criminal penalties for those aiding, advising, abetting or entering into a suicidal pact; and 11 states have provided protection from criminal actions for those who try to stop someone else from committing suicide. In terms of civil laws, Davidson finds that "mature minor laws" in 35 states provide consent for a child or minor

to obtain his own treatment for substance abuse without having to obtain adult (parental) authority (and applies this to suicidal youngsters, also); 16 states have enacted laws that exert some control over insurance underwriters to make sure that suicide is covered in life insurance policies; seven states have laws requiring workers' compensation to include situations where work-related injury has contributed to a subsequent suicide (most states do not have such a law, preferring to follow the principle that suicide is an intervening act and subject to the person's own choice); 17 states have "dram shop laws" that make a person who sells or serves alcoholic beverages to a person responsible for that person going out and causing an injury or committing an accident (these laws have also begun to be applied to someone contributing to or in some way causing a subsequent suicide); and three states now have youth suicide prevention programs, California, Florida and New Jersey.

Davidson also identifies the individuals who can be sued for another person's suicide; those who cause mental conditions or physical injury which lead directly to another person's suicide (includes sexual abuse); "dram shop laws" violations; those with a legal duty such as jailers, staff in a mental hospital or a general medical hospital, and mental health professionals in private practice. Those who do not have a responsibility for another's suicide include the clergy, school guidance counselors, attorneys, pharmacists and parents. However, the exclusion of even these latter groups are now being challenged and precedents established with various court cases throughout the country.

Childress discused some of the ethical principles and problem areas that apply to suicide prevention which include: just because people are incompetent does not mean that there is a right to interfere; prediction of probability of suicide is at best highly uncertain; there is a need to balance the benefits of intervention against the harms of non-intervention; there is a requirement to choose the least restrictive, least humiliating and least insulting means of intervention; and there is the great difficulty of knowing exactly what a person's wishes really are, not only for the present, but also for the future. The problem areas include: how much parental authority in relationship with their child exists at different ages; who will use and how will information be used for the benefit of the child; how much education and discussion of the issues of suicide will benefit the suicidal person; and what is the most appropriate allocation of resources for prevention of suicide. Other problems for the law include when it should shift its approach from responsibility over children to consideration for the rights of adults; when does life

actually begin; at what point can a person be presumed to be functioning competently and voluntarily; how should the law approach "right to die" cases and when to apply "mandatory reporting laws," that is, notifying parents or guardians of potential risk for suicide.

NEEDS AND STRATEGIES

A number of general and specific recommendations emerge from the presentations. Pardes outlines a series of strategies that would begin to address the problem of youth suicide on a national scale. For example, he indicates, as do Litman and Hertzman, that special efforts must be aimed at older teenagers and young adults, since it is in the group from 16 up through 24 that the major contribution to the suicides among the young occurs. Second, health professionals and other caregivers for young people should be alerted and informed as to the general risk factors. This includes learning how to elicit the information and knowing especially the principles in communication when information is sought from someone in pain and distress. Next, a suitable network must be developed so that those young persons identified as being at risk can be appropriately referred. The nature of the referral itself is important, especially in trying to evoke a commitment to the referral.

General health professionals need to be alerted as well as mental health professionals. They often are the first to be contacted and serve truly as gatekeepers in the identification of potential suicides. In addition, we must be prepared to evaluate the various services so as to know exactly how they work and be prepared to improve them.

Research is needed on a number of broad and specific questions. Shaffer urges work on neurotransmitter metabolites and genetic pedigree to see how biological factors lead to suicide. Pardes raises the question of what tests can be developed to determine more accurately suicide potential; how many children die in epidemics each year; what starts an epidemic; how we can treat suicide attempters in order to insure that they do not later become completed suicides; what the role is and what the role of the media should be; and what is the breakdown between individuals with and without diagnosable psychiatric orders. There is a need to evaluate the importance of various risk factors and evaluate intervention programs to determine which are helpful and what specific features make them helpful. It is also important to

identify the therapeutically powerful factor in prevention and treatment and to determine what makes for fewer suicides in some cultures than in others. Last, but not least, there must be a constant flow of updated information, interchanging between investigators and people in the front line of activity. This requires funding which needs to be sustained and committed. "This item must be on the agenda of our country and stay there" (Pardes).

Rosenberg and Shaffer focus on the cluster phenomenon in particular communities. The researchers must address the questions of what the effect of a suicide on an individual is within the same family, school or community, and whether it is possible to identify those individuals at highest risk for subsequent suicides after an initial suicide. What is the role of imitation, of television deaths, of newspaper reports? Do adolescents differ from other groups from whom suicide risk factors have been characterized? Understanding more about the patterns and mechanisms behind suicide clusters is critically important for developing interventions. For example, it is not clear now whether immediate response should involve widespread discussion of the student's death or whether the school should take a low key approach and avoid increasing the attention given to the subject of suicide. Will the school's response put additional students at risk? There is question about the effectiveness of using educational approaches to prevent suicide. In line with this, there is question whether or not suicide prevention centers are effective.

Hertzman, Litman, Mitchell and others emphasize the need to explore the question of the relationship between substance abuse and suicide, its role in facilitating, contributing or preventing suicidal acting out, and its influence as an associative factor reflecting individual and community mores is yet to be explored.

Finally, Shaffer warns that enormous gaps still exist in our knowledge about youth suicide, gaps that urgently demand research. Background information gathered in methodically sound studies may fill in the gaps, might change the warning signs, evaluate effectiveness of school programs, and improve prevention, intervention and postvention efforts.

SUMMARY AND CONCLUSIONS

While the presentations reflect a variety of perspectives, certain conclusions and recommendations appear to have broad consensus.

GENERAL ISSUES

Adolescent suicide occurs mostly in the ages 16-19, when alcohol and drugs are first introduced to many young people.

The increase in the suicide rate of the young has been accompanied by a rise in drug abuse, alcohol abuse, delinquency and crime--all barometers of social stress.

The degree of interest in youth suicide is reflected in the fact that 1,270 (17%) of the 7,500 documents in the Suicide Information and Education Centre in Alberta, Canada, deal with suicide and the age cycle; and that 80% of these, or 1,017 are about suicide in children, adolescents and youth.

The suicide rate for Blacks is higher among the youth; the reverse is true for Whites. The drug correlating most highly with suicide in Washington, D.C., has been PCP, or phencyclidine.

Substance abuse treatment is tertiary prevention of abuse and primary and secondary prevention of suicide.

Our legal system must learn to recognize and attend to the potential for suicide in many of the children who come before the court.

Environmental and staffing factors play important roles in the differing suicide rates of youths in adult lockups and in juvenile detention homes.

Today's youth receive much more disturbing information through modern communications than the youth of earlier generations.

Difficulties in interpersonal communication lie at the heart of the youth suicide problem.

The heritage of love, hope, meaning and an identity must be transmitted to each child. Youth must be told that suicide does not solve problems, it creates them.

POLICIES

The Health and Human Services Task Force on Youth Suicide and the Youth Suicide National Center are welcome first steps in the effort to establish a national program for youth suicide prevention.

Youth suicide should be on the national agenda. The problem requires adequate and stable funding.

Current government policy using grants to train personnel of runaway and youth shelters on adolescent suicide prevention focuses on a critical group where suicide potential is high.

There must be close collaboration between government agencies, e.g., interagency task forces in Federal and State suicide programs.

State suicide prevention programs should be interdepartmental, drawing on all resources.

The government should provide leadership in suicide prevention programs, incorporating and using community-based strategies and existing networks.

Government agencies must also work with public schools in drug/suicide prevention.

Incarcerating our young in adult jails and lockups should be discontinued. It contributes disproportionately to the high rate of suicide among adolescents and youth.

Volunteers are a prime resource for educating people about youth suicide through direct contact and networking.

AREAS FOR RESEARCH

Well designed, controlled, and methodologically sound research in suicide is needed to identify high-risk youngsters and to specify the warning signs.

The Centers for Disease Control should concentrate on the need for better data on youth suicide. Targeted research specified by the Health and Human Services Task Force will explore social and psychological factors identified as causing risk.

A major research project in the Army will study suicide and suicide prevention among active duty personnel, their spouses and adolescents.

Research on suicide in American Indians must view each tribe as unique and separate and calculate the rates for on- and off-reservation suicides separately.

Young people themselves should be asked why they choose life--why they do not choose to die. They should be involved in finding answers to why other youth commit suicide and in asking what they think can be done about it.

The relationship between substance abuse and suicide needs to be studied to determine whether substance abuse is facilitative, causative, protective or incidental to suicide.

The differences, if any, in suicidal behavior, or lack of it, between youth from families where religion is important and where it is not should be determined.

Evaluation studies of the school-based suicide prevention programs are urgently needed.

Research on suicide clusters should address the effects of suicide on individuals in the same family, school, or community, and identify remaining individuals at highest risk.

The extent to which biological factors, such as neurotransmitter metabolites, predispose suicide, and how they play this role needs to be studied.

The role of imitation in suicide clusters, attempted suicide, and completed suicide should be explored.

The proportion of teen suicides that appear in clusters should be determined.

The influence of fictional stories in movies and television on the occurrence of suicidal behavior among youth should be evaluated.

Studies are needed on how the media can most usefully report suicides.

The effectiveness of suicide prevention centers in preventing and reducing suicidal behavior needs creative research approaches.

Research should be conducted on the direct and comparative benefits of various suicide survivor group models.

There is a need to assess the increase in the rate of suicide among Black youth and the high level of association with substance abuse.

The relationship between suicide and violence must be studied.

EDUCATION AND TRAINING

People in public life have influence over others; that influence should be used to promote life.

Music and art are effective and as yet relatively under-used means to get people's attention and to educate them about youth suicide.

Students, friends, teachers and parents should be taught about suicide and depression and how to respond to a suicidal crisis.

Under professional supervision, students can be trained to run a hotline telephone service on a college campus.

Judges, lawyers, probation officers and correction personnel must be trained in the identification of children at risk for suicide.

Churches, synagogues, and temples can be used to educate and increase community awareness among peers, parents and professionals.

Volunteers are a prime resource for educating people about youth suicide through direct contact and networking.

CLINICAL CONCERNS

Every completed suicide threatens twice more; it may be a trigger to a second suicide in a close time frame, and it may stimulate the long-term risk of suicide in survivors with unresolved grief.

Deaths from drug overdoses, car accidents, eating disorders and alcohol abuse may be suicides masquerading under other names.

Losses precipitate a depression; substance abuse may be a coping strategy to deal with the problems, not a causative factor.

Other self-destructive behaviors to be attended to include: auto accidents, victim-precipitated homicide, refusal to take medication, substance abuse, dangerous activities and proneness to accidents.

Students are mostly concerned about intimate and personal problems with family, love, life, school, feelings; they are less concerned with nuclear war, rock music, etc.

When information about a suicide or a suicide attempt is hidden from students by school authorities, it only serves to increase rumors and heighten anxiety.

Teenagers most often turn to peers for help.

Youth at runaway shelters are at special risk for suicide as indicated by the fact that 33% of girls and 15% of boys have attempted suicide.

Suicide risk among the disabled and handicapped is greater at the onset, when the condition worsens, when the treatment team has become discouraged, and when agency services are withdrawn.

High unemployment on reservations and the lack of a viable, active economy have contributed to the high suicide rates among Native Americans.

There is as yet no recognized measuring instrument for evaluating suicidal risk in adolescents; clinicians are using adult criteria.

TREATMENT SUGGESTIONS AND CONCERNS

Multi-dimensional treatment with quality human interaction is most needed with suicide prevention.

Treatment of suicidal adolescents involves two stages: (a) management of the acute emergency state, and (b) treatment of underlying psychiatric conditions.

Suicide prevention must include the family.

Most suicide prevention efforts lack continuity of care, especially through follow-up programs.

Schools will need help managing suicidal crises once consciousness has been raised and programs initiated.

Clinical depression is an important predictor of suicide, but less than one out of three depressed persons seeks treatment, and less than half of these see a mental health professional.

Depression often is not recognized; when it is, doctors and patients don't always know the effective treatments that are now available.

Existing mental health delivery models are inadequate to meet adolescent needs; contacting mental health agencies for help must be available for guidance and for serious cases.

Survivor groups provide models for surviving the suicide of a loved one.

STRATEGIES AND RECOMMENDATIONS FOR YOUTH SUICIDE PREVENTION

Needed are a national strategy and a centralized source of leadership, guidance and information that will support, encourage and improve existing efforts and facilitate an effective national mobilization to prevent youth suicide. This can best be achieved by a partnership of public and private leadership and resources.

The corporate community should become involved in the issue of youth suicide.

Because suicide statistics are imprecise, we need to develop a uniform set of criteria for classification of suicide, eliminate delays in reporting, develop a surveillance system and establish a data base.

General health practitioners should be encouraged to make a general psychiatric diagnosis of people who express psychological problems through a physical illness.

All mental health professionals must be alerted to general risk factors for suicide.

The exchange of information about suicide between investigators, clinicians and gatekeepers must be fostered.

Students should be given the opportunity to express their feelings and thoughts when suicide attempts occur in their schools, possibly through discussion groups led by experts in the field of suicide prevention.

Suicide prevention efforts among the young will be most efficient if aimed at older teens and young adults where the greatest number and higher rate occur.

Survivor groups should be available in every community.

The economic issues on Indian reservations must be addressed if the suicide rate is to be diminished.

Telephone services for teens by teens, screened and trained and supervised by professionals, are best established only in large metropolitan communities.

For suicide prevention in schools, policies, organizational strategies, and skilled internal resources are needed.

Staff of runaway shelters should upgrade their sensitivity to suicide danger signs and learn how to respond to suicidal youth.

Trained bilingual counselors would more easily gain the confidence of suicidal Hispanic youth.

APPENDIX

Youth Suicide Prevention Month, 1985

By the President of the United States of America

A Proclamation

During the past 20 years, the suicide rate has tripled among young people aged 15–24. In fact, suicide has become the third leading cause of death in this age group. Last year alone, over 5,000 young Americans took their own lives, and many more attempted to do so.

When a young person commits suicide, it is a personal tragedy as well as a source of deep anguish for family, friends, and neighbors. But it is also a tragedy for society, which must cope not only with the loss of human potential that is the result of the death of any individual, but also with its responsibility to identify the causes of suicide and develop strategies to reduce its incidence. Although the issues involved in each case are complex and unique, we can draw encouragement from the fact that suicide is no longer a silent subject but a recognized public health problem that can and must be addressed.

Because the root causes of suicide involve so many different psychological, physical, social, and spiritual dimensions, successful preventive action requires the combined efforts of individuals, families, communities, organizations, and governments at all levels. Young people and families who have a member who may be contemplating suicide need to know that there are indeed places to turn for advice and assistance. People who come into contact with youth—educators, counselors, coaches, ministers, health care providers—can play a key role in helping a despondent young person by identifying the existence of a problem or contributing factors like drug abuse and family break-up. Government can assist through research and policies which strengthen the family unit and foster a sense of individual self-worth. In short, all of us have the opportunity and responsibility to help deal with this growing problem.

In recognition of the increase in suicide among America's youth and its consequences for our society, the Congress, by Senate Joint Resolution 53, has designated the month of June 1985 as "Youth Suicide Prevention Month" and authorized and requested the President to issue a proclamation in observance of this month.

NOW, THEREFORE, I, RONALD REAGAN, President of the United States of America, do hereby proclaim the month of June 1985 as Youth Suicide Prevention Month. I call upon the Governors of the several States, the chief officials of local governments, all health care providers, educators, the media, public and private organizations, and the people of the United States to observe this month with appropriate programs and activities.

IN WITNESS WHEREOF, I have hereunto set my hand this fourth day of June, in the year of our Lord nineteen hundred and eighty-five, and of the Independence of the United States of America the two hundred and ninth.

Ronald Reagan

99TH CONGRESS
2D SESSION

S. J. RES. 266

To authorize and request the President to designate the month of June 1986 as "Youth Suicide Prevention Month".

IN THE SENATE OF THE UNITED STATES

FEBRUARY 6 (legislative day, JANUARY 27), 1986

Mr. DENTON (for himself and Mr. SPECTER) introduced the following joint resolution; which was read twice and referred to the Committee on the Judiciary

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JOINT RESOLUTION

To authorize and request the President to designate the month of June 1986 as "Youth Suicide Prevention Month".

Whereas the youth of society represent the hope for the future;

Whereas the rate of youth suicide has increased more than threefold in the last two decades;

Whereas over five thousand young Americans took their lives last year, many more attempted suicide, and countless families were affected;

Whereas youth suicide is a phenomenon which must be addressed by a concerned society; and

Whereas youth suicide is a national problem which can only be solved through the combined efforts of individuals, families, communities, organizations, and government to educate society: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the month of June 1986 is designated as "Youth Suicide Prevention Month" and the President is authorized and requested to issue a proclamation calling upon the Governors of the several States, the chief officials of local governments, and the people of the United States to observe such month with appropriate programs and activities.

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RESOURCES

YOUTH SUICIDE NATIONAL CENTER

FILM AND MEDIA RESOURCES ON YOUTH SUICIDE

The following is a list of available films dealing with youth suicide; and does not imply a recommendation of those listed. These films should be previewed before showing. They should be shown only if followed by discussion led by a qualified leader.

1. ABC NOTEBOOK: TEEN SUICIDE
   Produced by ABC and preceded the airing of the film, "Surviving." It deals with the pressures and stresses of teen-age lives, and interviews teachers, parents and teenagers. 20 minutes. Coronet/MTI Teleprogram, 108 Wilmot Road, Deerfield, IL 60015. (800), 621-7870.

2. A CASE OF SUICIDE
   A BBC documentary which uses the recollections of the mother and husband of an 18-year-old woman who committed suicide, as well as the clues preceding the act, and the woman's family background. MI Media, University of MI, 416 Fourth Street, Ann Arbor, MI 48109, (313) 764-5360.

3. ADOLESCENT SUICIDE: A MATTER OF LIFE AND DEATH
   Vignettes shown from the viewpoint of adolescents explore the emotional impact of quarreling parents, death of a loved one, juvenile detention, teenage pregnancy, joblessness, academic suspension and other situations surrounding or leading to adolescent suicide. The myths of suicide are discussed and steps toward prevention are addressed. 39 minutes. American Personnel and Guidance Association, 2 Skyline Place, Suite 400, 5203 Leesburg Pike, Falls Church, VA 22041. (703) 823-9800.

4. A LAST CRY FOR HELP
   Unable to talk with anyone about her feelings of depression, a seemingly popular teenage girl attempts suicide. When her parents deny that any problem

exists, a psychologist helps the girl understand that things won't change until she takes control of her own life. Offers illustration of how family therapy is conducted and how it works -- or why it does not. 32 minutes. Edited from ABC-TV Movie/LCA film, 16 mm for purchase or rental through Coronet/MTI Teleprogram, 108 Wilmot Road, Deerfield, IL 60015. (800) 621-7870.

5. AMY AND THE ANGEL
Depressed about her lack of social life and her parents' divorce, 17-year-old Amy considers suicide. Then her guardian angel shows her how dismal life would have been if she had never been born. This dramatization seeks to convey the message that things are never as bad as they seem and obstacles can be overcome. 30 minutes. Produced by LCS Film/ABC After School Special, Emmy nominated, 16 mm for purchase or rental. Coronet/MTI Teleprogram, 108 Wilmot Road, Deerfield, IL 60015. (800) 621-7870.

6. A TRIBUTE TO TIM
Story of a teenage boy and how his friends attempt to help him. Suicide Prevention and Education Center, 982 Eastern Parkway, Louisville, KY 40217. (502) 635-5924.

7. BEFORE IT'S TOO LATE
Designed to teach students in grade 9-12 how to spot suicidal behavior and what to do if someone they know is suicidal. 20 minutes. Walt Disney Disney Media Company, 500 South Buena Vista Street, Burbank, CA 91521. (818) 956-3000.

8. BUT JACK WAS A GOOD DRIVER
A funeral is ending. As Bob and his classmate, Ed, move to their cars, the conversation reveals both boys to be secretly and painfully preoccupied with the possibility that their friend may have taken his own life -- that he may have deliberately driven his car off the road at high speed. As they explore their feelings, Bob and Ed explore the subject of suicide. 16 mm. 15 minutes. Color. Produced by Steve Katten, 1974. McGraw-Hill Films, P.O. Box 641, Del Mar, CA 92014 (619) 453-5000 of (800) 421-0833.

9. CHILDHOOD'S END
A Canadian film which focuses on a bright young man who kills himself. The film includes interviews with his family and friends. 30 minutes. Linda Gottesman, Filmmakers Library, 133 E. 58th Street, Suite 703A, New York, NY 10022.

10. DID JENNY HAVE TO DIE?
An analysis of a case of teen suicide reveals some of the causes, warning signs and ways of preventing adolescent death. Students view the details of the tragedy through the eyes of family members, friends, teachers - and the victim herself.

Part I - Road to Nowhere
Jennifer was 16, pretty, bright, popular, talented -- and a suicide. First person accounts by those who knew her best reveal some of the events and inner problems that led to Jennifer's tragic decision.

Part II - Behind the Smiles
Those who presented the facts of the case in Part I now consider, in hindsight, some of the warning signals that might have suggested the need for help.

Part III - A Foundation for Living
This section draws from the specifics already presented to generalize about the whys of teenage suicide and the ways we can anticipate and prevent it. Jennifer's family, teacher and friends consider what they might have done to help her.

35 minutes. Produced by Jacoby/Storm Productions. Three filmstrips, three cassettes, Teacher's Guide No. 239-LM. Sunburst Communications, Room LM 8, 39 Washington Avenue, Pleasantville, NY 10570. (914) 769-5030/(800) 431-1934.

11. EVERYTHING TO LIVE FOR
This documentary tells the stories of four young people who either attempted or completed suicide. The film seeks to increase awareness of the family and social pressures that often force teenagers to the brink, and of the warning signals that usually precede a suicide attempt. Viewers also learn about the various organizations founded to help teens deal positively with their problems. Produced by Group W. Station KDKA-TV, Pittsburgh, 16 mm film for purchase or rental. 24 minutes. Coronet/MTI Teleprogram, 108 Wilmot Road, Deerfield, IL 60015. (800) 621-7870.

12. FAMILY OF WINNERS
Drama of one boy's stressful life situations and subsequent suicidal depression. Paulist Productions, P.O. Box 1057, Pacific Palisades, CA 90272. (213) 454-0688.

13. HEAR ME CRY

In this drama, two boys develop a close friendship as a result of serious difficulties each is experiencing in relationships with their parents. But their mutual unhappiness only heightens their feelings of despair. When a suicide pact results in the death of one boy, a tragic moment of truth confronts all concerned. LCA Films/CBS Schoolbreak Special. 30 minutes. 16 mm and video formats for purchase or rental. Coronet/MTI Teleprogram, 108 Wilmot Road, Deerfield, IL 60015. (800) 621-7870.

14. HELP ME! THE STORY OF TEENAGE SUICIDE

25 minutes. SL Film Productions, P.O. Box 41108, Los Angeles, CA 90014. (213) 254-8528.

15. IN LOVELAND: STUDY OF TEENAGE SUICIDE

Why would an average boy take his own life at age 15? This film reconstructs the tragic course of events that ended in the death of Mark Cada, Loveland, CO. Interviews with Mark's family and friends underline the importance of attending to warning signs and becoming more sensitive to the needs of troubled teenagers. Produced by the ABC News. 28 minutes. 16 mm and video formats for purchase or rental. Coronet/MTI Teleprogram, 108 Wilmot Road, Deerfield, IL 60015. (800) 621-7870.

16. INSIDE, I ACHE

Explores the long taboo subject of teenage suicide. Explores the reasons for suicide, the warning signs, places to seek help, and urges friends of those in trouble to "tell." For high school, college and adult audiences. 30 minutes. Distributed in cooperation with Mass Media Ministries by NFTY (16 mm rental) and UAHC Television and Film Institute (video purchase), 838 Fifth Avenue, New York, NY 10021. (212) 249-0100.

17. "IS ANYONE LISTENING?" AND "HEARING BETWEEN THE LINES" CBS, FOR OUR TIMES

Two CBS 30 minute TV programs with news correspondent, Douglas Edwards. An informative booklet accompanies this. VCR.

Part I: "Is Anyone Listening?" focuses on Alberta, Canada where the teenage suicide rate is the highest among the provinces, and where there has been a far reaching and effective approach to the problem.

Part II: "Hearing Between the Lines" examines issues of teen suicide from the perspective of a serene upstate New York farmland community and the frenetic paced life style of New York City. The Youth Suicide

National Center, 1825 Eye Street, N.W., #400, Washington, DC 20006. (202) 429-2016.

18. KEEPING YOUR TEENAGER ALIVE: THEORY, PREVENTION AND TREATMENT OF ADOLESCENT SUICIDE
Teaching session with Carl Tishler, Ph.D. examines the problems of teenage accidents and suicide. Describes the factors essential to teenage care, the symptoms of depression, elements of loss and treatment factors when working with adolescents. Nearly two hours. Video formats for purchase. Vidcam Inc., 6322 Kings Pointe Road, Grand Blanc, MI 48439. (313) 694-0996.

19. LET'S STOP TEEN SUICIDE
The upbeat theme "Talk it over, talk it out," dramatically shows teens what they can say and do when they know a suicidal friend. Neighborhood Service Organization, Suicide Prevention Center, 220 Bagley, Suite 626, Detroit, MI 48226 (313) 963-7890.

20. PREVENTING TEEN SUICIDE: YOU CAN HELP
Tells the story of Jennifer and explains why teens commit suicide, signs and symptoms, myths that surround teen suicide, and prevention techniques. Of special interest is the filmstrip "Did Jennny Have to Die?", included in this series. Set of three filmstrips with soundtrack (record or cassette) plus Teacher's Guide. For purchase. Sunburst Communications, Room K2323, 39 Washington Avenue, Pleasantville, NY 10570. (914) 769-5030/(800) 431-1934.

21. RONNIE'S TUNE
Through the eyes of an 11 year old girl, one sees the effects of a teenager's suicide upon her family. Wombat Productions, Inc., P.O. Box 70, Ossining, NY 10562, (914) 762-0011.

22. SUICIDE AT 17
Why did Bobbie Benton take his own life? He had friends, popularity, a record of achievement in the classroom and the gym, loving and conscientious parents and teachers, and a coach who cared. A film documenting the suicide of one teenager. Produced By Ira Eisenberg. 16 mm, color, 18 minutes. Order from Lawren Productions, Inc., P.O. Box 66, Mendocino, CA 95460. (707) 937-0536.

23. SUICIDE: CAUSES AND PREVENTION
Seeks to evaluate the causes of suicide in our society and suggests ways to help a suicidal person. Human

Relations Media. Set of two filmstrips with soundtrack (record or cassette) plus Teacher's Guide. For purchase. Sunburst Communications, Room K2323, 39 Washington Avenue, Pleasantville, NY 10570. (800) 431-1934.

24. SUICIDE: TEENAGE CRISIS
The film explores the problem of teenage suicides and includes descriptions of a variety of community and school programs. producer: "30 Minutes" CBS. 10 minutes, color. For purchase or rental, contact CRM Mcgraw-Hill Films, 110 15th Street, Del Mar, CA 92014. (619) 481-81184.

25. SUICIDE: THE WARNING SIGNS
The film combines dramatic enactment with documented remarks from a recognized authority on youth suicide. There are three dramatized vignettes:

1. Gregg, a 14-year-old boy who is known to his peers as the class clown, continually taking unusual risks to gain his friends' attention. His doctor expresses concern to Gregg's mother that Gregg is more than accident prone, and recommends counseling.

2. Carol has been a determined achiever and successful with her peers. In the film we see that she is depressed and under stress, and learn that she takes diet pills and sedatives.

3. Curtis is a black college student who has experienced loss of a girlfriend and poor grades. He gives away favorite possessions and writes a farewell note to a friend.

Through narration and interviews, the film brings out a number of clues that may indicate that a person is considering suicide. The film emphasizes that parents, teachers, and teenagers themselves can save lives by learning to recognize these danger signals and by giving "psychological first aid." A Central Production 16 mm film, color, 24 minutes. Coronet/MTI Teleprogram, 108 Wilmot Road, Deerfield, IL 60015. (800) 621-7870.

26. SUICIDE: WHO WILL CRY FOR ME?
Filmstrips and recordings seek to provide information and put the subject into perspective aiming toward the particular problems of young people.

Part I: "Dancing with Death" introduces the subject of suicide by portraying a 14-year-old girl who takes her own life.

Part II: "Dangling Their Feet in the Pool of Death" analyzes teenage suicides and suicide attempts.

Part III: "You Can Always Die Next Thursday" discusses various ways of preventing suicide.

26 minutes. Order from Audio Visual Narrative Arts, P.O. Box 9, Pleasantville, NY 105070. (914) 769-8545.

27. TEENAGE BLUES: COPING WITH DEPRESSION
Introduces students to the concept of depression, some common causes and symptoms and where and how to get help. Offers specific advice on how to get a friend to "open up," how to spot suicidal tendencies, and where to get help.

Part I: Helping Yourself

Part II: When You Need Help

Part III: Helping Others Cope

Three filmstrips/guide or one videocassette/guide. Sunburst Communications, 39 Washington Avenue, Room LM 8, Pleasantville, NY 10570. (914) 431-1934/(800) 431-1934.

28. TEENAGE SUICIDE
Narrated by Timothy Hutton. Explores the lives and deaths of four teenagers. Films, Inc./PMI, 5547 N. Ravenswood, Chicago, IL 60640 (312) 878-2600.

28. TEENAGE SUICIDE
Interviews with teens offer insights into their view of suicide as a viable option. Professionals in the field alert viewers to the warning signs that often precede a suicide attempt and emphasize the need for parents to listen to what their children are saying. The film also takes a look at the network of Suicide Prevention Centers across the nation. Produced by CBS "News Magazine," 16 mm and video formats for purchase or rental. Coronet/MTI Teleprogram, 108 Wilmot Road, Deerfield, IL 60115. (800) 621-7870.

29. TEENAGE SUICIDE: A CRY FOR HELP
Many teenagers opt for death. What are the reasons? What can we do about them?. An Analysis of a serious problem. Filmstrip/cassette/guide. Kidsrights, 120-A West Fifth Avenue, P.O. Box 851, Mount Dora, FL 32757.

30. TEENAGE SUICIDE: DON'T TRY IT
Documentary establishes extent of problem, and then

demonstrates what some communities are doing to prevent it. Alan Landsburg Productions, 1554 Sepulveda Boulevard, Los Angeles, CA 90025. (213) 208-2111.

31. TEENAGE SUICIDE: IS ANYONE LISTENING?
This film documents the problems of two young people who have attempted suicide. Barr Films, P.O. Box 5667 Pasadena, CA 91107. (213) 793-6153.

32. TEEN SUICIDE: WHO, WHY AND HOW YOU CAN PREVENT IT
Videotaped interviews with people who have faced the tragedy of teen suicide. Helps young people recognize critical signs of trouble in themselves or friends, and where and how to seek help. Live Action Video. Produced by Guidance Associates. Avna Media, Box 1040, Mount Kisco, NY 10549.

33. TEENS WHO CHOOSE LIFE: THE SUICIDAL CRISIS
Explores the special dynamics of teen suicide using the moving stories of three teenagers who attempted suicide and survived. Helps viewers understand the events and feelings that may precipitate a suicidal crisis. Emphasizes that there are other ways to cope with stress and depression, and demonstrates that the first step is "to choose life".

1. Narrates the story of Keith, whose depression over worsening relations with his family led him to try suicide. Relates how counseling helped him eventually effect the positive changes in his life that made him glad his suicide attempt failed.

2. Dramatizes the story of Gail, whose anger at being rejected led her to slash her wrists. Shows how therapy awakens Gail to the realization that living - not dying - takes courage.

3. Uses the story of Erica, whose anger over her parents' sudden divorce triggered suicidal thoughts. Stresses that fantasies about suicide are common and don't necessarily mean that one is suicidal. Sunburst Communications, 39 Washington Avenue, Pleasantville, NY, 10570. (914) 769-5030, (800) 431-1934.

33. URGENT MESSAGES
Introduced by Patty Duke. The story of three suicidal teenagers - two tell their own stories; and the classmates of a third tell what it feels like to lose their friend. The Media Guild, 11722 Sorrento Valley Road, Suite E, San Diego, CA 92121-1021.

5/86.

YOUTH SUICIDE NATIONAL CENTER

SUGGESTED READING FOR TEENS

The following books have been reviewed by librarians and are suitable for school and public libraries.

FICTION

A HOUSE FOR JONNIE O by Blossom Elfman: A young man comes to terms with his own life after the suicide of a friend.

AMEN, MOSES GARDENIA by Jean Ferris: Virtually ignored by her alcoholic and workaholic father, Farrel suffers bouts of depression which worsen when she thinks her new boyfriend is not serious.

BLUES I CAN WHISTLE by A.E. Johnson: An intense young man attempts suicide, but decides to live and try to understand himself.

CLOSE TO THE EDGE by Gloria Miklowitz: Jenny Hartley takes the news of Cindy's suicide attempt seriously. When Cindy does kill herself, it's Jenny's association with a senior citizen group that helps her put the death in perspective.

DROWNING BOY by Susan Terris: A series of painful events brings Jason to the brink of suicide, but he realizes in time that he doesn't really want to die.

GRANDPA AND ME by Stephanie Tolan: Kerry's grandfather begins acting strangely, and eventually commits suicide. She can understand, and remembers him with love.

HOUR OF THE WOLF by Patricia Calvert: A young man comes to terms with his own life after the suicide of a friend.

THE LANGUAGE OF GOLDFISH by Zibby Oneal: Afraid of changing and growing up, 13-year-old Carrie suffers a nervous breakdown and retreats into her childhood world.

LAUREN by Harriet Luger: Unable to solve the problems of an unwanted pregnancy, 17-year-old Lauren considers suicide.

MAYBE IT WILL RAIN TOMORROW by Jane Zalben: When Beth's mother committed suicide, she not only had to learn to accept her mother's death, but also learn to live with her father, step-mother and new baby.

NOTES FOR ANOTHER LIFE by Sue Ellen Bridgers: Two teenagers must cope with overwhelming crises in their family, and discover the durability of love.

PORTRAIT OF MYSELF by Winifred Madison: 15-year-old Catherine yearns for beauty and self-assurance, but when the teacher she adores rejects her drawings and recommends her expulsion, she attempts suicide.

REMEMBERING THE GOOD TIMES by Richard Peck: Buck and Kate know their friend Tran is overwhelmed by the pressures in his life, but never suspect that he might resort to suicide.

THE GIRL INSIDE by Jeannette Eyerly: After a series of tragedies, Christina is contemplating suicide. She discovers that one must live to help others as well as oneself.

THE WORLD TURNED INSIDE OUT by Gail Radley: Explores the efforts made by Jeremy and his family to cope with stress and the tragedy of a suicide.

TUNNEL VISION by Fran Arrick: The friends and family of a suicide victim grapple with feelings of confusion, anger and guilt as they try to understand why a 15-year-old boy would want to take his own life.

The following books have been reviewed by the Youth Suicide National Center and are useful resources for learning more about youth suicide.

NON-FICTION

MY SON, MY SON by Iris Bolton: A mother's story of surviving the loss of her son to suicide. If the reader has sustained a loss, this book's message is one of realistic hope, of reassurance, of practical emotional support and healing. In the absence of loss, the message is one of such heightened awareness of what is of value in life that it generates the resolve to nurture those things which in turn can only reduce many of the painful aspects of life that are conducive to loss. Published by Bolton Press, 1325 Belmore Way, N.E., Atlanta, GA 30338. 1983.

PREVENTING TEENAGE SUICIDE: THE LIVING ALTERNATIVE HANDBOOK by Polly Joan: This book is described as "a treatment manual for young adults that encourages young people to talk about what they are feeling and to take each others feelings seriously." It provides suggestions for teaching a five-session unit which covers the dynamics of suicidal feelings and depression, causes, warning signs and clues, intervention procedures and listening awareness. Published by Human Sciences Press, Inc., 72 Fifth Avenue, New York, NY 10011. 1986.

TOO YOUNG TO DIE by Francis Klagsburn: Research findings, literary illustrations and case examples are mingled together with suggestions for talking with suicidal teenagers, calming them through crises and leading them to sources of help. Published by Simon & Schuster, Inc., 1230 Avenue of the Americas, New York, NY 10020. 1985.

VIVIENNE by John E. Mack and Holly Hickler: The writings and diary of 14-year-old Vivienne discovered after her suicide, combined with the insights of clinical psychiatrist John E. Mack, tells the story of her secret life and her heartbreaking death. Published by The New American Library, Inc. 1633 Broadway, New York, NY 10019. 1981.

WHEN LIVING HURTS by Sol Gordon: This warm and lively what to do book, offers help to troubled teenagers and their friends by teaching them how to recognize and cope with feelings that, if ignored, might lead to suicide. Published by Union of American Hebrew Congregations, 838 Fifth Avenue, New York, NY 10021. 1985.

PAMPHLETS

"Youth Suicide: Community Response to A National Problem". Youth Suicide National Center, 1825 I Street, N.W., Suite 400, Washington, D.C. 20006.

"Suicide In Youth and What You Can Do About It": A Guide for Students. The Youth Suicide National Center, 1825 I Street, N.W., Suite 400, Washington, D.C. 20006.

"Suicide In Youth and What You Can Do About It": A Guide for School Personnel. The Youth Suicide National Center, 1825 I Street, N.W., Suite 400, Washington, D.C. 20006.

"Grief After Suicide". Mental Health Association in Waukesha County, Inc., 414 W. Moreland Boulevard, Room 101, Waukesha, WI 53186.

"About Suicide Among Young People". Channing L. Bete Co., Inc., South Deerfield, MA 01373.

Youth Suicide: An Annotated Bibliography 1971-1980

Compiled by the staff of the Suicide Prevention Center and
The Institute for Studies of Destructive Behaviors

May be ordered from:

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	AK-19	**TEEN LINE: A COMMUNITY MODEL** — Terry Lipton, M.D.; **UNION OF AMERICAN HEBREW CONGREGATIONS TASK FORCE ON YOUTH SUICIDE** — Rabbi Ramie Arian	$8 00	
	AK-21	**INFORMATION ABOUT YOUTH SUICIDE: MEDIA AND THE PUBLIC** — Lynne Peterson. **CENTER FOR INFORMATION RESOURCE MATERIALS** — Brian Tanney, M D	$8 00	
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LEGISLATION

California

Senate Bill No. 947

CHAPTER 750

An act to add and repeal Chapter 3 (commencing with Section 10200) of Part 7 of the Education Code, relating to schools, and making an appropriation therefor.

[Approved by Governor September 12, 1983. Filed with Secretary of State September 13, 1983.]

LEGISLATIVE COUNSEL'S DIGEST

SB 947, Presley. Schools: youth suicide prevention school programs.

Current law authorizes various programs to be jointly conducted by state and local educational agencies or institutions.

This bill would provide for the development of a statewide youth suicide prevention program through the establishment of state-mandated demonstration programs in 2 designated counties. Existing suicide prevention and crisis centers located within those counties would serve as coordinating centers for the planning and development of the statewide program. Any interested county which submits a request to the State Department of Education to participate in that process by a specified date would be permitted to do so.

The bill would require the Department of Education to annually report to the Legislature regarding the status and effectiveness of the programs established pursuant to this act, and would establish a continuously appropriated Youth Suicide Prevention School Program Fund to be administered by the department for the purposes of this act. The bill would express the intent of the Legislature that $300,000 be appropriated to this fund by the Budget Act of 1984, and in the event that a lesser amount or no money is appropriated, that the Youth Suicide Prevention School Program only be implemented to the extent funds are made available. The bill would specify that none of the provisions of this act shall be construed to prohibit the department from providing financial assistance from that fund to other counties, in addition to the counties maintaining the demonstration programs, for purposes of youth suicide prevention school programs. Any county receiving such funds would be required to annually provide the Director of Finance, the Legislature, and the department with a specified accounting and program evaluation report for the previous year.

The provisions of this bill would become operative on July 1, 1984.

Article XIII B of the California Constitution and Sections 2231 and 2234 of the Revenue and Taxation Code require the state to reimburse local agencies and school districts for certain costs mandated by the state. Other provisions require the Department of

Finance to review statutes disclaiming these costs and provide, in certain cases, for making claims to the State Board of Control for reimbursement.

This bill would impose a state-mandated local program in the two counties designated to maintain the demonstration youth suicide prevention school programs pursuant to the provisions of the bill.

This bill would provide that no appropriation is made by this act for the purpose of making reimbursement pursuant to the constitutional mandate or Section 2231 or 2234, but would recognize that local agencies and school districts may pursue their other available remedies to seek reimbursement for these costs.

This bill would repeal the provisions establishing the youth suicide prevention school programs on June 30, 1987.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Chapter 3 (commencing with Section 10200) is added to Part 7 of the Education Code, to read:

CHAPTER 3. YOUTH SUICIDE PREVENTION SCHOOL PROGRAM

10200. The Legislature makes the following findings and declarations of intent:

(a) A statewide youth suicide prevention program is essential in order to address the continuing problem of youth suicide throughout the state.

(b) The suicide problem often exists in combination with other problems, such as drug abuse and alcohol use.

(c) A suicide prevention program for young people must emphasize a partnership between educational programs at the state and local levels and community suicide prevention and crisis center agencies. In order to facilitate this partnership, the Legislature finds and declares that it is of vital importance that a statewide primary prevention program be established with shared responsibility at both the state and county levels, and that this cooperation shall be a major tool in efforts to achieve the successful prevention of youth suicide.

(d) The program established pursuant to this chapter is intended by the Legislature to delegate primary responsibility for the development of a youth suicide prevention program to existing county suicide prevention agencies through the establishment of a demonstration program. The Legislature recognizes that county suicide prevention and crisis center agencies are best suited for dealing with youth suicide, as demonstrated by their past success in youth suicide prevention in California.

10205. (a) In view of the purpose and intent of this chapter, as expressed in Section 10200, highest priority for program funding under this chapter shall be designated to those counties which

emphasize joint school-community youth suicide prevention programs.

(b) It is the intent of the Legislature that, to the maximum extent possible, funds made available for the purpose of this chapter shall be used to support existing programs which have demonstrated a capacity to meet the needs of young people and families in the prevention of suicide, and to support two demonstration youth suicide prevention school programs, one of which shall be located in a Northern California county, the other in a Southern California county.

(c) In view of the urgent need to begin development of a statewide youth suicide prevention program at the lowest cost to the state, and with the participation of existing suicide prevention and crisis center agencies to the greatest extent possible, and in order to ensure that the program will meet the needs of all economic and ethnic groups in California, the Legislature hereby designates San Mateo County and Los Angeles County as the locations of the two demonstration youth suicide prevention school programs.

10210. (a) The demonstration programs in San Mateo and Los Angeles counties, hereinafter referred to as "demonstration counties," shall be maintained for a period not to exceed three years from the operative date of this chapter, according to the following schedule:

(1) Planning and development of the county demonstration program shall be completed by June 30, 1985.

(2) Implementation of the county demonstration program shall be completed by June 30, 1986.

(3) Each demonstration county shall evaluate its demonstration program and submit a report of its findings to the State Department of Education, the Legislature, and the Governor on or before January 1, 1987.

10212. (a) Until October 1, 1984, any county in the state may, through its board of education, submit a request to participate in the planning and development of the statewide program to the State Department of Education.

(b) Each demonstration county shall designate the suicide prevention and crisis centers located within the county to serve as coordinating centers for the planning and development of the statewide youth suicide prevention school program. The State Department of Education, in cooperation with the designated coordinating centers, shall publish procedures for the participation of all interested counties in the planning and development of the statewide program.

(c) Planning and development of the statewide program shall be completed by June 30, 1985.

10213. No provision of this chapter shall be construed to prohibit the State Department of Education from providing financial assistance from the Youth Suicide Prevention School Program Fund

to other counties, in addition to the demonstration counties, for purposes of youth suicide prevention school programs, including, but not limited to, those programs set forth in Section 10215.

10214. Funds received by a county board of education in order to carry out the purposes of this chapter shall be deposited in a separate county Youth Suicide Prevention School Program Fund established for that purpose. On or before January 1 of each year, any county which has received state funds for the purposes of this chapter shall provide the Director of Finance, the Legislature, and the State Department of Education with an accounting of expenditures for its youth suicide prevention school program and revenues received for the program from sources other than the state, and with a program evaluation report for the previous year.

10215. The youth suicide prevention school programs established pursuant to Section 10210 shall plan, fund, and implement educational programs, which may include any of the following:

(a) Classroom instruction designed to achieve any of the following objectives:

(1) Encourage sound decision making and promote ethical development.

(2) Increase pupils' awareness of the relationship between drug and alcohol use and youth suicide.

(3) Teach pupils to recognize signs of suicidal tendencies, and other facts about youth suicide.

(4) Inform pupils of available community youth suicide prevention services.

(5) Enhance school climate and relationships between teachers, counselors, and pupils.

(6) Further cooperative efforts of school personnel and community youth suicide prevention program personnel.

(b) Nonclassroom school or community based alternative programs, including, but not limited to:

(1) Positive peer group programs.

(2) A 24-hour "hotline" telephone service, staffed by trained professional counselors.

(3) Programs to collect data on youth suicide attempts.

(4) Intervention and postvention services.

(5) Parent education and training programs.

(c) Teacher training programs.

10220. The Department of Education shall enter into an interagency agreement with the appropriate county board of education for the implementation of an approved Youth Suicide Prevention School Program.

10230. The Department of Education, the county board of education, school districts, and the county suicide prevention agency in each county maintaining a program pursuant to this chapter shall establish procedures for the cooperative collection and dissemination of data regarding the implementation of the

provisions of this chapter.

10235. The Department of Education shall submit an annual report to the Legislature regarding the current status and effectiveness of the programs established pursuant to this chapter.

10240. There is hereby created in the State Treasury a fund which shall be known as the Youth Suicide Prevention School Program Fund. The fund shall consist of funds appropriated by the annual Budget Act, as well as any private sector money as may be made available. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated. The Department of Education shall administer the fund for the purposes of this chapter, and shall use no more than 5 percent of the balance of the fund to meet administrative costs.

10242. The provisions of this chapter shall become operative on July 1, 1984.

10245. This chapter shall remain in effect only until June 30, 1987, and as of that date is repealed, unless a later enacted statute, which is chaptered before June 30, 1987, deletes or extends that date.

SEC. 2. It is the intent of the Legislature that the sum of three hundred thousand dollars ($300,000) be appropriated from the General Fund to the Youth Suicide Prevention School Program Fund by the 1984–85 Budget Act. In the event that a lesser amount or no money is appropriated, it is the intent of the Legislature that the Youth Suicide Prevention School Program be implemented only to the extent that funds are made available.

SEC. 2.5. It is the intent of the Legislature that the Department of Education use a part of the amount appropriated from the General Fund to the Youth Suicide Prevention School Program Fund by the 1984–85 Budget Act for the purpose of complying with Section 10235 of the Education Code. It is also the intent of the Legislature that the costs of complying with Section 10235 of the Education Code not be included in calculating the 5-percent limitation on expenditures for administrative costs imposed by Section 10240 of the Education Code.

SEC. 3. Notwithstanding Section 6 of Article XIII B of the California Constitution and Section 2231 or 2234 of the Revenue and Taxation Code, no appropriation is made by this act for the purpose of making reimbursement pursuant to these sections. It is recognized, however, that a local agency or school district may pursue any remedies to obtain reimbursement available to it under Chapter 3 (commencing with Section 2201) of Part 4 of Division 1 of that code.

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California

Assembly Bill No. 2541

CHAPTER 1286

An act to amend Sections 4075, 4076, 4078, 5651.1, and 5755 of, and to add Sections 319.1, 635.1, 4075.5, 4079, 5150.1, 5150.2, 5150.3, 5578.5, 5600.1, 5704.7, 5705.4, 5769, and 5770.5 to, to add Chapter 6.5 (commencing with Section 5560) to Part 1 of Division 5 of, Chapter 2.6 (commencing with Section 5680), Chapter 2.7 (commencing with Section 5690), Chapter 2.8 (commencing with Section 5697), Chapter 3.1 (commencing with Section 5725), and Chapter 4.1 (commencing with Section 5775) to Part 2 of Division 5 of, the Welfare and Institutions Code, relating to mental health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor September 30, 1985. Filed with Secretary of State September 30, 1985.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2541, Bronzan. Mental health.

Existing law requires the juvenile court to evaluate minors before it who may become dependents or wards of the juvenile court.

This bill would require the court to notify the local director of mental health services when it believes that a minor who is a dependent child of the court may need specialized mental health treatment.

Existing law requires the State Department of Mental Health to set rates of payment by the state to private residential care facilities for the mentally disabled caring for mentally disordered persons. The department is required to adopt regulations regarding setting of those rates and adopting eligibility criteria for these private facilities by July 1, 1980. Existing law also requires the department to propose the rates to the Legislature by March 1 to be operative by July 1 of each year subject to the appropriation of sufficient funds for that purpose in the Budget Act.

This bill would do all of the following in relation to rates of payment established for mentally disordered in private residential care facilities if SB 155 is not enacted:

(1) Require regulations to be adopted by October 1, 1985, to establish eligibility criteria for these private residential care facilities and delete the condition that the rates shall be operative subject to the appropriation of sufficient funds.

(2) Delete an obsolete reference to cost-of-living adjustments in the rates.

(3) Require the department, in recommending funds to be appropriated for these private facilities, to include actual caseload numbers, caseload estimates, and separate county and state

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mental health treatment services and whether appropriate treatment is available through the minor's own resources, those of the family or another private party, or through another agency, and to ensure access to services available within the county's program. This determination shall be submitted in writing to the notifying agency within 30 days. If appropriate treatment is not available within the county's program, nothing in this section shall prevent the court from ordering treatment directly or through a family's private resources.

Article 2. Programs to Reduce the Incidence of Youth Suicide

5698. The department shall develop a five-year youth suicide prevention program to develop all of the following:

(a) Research and data collection on youth suicide.

(b) Public education material production and distribution in conjunction with other public agencies and the private sector throughout the state.

(c) Training programs involving students, parents, teachers, school administrators, mental health professionals, local social service agencies, juvenile justice representatives, and others concerned with the problem of youth suicide.

(d) A final evaluation and report to the Governor and Legislature no later than July 1, 1991.

SEC. 10.5. Section 5704.7 is added to the Welfare and Institutions Code, to read:

5704.7. The State Department of Mental Health and the State Department of Health Services shall implement a cost study, to be completed by January 31, 1987, to determine the actual cost, per reimbursable service function, of Short-Doyle mental health services provided to children, adolescents, and their families. These costs shall be the basis for the calculation and establishment of distinct rates or reimbursement for services provided to children, adolescents, and their families under the Short-Doyle/Medi-Cal Program effective July 1, 1987. The State Department of Health Services shall make the necessary amendments to the State Medicaid Plan and to regulations pertaining to reimbursement for Short-Doyle mental health services provided to Medi-Cal beneficiaries.

SEC. 11. Section 5705.4 is added to the Welfare and Institutions Code, to read:

5705.4. For the 1985–86 and 1986–87 fiscal years, the cost requirement for local financial participation pursuant to Section 5705, including administrative costs, shall be waived for supplemental rates of payment for residential care facilities for the mentally disordered pursuant to Section 4076.

SEC. 12. Chapter 3.1 (commencing with Section 5725) is added to Part 2 of Division 5 of the Welfare and Institutions Code, to read:

provisions to assist students in obtaining the health examination. However, any child shall be exempt from requirement of a health medical or physical examination upon written request of the parent or guardian of such child stating objections to such examination on religious grounds.

Section 23. Paragraph (e) is added to subsection (3) of section 230.2313, Florida Statutes, to read:

230.2313 Student services programs.--

(3) A "student services program" is defined as a coordinated effort which shall include, but not be limited to:

(e) Health services, as described in s. 402.32.

Section 24. Short title.--Sections 1 through 3 of this act may be cited as the "Florida Youth Emotional Development and Suicide Prevention Act."

Section 25. Legislative intent.--The incidence of teenage suicide has escalated rapidly over the past 10 years. The rate of suicide among teenagers has increased 122 percent during the past 20 years, and suicide has been the third leading cause of death of persons age 15 through 24 during the past 10 years. The impact of the incidence of teenage suicide has caused the Legislature to determine that the prevention of suicide by youths is a priority of this state. The Legislature makes the following findings and declarations:

(1) A statewide program to promote the positive emotional development of youths and to prevent suicide by youths is essential to address the continuing problem of youth suicide in this state.

(2) The emotional development problems of youth often are compounded by other problems such as drug abuse, alcohol abuse, and school and family problems.

(3) A suicide prevention program for Florida can best be accomplished by coordinating the educational programs at the state and local levels with the community suicide prevention and crises center agencies. It is the intent of the Legislature that cooperation among these groups shall be a major component in its effort to achieve the successful prevention of youth suicide.

(4) Crises intervention and suicide prevention for the purposes of this act shall center on:

(a) Better detection by students, teachers, and family members of the signs of emotional distress in a youth that might result in suicide.

(b) Defined responsibility for school counselors.

(c) Timely referral of potential suicide victims to community professionals as needed.

(d) Cooperation between school and nonschool professionals.

Section 26. Plan for comprehensive approach.--

(1)(a) The Department of Health and Rehabilitative Services shall develop a state plan for the prevention of youth suicide and shall submit the plan to the Speaker of the House of Representatives, the President of the Senate, and the Governor no later than January 15, 1985. The Department of Education shall participate and fully cooperate in the development of the state plan at both the state and local levels. Furthermore, appropriate local agencies and organizations shall be provided an opportunity to participate in the development of the state plan at the local level. Appropriate local groups and organizations shall include, but not be limited to, community mental health centers; the schoc boards of the local school districts; the district human

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rights advocacy committees; private or public organizations or programs, including Parent Teacher Associations, with recognized expertise in working with children who are emotionally distressed and with expertise in working with the families of such children; law enforcement agencies; and the circuit courts. The state plan to be provided to the Legislature and the Governor shall include, as a minimum, the information required of the various groups in paragraph (b).

(b) The development of the comprehensive state plan shall be accomplished in the following manner:

1. The Department of Health and Rehabilitative Services shall establish an interprogram task force comprised of representatives from the Children, Youth, and Families Program Office; the Alcohol, Drug Abuse, and Mental Health Program Office; the Health Program Office; the Developmental Services Program Office; and the Office of Evaluation. One representative of the Department of Law Enforcement and one representative of the Department of Education shall also serve as members of the interprogram task force. The interprogram task force shall be responsible for:

a. Developing a plan of action for better coordination and integration of the goals, activities, and funding pertaining to the state plan for the prevention of youth suicide to be developed by the Department of Health and Rehabilitative Services to maximize staff and resources at the state level. The plan of action shall be included in the state plan.

b. Providing a basic format to be used by the service districts of the Department of Health and Rehabilitative Services in the preparation of local plans of action to provide for uniformity in the service district plans and to

provide for greater ease in compiling information for the state plan.

c. Providing the service districts with technical assistance in the development of local plans of action, if requested.

d. Examining the local plans to determine if all the requirements of the local plans have been met and, if they have not, informing the service districts of the deficiencies and requesting the additional information needed.

e. Preparing the state plan for submission to the Legislature and the Governor. Such preparation shall include the collecting of information obtained from the local plans, the cooperative plans with the Department of Education, and the plan of action for coordination and integration of activities of the Department of Health and Rehabilitative Services into one comprehensive plan. The state comprehensi- plan shall include a section reflecting general conditions a needs, an analysis of variations based on population or geographic areas, identified problems, and recommendations f. change.. In essence, the plan shall provide an analysis and summary of each element of the local plans to provide a statewide perspective. The plan shall also include each separate local plan of action.

f. Working with the specified state agencies in fulfilling the requirements of this paragraph.

2. The Department of Health and Rehabilitative Services and the Department of Education shall work together to develop ways to inform and instruct appropriate district school personnel in all school districts in the detection o: conditions which indicate youth suicidal tendencies and in t proper action that should be taken when there is reason to

suspect that a student is contemplating suicide. The plan for accomplishing this end shall be included in the state plan.

3. The Department of Law Enforcement and the Department of Health and Rehabilitative Services shall work together to develop ways to inform and instruct appropriate local law enforcement personnel in the detection of youth suicidal tendencies, and in the proper action that should be taken to prevent suicide.

4. Within existing appropriations, the Department of Health and Rehabilitative Services shall work with other appropriate public and private agencies to emphasize efforts to educate the general public about the problem of youth suicide and ways to detect the warning signs that indicate a youth is planning to commit suicide, and in the proper action that should be taken to prevent a suicide. The plan for accomplishing this end shall be included in the state plan.

5. The Department of Education and the Department of Health and Rehabilitative Services shall work together on the enhancement or adaptation of curriculum materials to assist instructional personnel in providing instruction through a multidisciplinary approach on the identification, intervention, and prevention of youth suicide. The curriculu materials shall be geared toward a program of instruction at the 9-12 grade level. Strategies for requiring all school districts to utilize the curriculum are to be included in the comprehensive state plan for the prevention of youth suicide.

6. The Department of Education shall develop audio-visual and other training materials relating to suicide prevention and positive emotional development and shall distribute such materials to each school district for require in-service training for all teachers and administrators.

7. Each service district of the Department of Health and Rehabilitative Services shall develop a plan for its specific geographic area. The plan developed at the district level shall be submitted to the interprogram task force for use in preparing the state plan. The service district local plan of action shall be prepared with the involvement and assistance of the local agencies and organizations listed in paragraph (a) and representatives from those departmental district offices participating in the prevention of youth suicide. To accomplish this, the district administrator in each service district shall establish a task force on the prevention of youth suicide. The district administrator shall appoint the members of the task force in accordance with the membership requirements of this section. In addition, the district administrator shall ensure that each subdistrict is represented on the task force; and, if the district does not have subdistricts, the district administrator shall ensure that both urban and rural areas are represented on the task force. The task force shall develop a written statement clearly identifying its operating procedures, purpose, overall responsibilities, and method of meeting responsibilities. The district plan of action to be prepared by the task force shall include, but shall not be limited to:

a. Documentation of the magnitude of the problems of youth suicide in its geographical area.

b. A description of programs currently serving suicidal or emotionally upset youth and their families and of programs for the prevention of youth suicide, including information on their impact, cost-effectiveness, and sources of funding.

c. A continuum of programs and services necessary for a comprehensive approach to the prevention of youth suicide as well as a brief description of such programs and services.

d. A description, documentation, and priority ranking of local needs related to youth suicide prevention based upon the continuum of programs and services.

e. A plan for steps to be taken in meeting identified needs, including the rapid coordination and integration of services, the avoidance of unnecessary duplication and cost.

f. A plan for alternative funding strategies for meeting needs through the reallocation of existing resources, utilization of volunteers, contracting with local universities for services, and local government or private agency funding.

g. A description of barriers to the accomplishment of a comprehensive approach to the prevention of youth suicide.

h. Recommendations for changes that can be accomplished only at the state program level or by legislative action. The district local plan of action shall be submitted to the interprogram task force by October 1, 1984.

Section 27. Subsections (2) and (3) of section 230.2313, Florida Statutes, are amended to read:

230.2313 Student services programs.--

(2) It is the intent of the Legislature to articulate the functions served by each of the components of a program of student services. It is further the intent of the Legislature that each school district develop a plan for providing student services to all students in the public school system, including area vocational-technical centers. Each school in a district shall submit a written student services plan to the superintendent and the school board annually. This school plan shall be jointly developed by the principal, staff

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members and school advisory committee. These plans This plan shall be designed to ensure effective use of available resources and avoid unnecessary duplication. It is the intent of the Legislature that Student Services Coordinators be given time to fulfill their responsibilities under this section.

(3) A "student services program" is defined as a coordinated effort which shall include, but not be limited to:

(a) Guidance services, which shall include, but not be limited to, the availability of individual and group counseling to all students; orientation programs for new students at each level of education and for transferring students; consultation with parents, faculty, and out-of-school agencies concerning student problems and needs; utilization of student records and files; supervision of standardized testing and interpretation of results; the following up of early school dropouts and graduates; a school-initiated system of parental involvement; an organized system of informational resources on which to base educational and vocational decisionmaking; and educational and job placement.

(b) Psychological services, which shall include, but not be limited to, evaluation of students with learning or adjustment problems; evaluation of students in exceptional-child education programs; consultation and counseling with parents, students, and school personnel; a system for the early identification of learning potential and factors which affect the child's educational performance; a system of liaison and referrals, with resources available outside of the school; and written policies which assure ethical procedures in psychological activities.

(c) Visiting teacher and school social work services, which shall include, but not be limited to, providing casework

to assist in the prevention and remediation of problems of attendance, behavior, adjustment, and learning and serving as liaison between the home and school by making home visits and referring students and parents to appropriate school and community agencies for assistance.

(d) Occupational and placement services, which shall include, but not be limited to, the dissemination of career education information, placement services, and follow-up studies. Such follow-up studies may be conducted on a statistically valid random-sampling basis where appropriate and shall be stratified to reflect the appropriate vocational programs of students graduating from or leaving the public school system. The occupational and placement specialist shall serve as liaison between employers and the school. It shall be the responsibility of district placement personnel to make written recommendations to the superintendent for consideration by the district school board concerning areas of curriculum deficiency having an adverse effect on the employability of job candidates or progress in subsequent educational experiences. Further, district administrative personnel shall report to the school board concerning adjustments in program outcomes, curricula, and delivery of instruction as they are made with the use of placement and follow-up information.

(e) The distribution of a suicide prevention public awareness program developed for distribution by the interprogram task force established by the Department of Health and Rehabilitative Services.

Section 28. Paragraph (a) of subsection (2) of sectic 231.17, Florida Statutes, is amended to read:

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231.17 Certificates granted on application to those meeting prescribed requirements.--

(2)(a) Each certificate issued shall be valid for a period not to exceed 5 years, and each applicant for initial regular certification shall demonstrate, on a comprehensive written examination or through such other procedures as may be specified by the state board, mastery of those minimum essential generic and specialization competencies and other criteria as shall be adopted into rules by the state board, including, but not limited to, the following:

1. The ability to write in a logical and understandable style with appropriate grammar and sentence structure;

2. The ability to read, comprehend, and interpret professional and other written material;

3. The ability to comprehend and work with fundamental mathematical concepts;

4. The ability to recognize signs of severe emotional distress in students and techniques of crisis intervention with emphasis on suicide prevention and positive emotional development.

5.4. The ability to comprehend patterns of physical, social, and academic development in students, including exceptional students in the regular classroom, and to counsel the same students concerning their needs in these areas; and

6.5. The ability to recognize and be aware of the instructional needs of exceptional students.

Section 29. Paragraph (b) of subsection (1) of section 232.246, Florida Statutes, is amended to read:

232.246 General requirements for high school graduation.--

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(1)

(b) Beginning with the 1986-1987 school year and each year thereafter, successful completion of a minimum of 24 academic credits in grades 9 through 12 shall be required for graduation. The 24 credits shall be distributed as follows:

1. Four credits in English, with major concentration in composition and literature.

2. Three credits in mathematics.

3. Three credits in science, two of which must have a laboratory component. The State Board of Education may grant an annual waiver of the laboratory requirement to a school district that certifies that its laboratory facilities are inadequate, provided that the district submits a capital outlay plan to provide adequate facilities and makes the funding of this plan a priority of the school board.

4. One credit in American history.

5. One credit in world history, including a comparative study of the history, doctrines, and objectives of all major political systems in fulfillment of the requirements of s. 233.064.

6. One-half credit in economics, including a comparative study of the history, doctrines, and objectives of all major economic systems. The Florida Council on Economic Education shall provide technical assistance to the department and local school boards in developing curriculum materials for the study of economics.

7. One-half credit in American government.

8. One-half credit in practical arts vocational education or exploratory vocational education.

9. One-half credit in performing fine arts to be selected from music, dance, drama, painting, or sculpture.

10. One-half credit in life management skills to include positive emotional development, nutrition, drug education, consumer education, cardiopulmonary resuscitation and the hazards of smoking. Such credit shall be given for a course to be taken by all students in either the ninth or tenth grade.

11. One-half credit in physical education to include assessment, improvement, and maintenance of personal fitness.

12. Nine elective credits.

Section 30. This act shall take effect January 1, 198 except that sections 20-25 shall take effect July 1, 1984 or upon becoming a law, whichever occurs later.

ASSEMBLY, No. 2286

STATE OF NEW JERSEY

INTRODUCED JUNE 25, 1984

By Assemblymen OTLOWSKI, KARCHER, HAYTAIAN, PELLY, DEVERIN and PATERNITI

AN ACT establishing a State Suicide Prevention Advisory Council and a pilot program for the prevention of teenage suicide in the Department of Human Services and making an appropriation therefor.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. The Legislature finds and declares that the rate of suicides among adolescents has become a serious and growing problem in our society today; that mental health professionals agree that many suicides can be prevented through suicide prevention programs in the schools and the community; and that in order to provide for the development of the most effective and efficient prevention and crisis intervention programs in New Jersey, it is necessary to establish a youth suicide prevention pilot program in the State Department of Human Services to be administered by county mental health agencies.

2. The Commissioner of Human Services shall establish a pilot program in two counties which shall be administered by the county mental health agencies. The purpose of the program is to provide mechanisms for the prevention of teenage suicides and may include such programs as a 24 hour "hotline" telephone service staffed by trained professional counselors, crisis intervention and post-intervention services and parent and student education programs. All educational programs shall be developed in consultation with the Commissioner of Education.

3. The commissioner shall solicit proposals for demonstration projects from counties interested in participating in this program. The commissioner shall review the project proposals and approve and fund within the limits of monies appropriated for this purpose two proposals which would best meet the objectives of the demonstration program.

4. a. There is established in the Department of Human Services a State Suicide Prevention Advisory Council consisting of seven members as follows: the Commissioner of Human Services or his designee, the Commissioner of Education or his designee, two representatives of county mental health agencies from separate counties to be appointed by the Governor for terms of two years, no more than one of whom shall be of the same political party; and three public members who are residents of this State, one of whom shall be appointed by the Governor, one of whom shall be appointed by the President of the Senate, and one of whom shall be appointed by the Speaker of the General Assembly. Of the public members first appointed, the member appointed by the Governor shall serve for a term of one year and the members appointed by the President and the Speaker shall serve for a term of two years.

b. Vacancies in the membership of the council shall be filled in the same manner as the original appointment, but for the unexpired term. A member of the council is eligible for reappointment. The members of the council shall serve without compensation, but the council shall reimburse its members for the reasonable expenses incurred in the performance of their duties.

c. The Commissioner of Human Services is the chairman and chief executive officer of the council, and the members shall elect a secretary who need not be a member of the council.

d. The council shall be appointed within 60 days after the effective date of this act and shall organize as soon as may be practicable after the appointment of the members.

5. It shall be the duty of the council to coordinate the activities and efforts of youth suicide prevention programs throughout New Jersey and to disseminate information, including the most recent research findings of studies into the causes of youth suicide and the most effective methods of prevention, to the maximum extent possible to programs Statewide that seek in particular to address the problem of youth suicide through the schools and through other agencies or forums in the community at large.

6. The Commissioner of Human Services shall report to the Governor and Legislature no later than four months before the expiration date of this act concerning the effectiveness of the pilot program and the means by which it could be implemented on a Statewide basis.

7. There is appropriated $80,000.00 from the General Fund to the Department of Human Services to carry out the purposes of this act.

8. This act shall take effect immediately and shall expire on January 1 following the third anniversary of the effective date.

STATEMENT

This bill would establish a demonstration youth suicide prevention program in the Department of Human Services as a means of addressing the serious and growing problem of teenage suicide. The Commissioner of Human Services is directed to establish guidelines for prevention projects which shall be administered by the county mental health agency in cooperation with the Commissioner of Education. The commissioner shall solicit proposals for demonstration projects from the various counties and select and fund two projects for the demonstration program. It is the intent of the bill that the commissioner seek, to the maximum extent possible, to fund a demonstration program in a county in northern New Jersey and a program in southern New Jersey. The bill appropriates $80,000.00 to carry out the program.

The bill further provides that the demonstration program shall operate for three years and that at the end of the program, the Commissioner of Human Services shall report to the Legislature and Governor on the effect of the program and provide recommendations for establishing suicide prevention programs on a Statewide basis.

The bill also establishes a seven member State Suicide Prevention Advisory Council in the Department of Human Services to coordinate youth suicide prevention programs in New Jersey.

1985 ASSEMBLY BILL 180

March 21, 1985 - Introduced by Representatives KRUSICK, BARRETT, GRUSZYNSKI, MAGNUSON, GROBSCHMIDT, YORK, HAUKE, NEUBAUER, RUTKOWSKI, SHOEMAKER, R. TRAVIS, HASENOHRL, BOLLE, BELL, CRAWFORD, WILLIAMS, BARCA, TESMER, D. TRAVIS, RADTKE, ROSENZWEIG, S. COGGS, SEERY, MUSSER, PLIZKA, ZEUSKE, MERKT, R. THOMPSON, OURADA and M. COGGS, cosponsored by Senators OTTE, HELBACH, PLEWA, STROHL, CZARNEZKI, ANDREA, CHILSEN, LORMAN and VAN SISTINE. Referred to Committee on Education.

AN ACT to create 20.255 (1) (dm), 20.255 (2) (dm), 115.365 and 118.01 (2) (d) 7 of the statutes, relating to providing assistance to schools for suicide prevention programs, granting rule-making authority and making an appropriation.

Analysis by the Legislative Reference Bureau

This bill directs the department of public instruction to conduct training programs in suicide prevention for the staff of public and private schools, to create an advisory council on suicide prevention and to provide fellowship grants to support advanced training or education in suicide prevention.

In addition, the bill directs the department to fund suicide prevention demonstration projects operated by public school districts.

Finally, the bill requires each school board to provide an instructional program designed to give pupils the skills needed to make sound decisions, knowledge of the conditions which may cause and the signs of suicidal tendencies and knowledge of available community youth suicide prevention services. Instruction must be designed to help prevent suicides by pupils by promoting their positive emotional development.

For further information, see the state and local fiscal estimate which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 20.005 (3) (schedule) of the statutes: at the appropriate place, insert the following amounts for the purposes indicated:

			1985-86	1986-87
20.255 PUBLIC INSTRUCTION, DEPARTMENT OF				
(1) EDUCATIONAL LEADERSHIP				
(dm) Suicide prevention programs	GPR	A	258,000	238,000
(2) AIDS FOR LOCAL EDUCATIONAL PROGRAMMING				
(dm) Aid for suicide prevention programs	GPR	A	391,500	391,500

SECTION 2. 20.255 (1) (dm) of the statutes is created to read:

20.255 (1) (dm) Suicide prevention programs. The amounts in the schedule for the purpose of s. 115.365 (2) and the administration of s. 115.365 (3).

SECTION 3. 20.255 (2) (dm) of the statutes is created to read:

20.255 (2) (dm) Aid for suicide prevention programs. The amounts in the schedule for the purpose of s. 115.365 (3).

SECTION 4. 115.365 of the statutes is created to read:

115.365 ASSISTANCE TO SCHOOLS FOR SUICIDE PREVENTION PROGRAMS. (1) The purpose of this section is to enable and encourage public and private schools to develop comprehensive programs to prevent suicide among minors.

(2) The department shall:

(a) Develop and conduct training programs in suicide prevention for the professional staff of public and private schools. The programs shall include information on how to assist minors in the positive emotional development which will help prevent suicidal tendencies; the detection, by minors, school staff and parents, of conditions which indicate suicidal tendencies; the proper action to take when there is reason to believe that a minor has suicidal tendencies or is contemplating suicide; and the co-

ordination of school suicide prevention and intervention programs and activities with the programs and activities of other state and local agencies. In developing the training programs, the department shall consult with the department of health and social services, the council on criminal justice, local law enforcement agencies, local crisis intervention agencies and other state and community agencies that deal with suicide among minors. Persons other than public and private school professional staff may attend the training programs. The department may charge such persons a fee sufficient to cover the increased costs to the department of their participation in the programs.

(b) Provide consultation and technical assistance to public and private schools for the development and implementation of suicide prevention programs and the coordination of those programs with the suicide prevention and intervention programs of other state and local agencies.

(c) Develop and distribute, for use by public and private schools, programs and materials designed to inform parents and increase public awareness of the problems of suicide by minors and the assistance available when there is reason to believe a minor has suicidal tendencies or is contemplating suicide.

(d) Provide fellowship grants to professional staff of public and private schools for advanced training or education in suicide prevention.

(e) Develop informational resources for suicide prevention programs and services and provide access to the resources to public and private schools, local law enforcement agencies, local crisis intervention agencies and other community agencies which deal with suicides among minors. Informational activities of the department shall include:

1. The screening, revision and evaluation of available information resources.

2. The establishment of a central depository and loan program for high-cost informational resources.

3. The systematic dissemination of information concerning available resources to appropriate public and private school staff.

(f) Create a council under s. 15.04 (1) (c) to advise the department concerning the administration of this section. The council shall include professional staff from schools and from community agencies that provide resources related to suicide prevention.

(3) (a) The department shall, from the appropriation under s. 20.255 (2) (dm), fund suicide prevention demonstration projects operated by public school districts which are designed to inform students on the detection of conditions which indicate suicidal tendencies among minors and the proper action that should be taken when there is reason to believe that a minor has suicidal tendencies or is contemplating suicide. The department shall:

1. Administer grant application and disbursement of funds.

2. Monitor program implementation.

3. Assist in and assure evaluation of demonstration projects.

4. Report biennially under s. 15.04 (1) (d) on program progress and project evaluation.

5. Promulgate necessary rules for the implementation of this subsection.

(b) Grants under this subsection may not be used to replace funding available from other sources.

(c) Grants under this subsection may be made only where there is a matching fund contribution from the local area in which a program is designed to operate of 20% of the amount of the grant obtained under this

subsection. Private funds and in-kind contributions may be applied to meet the requirement of this paragraph.

(d) A school district applying for a grant under this subsection shall submit with its application a plan, developed in consultation with the boards established under ss. 51.42 and 51.437, local law enforcement agencies and, as appropriate, other local agencies. The department shall by rule establish requirements for consulting with other agencies on the development of the plan. The plan shall provide for interagency cooperation and the coordination of suicide prevention and intervention programs and activities involving minors.

(e) The council established under sub. (2) (f) shall submit an advisory recommendation with respect to the application to the department prior to the approval or denial of the application.

SECTION 5. 118.01 (2) (d) 7 of the statutes is created to read:

118.01 (2) (d) 7. The skills needed to make sound decisions, knowledge of the conditions which may cause and the signs of suicidal tendencies, knowledge of the relationship between youth suicide and the use of alcohol and controlled substances under ch. 161 and knowledge of the available community youth suicide prevention and intervention services. Instruction shall be designed to help prevent suicides by pupils by promoting the positive emotional development of pupils.

(End)

Suicide Prevention and Crisis Intervention Agencies

SUICIDE PREVENTION AND CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

COMPILED BY THE

AMERICAN ASSOCIATION OF SUICIDOLOGY

2459 S. Ash
Denver, CO 80222

1985

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

* Member, American Association of Suicidology
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ALASKA

ANCHORAGE
* ANCHORAGE COMM. MENTAL HEALTH
SERVICES, INC.
4020 FOLKER
ANCHORAGE AK 99508
Crisis Phone 1:(907)563-1000
Business Phone:(907)563-1000
Hrs Avail:24

FAIRBANKS
*#FAIRBANKS CRISIS CLINIC FOUNDATION
P.O. Box 832
FAIRBANKS AK 99707
Crisis Phone 1:(907)452-4403
Business Phone:(907)479-0166
Hrs Avail:24

KENAI
CENTRAL PENNISULA MH CENTER
11355 KENAI SPUR RD., STE. 228
KENAI AK 99611
Crisis Phone 1:(907)283-7501
Business Phone:(907)283-7501
Hrs Avail:24

WASILLA
* MAT-SU CRISIS LINE
P.O. Box 873388
WASILLA AK 99687
Crisis Phone 1:(907)376-3706
Business Phone:(907)376-3356
Hrs Avail:24

ANCHORAGE
*#SUICIDE PREVENTION AND CRISIS CENTER
2611 FAIRBANKS ST.
ANCHORAGE AK 99503
Crisis Phone 1:(907)276-1600
Business Phone:(907)272-2496
Hrs Avail:24

JUNEAU
JUNEAU MENTAL HEALTH CLINIC
210 ADMIRAL WAY
JUNEAU AK 99801
Crisis Phone 1:(907)586-5280
Crisis Phone 2:(907)789-4889
Business Phone:(907)586-5280
Hrs Avail:08:00AM-04:30PM

KETCHIKAN
GATEWAY MENTAL HEALTH
3134 TONGASS
KETCHIKAN AK 99901
Crisis Phone 1:(907)225-4135
Business Phone:(907)225-4135
Hrs Avail:24

ALABAMA

ANDALUSIA
SOUTH CENTRAL MENTAL HEALTH BOARD
HELPLINE
P.O. Box 1028
ANDALUSIA AL 36420
Crisis Phone 1:(205)222-7794
Business Phone:(205)222-2523

AUBURN
CRISIS CENTER OF E. ALABAMA, INC.
P.O. Box 1949
AUBURN AL 36830
Crisis Phone 1:(205)821-8600
Business Phone:(205)821-8600
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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BIRMINGHAM
*#CRISIS CENTER OF JEFFERSON COUNTY
3600 8TH AVE. S.
BIRMINGHAM AL 35222
CRISIS CENTER
(205)323-7777
Business Phone:(205)323-7782
Hrs Avail:24

DECATUR
CRISIS CALL CENTER
NORTH CENTRAL ALABAMA MH CENTER
P.O. Box 637
DECATUR AL 35601
Crisis Phone 1:(205)355-6091
Business Phone:(205)355-6091

FLORENCE
RIVERBEND CENTER FOR MENTAL HEALTH
P.O. Box 941
FLORENCE AL 35630
Crisis Phone 1:(205)764-3431
Business Phone:(205)764-3431

FOLEY
CONTACT SOUTH BALDWIN CO.
P.O. Box 481
FOLEY AL 36535
Crisis Phone 1:(205)943-5675
Business Phone:(205)943-5675

HUNTSVILLE
HUNTSVILLE, HELPLINE
P.O. Box 92
HUNTSVILLE AL 35804
Crisis Phone 1:(205)539-3424
Business Phone:(205)534-1779
Hrs Avail:24

MOBILE
* CONTACT MOBILE
3224 EXECUTIVE PARK CIRCLE
MOBILE AL 36606
Crisis Phone 1:(205)342-3333
Business Phone:(205)473-5330
Hrs Avail:24

MOBILE
MOBILE MENTAL HEALTH CENTER
CRISIS INTERVENTION SERVICES
2400 GORDON SMITH DRIVE
MOBILE AL 36617
Crisis Phone 1:(205)473-4423
Business Phone:(205)473-4423
Hrs Avail:24

MONTGOMERY
HELP A CRISIS
101 COLLISIUM BOULEVARD
MONTGOMERY AL 36109
Crisis Phone 1:(205)279-7837
Business Phone:(205)279-7830
Hrs Avail:24

TUSCALOUSA
INDIAN RIVERS MENTAL HEALTH CENTER
TUSCALOUSA CRISIS LINE
P.O. Box 2190
TUSCALOUSA AL 35403
Crisis Phone 1:(205)345-1600
Business Phone:(205)345-1600
Hrs Avail:24

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ARKANSAS

HOT SPRINGS
CONTACT HOT SPRINGS
705 MALVERN AVE.
HOT SPRINGS AR 71901
Crisis Phone 1:(501)623-2515
Business Phone:(501)623-4048
Hrs Avail:24

LITTLE ROCK
CRISIS CENTER OF ARKANSAS, INC.
1616 W. 14TH ST.
LITTLE ROCK AR 72202
Crisis Phone 1:(501)375-5151
Business Phone:(501)664-8834
Hrs Avail:12:00PM-12:00AM

LITTLE ROCK
CONTACT LITTLE ROCK
P.O. Box 2572
LITTLE ROCK AR 72203
Crisis Phone 1:(501)666-0234
Business Phone:(501)666-0235
Hrs Avail:24

PINE BLUFF
CONTACT PINE BLUFF
P.O. Box 8734
PINE BLUFF AR 71601
Crisis Phone 1:(501)536-4226
Business Phone:(501)536-4228
Hrs Avail:24

ARIZONA

CLIFTON
GRAHAM-GREENLEE COMM. SERVICE CENTER
169 FRISCO AVE.
P.O. Box 987
CLIFTON AZ 85533
Crisis Phone 1:(602)865-4531
Business Phone:(602)865-4531
Hrs Avail:24

PHOENIX
PHOENIX CRISIS INTERVENTION PROGRAM
1250 S. 7TH AVE.
PHOENIX AZ 85007
Crisis Phone 1:(602)258-8011
Business Phone:(602)258-8011
Hrs Avail:24

PHOENIX
PSYCHIATRIC CRISIS CENTER
MARICOPA COUNTY HOSPITAL
2601 E. ROOSEVELT
PHOENIX AZ 85008
Crisis Phone 1:(602)267-5881
Business Phone:(602)267-5881
Hrs Avail:24

SAFFORD
SAFFORD CRISIS LINE
P.O. Box 956
SAFFORD AZ 85546
Crisis Phone 1:(602)428-4550
Business Phone:(602)428-4550
Hrs Avail:24

TUCSON
TUCSON HELP ON CALL
INFORMATION AND REFERRAL SERVICE
2555 E. FIRST ST., SUITE #107
TUCSON AZ 85716
Crisis Phone 1:(602)323-9373
Business Phone:(602)323-1303
Hrs Avail:24

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CALIFORNIA

ANAHEIM
* HOTLINE HELP CENTER
P.O. Box 999
ANAHEIM CA 92805
Crisis Phone 1:(714)778-1000
Business Phone:(714)778-1000
Hrs Avail:24

BERKELEY
* SUICIDE PREV/CRISIS INTERV.
OF ALAMEDA COUNTY
P.O. Box 9102
BERKELEY CA 94709
Crisis Phone 1:(415)849-2212
Crisis Phone 2:(415)889-1333
Crisis Phone 3:(415)794-5211
Crisis Phone 4:(415)449-5566
Business Phone:(415)848-1515
Hrs Avail:24

SANTA CRUZ COUNTY
* SPS OF SANTA CRUZ COUNTY
P.O. Box 734
CAPITOLA CA 95010
Crisis Phone 1:(408)426-2342
Crisis Phone 2:(408)688-6581
Business Phone:(408)426-2342
Hrs Avail:24

EL CAJON
CRISIS HOUSE/CRISIS INTERV. CENTER
144 S. ORANGE
EL CAJON CA 92020
Crisis Phone 1:(714)444-1194
Business Phone:(714)444-6506
Hrs Avail:24

FRESNO
CONTACT FRESNO
7172 N. CEDAR
FRESNO CA 93710
Crisis Phone 1:(209)298-2022
Business Phone:(209)298-8001
Hrs Avail:24

ARCATA
ARCATA CONTACT CENTER
WARREN HOUSE #53 HSU
ARCATA CA 95521
Crisis Phone 1:(707)826-4400
Business Phone:(707)826-4373
Hrs Avail:24

SAN MATEO COUNTY
*#SUICIDE PREV./CC OF SAN MATEO COUNTY
1811 TROUSDALE DR.
BURLINGAME CA 94010
Crisis Phone 1:(415)877-5600
Crisis Phone 2:(415)367-8000
Crisis Phone 3:(415)726-5228
Business Phone:(415)877-5604
Hrs Avail:24

DAVIS
* SUICIDE PREVENTION OF YOLO COUNTY
P.O. Box 622
DAVIS CA 95617
Crisis Phone 1:(916)756-5000
Crisis Phone 2:(916)666-7778
Crisis Phone 3:(916)372-6565
Business Phone:(916)756-7542
Hrs Avail:24

FRESNO
* HELP IN EMOTIONAL TROUBLE
P.O. Box 4282
FRESNO CA 93744
Crisis Phone 1:(209)485-1432
Business Phone:(209)486-4703
Hrs Avail:24

FT. BRAGG
CRISIS LINE CAARE PROJECT
461 N. FRANKLIN ST.
P.O. Box 764
FT. BRAGG CA 95437
Crisis Phone 1:(707)964-4357
Business Phone:(707)964-4055
Hrs Avail:24

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AGENCIES IN THE UNITED STATES

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GARDEN GROVE
NEW HOPE COUNSELING CENTER
12141 LEWIS ST.
GARDEN GROVE CA 92640
Crisis Phone 1:(714)639-4673
Business Phone:(714)971-4123
Hrs Avail:24

LAFAYETTE
CONTACT CARE CENTER
P.O. Box 901
LAFAYETTE CA 94549
Crisis Phone 1:(415)284-2273
Business Phone:(415)284-2273
Hrs Avail:24

LAKEPORT
LAKE CO. MENTAL HEALTH EMERG. SERV.
922 BEVINS COURT
LAKEPORT CA 95453
Crisis Phone 1:(707)263-0160
Business Phone:(707)263-2258
Hrs Avail:24

LOS ANGELES
*#LOS ANGELES SPC
1041 S. MENLO
LOS ANGELES CA 90006
Crisis Phone 1:(213)381-5111
Business Phone:(213)386-5111
Hrs Avail:24

NEWARK
SECOND CHANCE, INC.
P.O. Box 643
NEWARK CA 94560
Crisis Phone 1:(415)792-4357
Business Phone:(415)792-4357
Hrs Avail:24

HEMET
VALLEY HOTLINE
602 E. FLORIDA
HEMET CA 92343
Crisis Phone 1:(714)676-5800
Business Phone:(714)658-7227
Hrs Avail:24

LAKE ARROWHEAD
THE HELP LINE
P.O. Box 1263
LAKE ARROWHEAD CA 92352
Crisis Phone 1:(714)337-4300
Business Phone:(714)337-4300
Hrs Avail:24

LOS ALAMITOS
WEST ORANGE COUNTY HOTLINE
P.O. Box 32
LOS ALAMITOS CA 90720
HOURS AVAIL 24 HRS.
(714)761-4575
Crisis Phone 2:(213)596-5548
Business Phone:(213)594-0969
Hrs Avail:24

NAPA
* NORTH BAY SUICIDE PREVENTION, INC.
P.O. Box 2444
NAPA CA 94558
FAIRFIELD
(707)422-2555
NAPA
(707)255-2555
VALLEJO
(707)643-2555
Business Phone:(707)257-3470
Hrs Avail:24

PACIFIC GROVE,
* SUICIDE PREVEN. CENT./MONTEREY CO.
P.O. Box 52078
PACIFIC GROVE, CA 93950-7078
Crisis Phone 1:(408)649-8008
SALINAS
(408)424-1485
Business Phone:(408)375-6966
Hrs Avail:24

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PASADENA
CONTACT PASADENA
73 N. HILL AVE.
PASADENA CA 91106
Crisis Phone 1:(818)449-4500
Business Phone:(818)449-4502
Hrs Avail:24

PASADENA
PASADENA MENTAL HEALTH CENTER
1495 N. LAKE
PASADENA CA 91104
Crisis Phone 1:(213)798-0907
Business Phone:(213)681-1381
Hrs Avail:09:00AM-12:00AM

PLEASANTON
* THE CENTER
COUNSELING, EDUCATION, CRISIS SERVICE
4361 RAILROAD AVE.; SUITE B
PLEASANTON CA 94566
Crisis Phone 1:(415)828-help
Business Phone:(415)462-5544
Hrs Avail:24

REDDING
* HELP, INC.
P.O. Box 2498
REDDING CA 96099
Crisis Phone 1:(916)246-2711
Business Phone:(916)225-5255
Hrs Avail:09:00AM-12:00AM

RIVERSIDE
RIVERSIDE CRISIS & OUTPATIENT SERV.
9707 MAGNOLIA ST.
RIVERSIDE CA 92503
Crisis Phone 1:(714)351-7853
Business Phone:(714)351-7861
Hrs Avail:M-TH8AM-9PM F8AM-5PM

SACRAMENTO
* SUICIDE PREV. SERV. OF SACRAMENTO
P.O. Box 449
SACRAMENTO CA 95802
Crisis Phone 1:(916)441-1135
Business Phone:(916)441-1138
Hrs Avail:24

SAN ANSELMO
MARIN SUICIDE PREVENTION CENTER
P.O. Box 792
SAN ANSELMO CA 94960
Crisis Phone 1:(415)454-4524
Business Phone:(415)454-4566
Hrs Avail:24

SAN BERNADINO
* SUICIDE & CRISIS INTERV. SERVICE
1669 N. "E" ST.
SAN BERNADINO CA 92405
Crisis Phone 1:(714)886-4889
Business Phone:(714)886-6730
Hrs Avail:24

SAN DIEGO
*# THE CRISIS TEAM
P.O. Box 85524
SAN DIEGO CA 92138
Crisis Phone 1:(619)236-3339
Crisis Phone 2:(800)351-0757
Business Phone:(619)236-4576
Hrs Avail:24

SAN DIEGO
* SUICIDE HOTLINE
HARBOR VIEW MED. CENT.
120 ELM ST.
SAN DIEGO CA 92101
Crisis Phone 1:(619)232-7070
TTY
(619)232-7078
Business Phone:(619)232-4331 x624
Hrs Avail:24

SAN DIEGO
SAN DIEGO HELP CENTER
5059 COLLEGE AVE.
SAN DIEGO CA 92115
Crisis Phone 1:(714)582-4357
Business Phone:(714)582-1288
Hrs Avail:02:00PM-10:00PM

SAN FRANCISCO
* SAN FRANCISCO SUICIDE PREVENTION
3940 GEARY BLVD.
SAN FRANCISCO CA 94118
Crisis Phone 1:(415)221-1423
Crisis Phone 2:(415)221-1424
Crisis Phone 3:(415)221-1428
Business Phone:(415)752-4866
Hrs Avail:24

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SAN JOSE
CONTACT SANTA CLARA CO.
P.O. Box 24978
SAN JOSE CA 95154
Crisis Phone 1:(408)266-8228
Business Phone:(408)266-1020
Hrs Avail:24

SAN LUIS OBISPO
SAN LUIS OBISPO COUNTY HOTLINE, INC.
P.O. Box 654
SAN LUIS OBISPO CA 93406
Crisis Phone 1:(805)544-6162
Business Phone:(805)544-6164
Hrs Avail:24

SANTA BARBARA
SANTA BARBARA CRISIS INTERVENTION
PSYCHIATRIC EMERGENCY TEAM
4444 CALLE REAL
SANTA BARBARA CA 93110
DAYTIME HRS. EXT.
(805)964-6713
Business Phone:(805)964-6713
Hrs Avail:24

SANTA MONICA
NEWSTART
1455 19TH ST.
SANTA MONICA CA 90404
Crisis Phone 1:(213)828-5561
Business Phone:(213)828-5561
Hrs Avail:24

ST. HELENA
* CRISIS-HELP OF NAPA VALLEY, INC.
1360 ADAMS ST.
ST. HELENA CA 94574
Crisis Phone 1:(707)963-2555
Crisis Phone 2:(707)944-2212
Business Phone:(707)942-4319
Hrs Avail:24

SAN JOSE
* SANTA CLARA SUICIDE & CRISIS SERVICE
2220 MOORPARK
SAN JOSE CA 95128
Crisis Phone 1:(408)279-3312
Business Phone:(408)279-6250
Hrs Avail:24

SANTA BARBARA
* CALL-LINE
P.O. Box 14567
SANTA BARBARA CA 93107
Crisis Phone 1:(805)569-2255
Business Phone:(805)961-4114
Hrs Avail:24

SANTA CRUZ
CRISIS INTERVEN. SERVICE
SANTA CRUZ MENTAL HEALTH SERVICES
1060 EMELINE AVE.
SANTA CRUZ CA 95060
NORTH COUNTY
(408)425-2237
SOUTH COUNTY
(408)722-3577
Business Phone:(408)425-2237

SONOMA
FAMILY CENTER CRISIS INTERV. PROG.
SONOMA VALLEY FAMILY CENTER CRISIS INTERVENTION PROGRAM
P.O. Box 128
SONOMA CA 95476
Crisis Phone 1:(707)938-help
Business Phone:(707)996-7877
Hrs Avail:24

STOCKTON
SAN JOAQUIN CO. MENTAL HEALTH
1212 N. CALIFORNIA
STOCKTON CA 95202
Crisis Phone 1:(209)948-4484
8A.M.-5P.M. MON-FRI
(209)982-1818
Business Phone:(209)948-4484
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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VENTURA
CRISIS EVALUATION UNIT
VENTURA CO. MENTAL HEALTH DEPT.
300 HILLMONT AVE.
VENTURA CA 93003
Crisis Phone 1:(805)652-6727
Business Phone:(805)652-6727
Hrs Avail:24

VISTA
LIFELINE COMMUNITY SERVICES
200 JEFFERSON STREET
VISTA CA 92083
Crisis Phone 1:(619)726-4900
Business Phone:(714)726-6396
Hrs Avail:M-F8AM-8PM SAT11AM-3PM

WALNUT CREEK
* CONTRA COSTA CRISIS/SUICIDE INTERV.
P.O. Box 4852
WALNUT CREEK CA 94596
Crisis Phone 1:(415)939-3232
Business Phone:(415)939-1916
Hrs Avail:24

YUBA CITY
SUTTER-YUBA MH CRISIS CLINIC
1965 LIVE OAK BLVD.
YUBA CITY CA 95991
Crisis Phone 1:(916)673-8255
Business Phone:(916)674-8500
Hrs Avail:24

COLORADO

ARVADA
CONTACT LIFE LINE OF DENVER
5742 FIELD STREET
ARVADA CO 80002
Crisis Phone 1:(303)458-7777
Business Phone:(303)421-6453
Hrs Avail:24

AURORA
COMITIS CRISIS CENTER
9840 E. 17TH AVE.
P.O. Box 913
AURORA CO 80040
Crisis Phone 1:(303)343-9890
Business Phone:(303)341-9160
Hrs Avail:24

BOULDER,
EMERG. PSYCH. SERVICES
1333 IRIS AVE.
BOULDER, CO 80302
Crisis Phone 1:(303)447-1665
Business Phone:(303)443-8500
Hrs Avail:24

COLO. SPRINGS
COLORADO SPRINGS CRISIS SERVICES
PIKES PEAK MENTAL HEALTH
875 W. MORENO
COLO. SPRINGS CO 80903
Crisis Phone 1:(303)471-8300
Business Phone:(303)471-3343
Hrs Avail:24

COLO. SPRINGS
TERROS
P.O. Box 2642
COLO. SPRINGS CO 80901
Crisis Phone 1:(303)471-4127
Business Phone:(303)471-4128
Hrs Avail:24

COLORADO SPGS.
HELPLINE OF COLO. SPGS.
12 N. MEADE AVE.
COLORADO SPGS. CO 80909
Crisis Phone 1:(303)471-4357
Business Phone:(303)633-4601
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION
AGENCIES IN THE UNITED STATES

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DENVER
* SUICIDE AND CRISIS CONTROL
2459 SOUTH ASH
DENVER CO 80222
Crisis Phone 1:(303)757-0988
Crisis Phone 2:(303)789-3073
Business Phone:(303)756-8485
Hrs Avail:24

FT. MORGAN
FT. MORGAN HELPLINE
330 MEAKER STREET
FT. MORGAN CO 80701
Crisis Phone 1:(303)867-3411
Crisis Phone 2:(303)867-2451
Business Phone:(303)867-3411
Hrs Avail:24

PUEBLO
*#PUEBLO SUICIDE PREVENTION, INC.
229 COLORADO AVE.
PUEBLO CO 81004
Crisis Phone 1:(303)544-1133
Business Phone:(303)545-2477
Hrs Avail:24

FT. COLLINS
* CRISIS/INFO. HELPLINE OF LARIMER CO.
700 W. MOUNTAIN AVE.
FT. COLLINS CO 80521-2506
Crisis Phone 1:(303)493-3888
Business Phone:(303)493-3896
Hrs Avail:24

GRAND JUNCTION
GRAND JUNCTION HELPLINE
P.O. Box 3302
GRAND JUNCTION CO 81502
Crisis Phone 1:(303)242-help
Business Phone:(303)245-3270
Hrs Avail:24

CONNECTICUT

GREENWICH
* HOTLINE OF GREENWICH, INC.
189 MASON ST.
GREENWICH CT 06830
Crisis Phone 1:(203)661-help
Business Phone:(203)661-4378
Hrs Avail:24

NORWALK
INFO LINE OF SOUTHWESTERN CT
7 ACADEMY ST.
NORWALK CT 06850
BRIDGEPORT
(203)333-7555
NORWALK
(203)853-2525
STAMFORD
(203)324-1010
Business Phone:(203)333-7555
Hrs Avail:24

PLAINVILLE
*#THE WHEELER CLINIC, INC.
EMERGENCY SERVICES
91 NORTHWEST DR.
PLAINVILLE CT 06062
Crisis Phone 1:(203)747-3434
Crisis Phone 2:(203)524-1182
Business Phone:(203)747-6801
Hrs Avail:24

UNCASVILLE
* CONTACT OF SE CONNECTICUT, INC.
P.O. Box 277
UNCASVILLE CT 06382
Crisis Phone 1:(203)848-1281
Business Phone:(203)848-1655
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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WESTPORT
OPEN LINE, LTD.
245 POST ROAD EAST
WESTPORT CT 06880
Crisis Phone 1:(203)226-3546
Business Phone:(203)226-3546
Hrs Avail:12:00PM-12:00AM

WASHINGTON DC

WASHINGTON
* FACT HOTLINE
(FAMILIES AND CHILDREN IN TROUBLE)
FAMILY STRESS SERVICES OF DC/NCPCA
2001 "O" ST., NW, SUITE G-1200
WASHINGTON DC 20036
Crisis Phone 1:(202)628-3228
Business Phone:(202)965-1900
Hrs Avail:24

WASHINGTON
D.C. SUICIDE PREVENTION
CRISIS RESOLUTION BRANCH
DC DEPT. OF HUMAN SERV.
1905 E. ST. S.E.
WASHINGTON DC 20005
Crisis Phone 1:(202)727-3622
Business Phone:(202)727-3622
Hrs Avail:24

WASHINGTON
* ST. FRANCIS CENTER
2633-15TH ST., NW, STE. #11
WASHINGTON DC 20009
Crisis Phone 1:(202)234-5613
Business Phone:(202)234-5613
Hrs Avail:24

WASHINGTON
D.C. HOTLINE
P.O. Box 12044
WASHINGTON DC 20005
Crisis Phone 1:(202)223-2255
Business Phone:(202)223-0020
Hrs Avail:1PM-1AM

DELAWARE

GEORGETOWN
GEORGETOWN HELPLINE
SUSSEX COUNTY COMMUNITY MHC
GEORGETOWN DE 19947
Crisis Phone 1:(302)856-6626
Business Phone:(302)856-2151
Hrs Avail:24

NEW CASTLE
PSYCHIATRIC EMERGENCY SERVICES
S. NEW CASTLE COUNTY COMMUNITY MH
14 CENTRAL AVENUE
NEW CASTLE DE 19720
Crisis Phone 1:(302)421-6711
Business Phone:(302)421-6711
Hrs Avail:08:00AM-12:00AM

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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WILMINGTON
CONTACT WILMINGTON, INC.
WASHINGTON ST. AT LEA BLVD.
WILMINGTON DE 19802
Crisis Phone 1:(302)575-1112
DEAF CONTACT
(302)656-6660
Business Phone:(302)762-4989
Hrs Avail:24

FLORIDA

BARTOW
* CRISIS INTERV. SERVICES
PEACE RIVER CENTER
1745 HIGHWAY 17 SOUTH
BARTOW FL 33830
Crisis Phone 1:(813)533-4323
Crisis Phone 2:(800)282-6342
Business Phone:(813)533-3141
Hrs Avail:24

DEFUNIAK SPRGS.
COPE CENTER
HWY. 90
DEFUNIAK SPRGS. FL 32433
Crisis Phone 1:(904)892-2167
Business Phone:(904)892-2167
Hrs Avail:24

FT. MYERS
FT. MYERS CRISIS INTERVENTION CENTER
LEE MENTAL HEALTH CENTER
P.O. Box 06137
FT. MYERS FL 33906
Crisis Phone 1:(813)332-1477
Business Phone:(813)334-3537
Hrs Avail:24

FT.WALTON BEACH
CRISIS LINE
205 SHELL AVE.
FT.WALTON BEACH FL 32548
Crisis Phone 1:(904)244-9191
CRESTVIEW,TOLL FREE
(904)682-0101
Business Phone:(904)244-0151 x35
Hrs Avail:24

BRADENTON,
MANATEE MENTAL HEALTH CENTER
CRISIS SERVICES
P.O. Box 9478
BRADENTON, FL 33506
Crisis Phone 1:(813)748-8648
Business Phone:(813)747-8648
Hrs Avail:24

FORT LAUDERDALE
CRISIS INTERV. CENTER OF BROWARD CO.
P.O. Box 7537
FORT LAUDERDALE FL 33338
Crisis Phone 1:(305)323-8553
Business Phone:(305)763-1213
Hrs Avail:24

FT. PIERCE
INDIAN RIVER COMM. MHC
800 AVE. H
FT. PIERCE FL 33450
Crisis Phone 1:(305)464-8111
Business Phone:(305)464-8111
Hrs Avail:24

GAINESVILLE
*#ALACHUA COUNTY CRISIS CENTER
730 N. WALDO RD.; SUITE #100
GAINESVILLE FL 32601
Crisis Phone 1:(904)376-4444
Crisis Phone 2:(904)376-4445
Business Phone:(904)372-3659
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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JACKSONVILLE
* SUICIDE PREVENTION SERVICE
2218 PARK ST.
JACKSONVILLE FL 32204
Crisis Phone 1:(904)384-2234
Business Phone:(904)387-5641
Hrs Avail:24

KEY WEST/MONROE COUNTY
* HELPLINE, INC.
FLA. KEYS MEMORIAL HOSP.
5900 JUNIOR COLLEGE RD.
KEY WEST FL 33040
Crisis Phone 1:(305)296-Help
Crisis Phone 2:(305)294-line
MIDDLE & UPPER KEYS
(800)341-4343
Business Phone:(305)294-5531 x.3412
Hrs Avail:24

KISSIMMEE,
HELP NOW IN OSCEOLA, INC.
917 EMMETT ST.
KISSIMMEE, FL 32741
Crisis Phone 1:(305)847-8811
Business Phone:(305)847-8811
Hrs Avail:24

LAKE CITY
COLUMBIA COUNSELING CENTER
P.O. Box 2818
LAKE CITY FL 32056
Crisis Phone 1:(904)752-1045
AFTER 5:00 P.M.
(904)752-2140
Business Phone:(904)752-1045
Hrs Avail:24

LAKELAND
CONTACT HELP LINE
P.O. Box 2021
LAKELAND FL 33803
Crisis Phone 1:(813)688-1977
Business Phone:(813)688-9114
Hrs Avail:24

MIAMI
* SWITCHBOARD OF MIAMI, INC.
35 S.W. 8TH ST.
MIAMI FL 33130
Crisis Phone 1:(305)358-4357
Business Phone:(305)358-1640
Hrs Avail:24

MILTON,
SANTA ROSA MH CRISIS LINE
705 STEWART ST. SW
MILTON, FL 32570
Crisis Phone 1:(904)623-6363
Business Phone:(904)626-0616
Hrs Avail:24

ORLANDO
WE CARE, INC.
112 PASADENA PLACE
ORLANDO FL 32803
Crisis Phone 1:(305)628-1227
TEEN/KID
(305)644-2027
Business Phone:(305)425-2624
Hrs Avail:24

ORLANDO
* MENTAL HEALTH SERVICES OF ORANGE
2520 NORTH ORANGE AVE.
ORLANDO FL 32804
Crisis Phone 1:(305)896-9306
Business Phone:(305)896-9306
Hrs Avail:24

OSPREY
LIFELINE
SUNCOAST MENTAL HEALTH CENTER
873 S. TAMIAMI TRAIL
OSPREY FL 33559
Crisis Phone 1:(813)957-5003
Business Phone:(813)966-7471
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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PANAMA CITY
PANAMA CITY CRISIS LINE
NORTHWEST MENTAL HEALTH CENTER
615 N. MCARTHUR AVE.
PANAMA CITY FL 32401
Crisis Phone 1:(904)769-9481
Business Phone:(904)769-9481
Hrs Avail:24

PENSACOLA
PENSACOLA HELP LINE
LAKEVIEW CENTER, INC.
1221 W. LAKEVIEW ST.
PENSACOLA FL 32501
Crisis Phone 1:(904)438-1617
Business Phone:(904)432-1222 x300
Hrs Avail:24

ROCKLEDGE
SUICIDE/CRISIS HOTLINE
BREVARD COUNTY MENTAL HEALTH CENTER
566 BARTON BLVD. #304
ROCKLEDGE FL 32955
Crisis Phone 1:(305)631-8944
Business Phone:(305)631-9790
Hrs Avail:24

ROCKLEDGE,
TEEN & PARENT STRESS LINE
1770 CEDAR ST.
P.O. Box 69
ROCKLEDGE, FL 32955
Crisis Phone 1:(305)631-8944
Business Phone:(305)631-9290
Hrs Avail:24

ST. PETERSBURG
HOTLINE/INFORMATION AND REFERRAL
P.O. Box 13087
ST. PETERSBURG FL 33733
Crisis Phone 1:(813)531-4664
Business Phone:(813)536-9464
Hrs Avail:24

TALLAHASSEE
* TELEPHONE COUNSEL. & REFERRAL SERV.
P.O. Box 20169
TALLAHASSEE FL 32316
Crisis Phone 1:(904)224-6333
Business Phone:(904)224-6333
Hrs Avail:24

TAMPA
*#SUICIDE & CRISIS CENTER OF
HILLSBOROUGH COUNTY
2214 E. HENRY AVE.
TAMPA FL 33610
Crisis Phone 1:(813)238-8821
Business Phone:(813)238-8411
Hrs Avail:24

TAMPA
CONTACT TAMPA HELP LINE
P.O. Box 10117
TAMPA FL 33679
Crisis Phone 1:(813)251-4000
Business Phone:(813)251-4040
Hrs Avail:24

W. PALM BEACH
* CRISIS LINE INFO. & REFERRAL SERVICE
P.O. Box 15522
W. PALM BEACH FL 33416
NORTH AND CENTRAL
(305)686-4000
SOUTH
(305)278-1121
WEST (GLADES)
(305)996-1121
Business Phone:(305)689-3334
Hrs Avail:24

WINTER HAVEN
POLK CO.HELP & RESOURCE LINE
COMMUNITY MENTAL HEALTH CENTER
WINTER HAVEN HOSPITAL
WINTER HAVEN FL 33880
Crisis Phone 1:(813)299-5858
Business Phone:(813)293-1121 x1158
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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GEORGIA

AGUSTA
HELP LINE
P.O. Box 1724
AGUSTA GA 30903
Crisis Phone 1:(404)724-4357
Business Phone:(404)724-4357
Hrs Avail:24

ATLANTA
DE KALB EMERG./CRISIS INTERV. SERV.
GEORGIA MENTAL HEALTH INSTITUTE
1256 BRIARCLIFF RD. N.E.
ATLANTA GA 30306
Crisis Phone 1:(404)892-4646
Business Phone:(404)892-4646
Hrs Avail:24

GAINESVILLE
CONTACT HALL COUNTY
P.O. Box 1616
GAINESVILLE GA 30503
Crisis Phone 1:(404)534-0617
Business Phone:(404)536-7145
Hrs Avail:24

MACON
CRISIS LINE OF MACON AND BIBB CO.
MERCER UNIVERSITY
P.O. Box 56
MACON GA 31207
Crisis Phone 1:(912)745-9292
Business Phone:(912)745-9292
Hrs Avail:24

RIVERDALE
CLAYTON CRISIS LINE
CLAYTON GENERAL HOSPITAL
11 S.W. UPPER RIVERDALE RD.
RIVERDALE GA 30274
Crisis Phone 1:(404)996-4357
Business Phone:(404)996-4361
Hrs Avail:24

ATLANTA
EMERGENCY MENTAL HEALTH SERVICE
99 BUTLER S.E.
ATLANTA GA 30311
Crisis Phone 1:(404)522-9222
Business Phone:(404)522-9222
Hrs Avail:24

COLUMBUS
CONTACT CHATTANOOCHEE VALLEY
P.O. Box 12002
COLUMBUS GA 31907
Crisis Phone 1:(404)327-3999
Business Phone:(404)327-0199
Hrs Avail:24

LAWRENCEVILLE
LAWRENCEVILLE EMERGENCY SERVICES
GWINNETTE COUNTY MENTAL HEALTH
100 CLAYTON ST. S.E.
LAWRENCEVILLE GA 30245
Crisis Phone 1:(404)963-8141
EVENING, WEEK-ENDS
(404)963-3223
Business Phone:(404)963-8141
Hrs Avail:24

MARIETTA
MARIETTA EMERGENCY SERVICES
COBB-DOUGLAS MENTAL HEALTH
COMMUNITY SERVICES BUILDING
737 CHURCH ST., SUITE #420
MARIETTA GA 30060
Crisis Phone 1:(404)422-0202
Business Phone:(404)424-0870
Hrs Avail:24

SAVANNAH
FIRST CALL FOR HELP
P.O. Box 9119
SAVANNAH GA 31412
Crisis Phone 1:(912)232-3383
Business Phone:(912)232-3383
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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HAWAII

HONOLULU/OAHU
* SUICIDE AND CRISIS CENTER
200 N. VINEYARD BLVD., RM.#603
HONOLULU HI 96817
Crisis Phone 1:(808)521-4555
Business Phone:(808)536-7234
Hrs Avail:24

LIHUE
HELPLINE KAUAI
P.O. Box 3541
LIHUE HI 96766
Crisis Phone 1:(808)822-4114
Business Phone:(808)822-7435
Hrs Avail:24

KAILUA-KONA
KONA CRISIS CENTER, INC.
P.O. Box 4363
KAILUA-KONA HI 96740
Crisis Phone 1:(808)329-9111
Business Phone:(808)329-6744
Hrs Avail:24

WAILUKU
* HELPLINE/SUICIDE & CRISIS CENTER
MAUI KOKUA SERVICES, INC.
95 MAHALANI STREET
WAILUKU HI 96793
Crisis Phone 1:(808)244-7407
Business Phone:(808)244-7405
Hrs Avail:24

IOWA

AMES
OPEN LINE
WELCH AVE. STATION
P.O. Box 1138
AMES IA 50010
Crisis Phone 1:(515)292-7000
Business Phone:(515)292-4983
Hrs Avail:18

CLEARLAKE
SUICIDE HELP-LINE OF IOWA
P.O. Box 711
CLEARLAKE IA 50428
IOWA TOLL FREE #
(800)638-help
Business Phone:(515)357-4357
Hrs Avail:24

CEDAR RAPIDS
* FOUNDATION 2, INC.
1251 THIRD AVE. SE
CEDAR RAPIDS IA 52403
Crisis Phone 1:(319)362-2174
Business Phone:(319)362-2176
Hrs Avail:24

DES MOINES
* COMMUNITY TELEPHONE COUNSELING/
CRISIS LINE
SERVICE OF THE AMER. RED CROSS
P.O. Box 7067
DES MOINES IA 50309
CRISIS
(515)244-1000
COUNSELING
(515)244-1010
Business Phone:(515)244-6700
Hrs Avail:M-TH3PM-8AM ALL OTHER 24

SUICIDE PREVENTION & CRISIS INTERVENTION
AGENCIES IN THE UNITED STATES

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DUBUQUE
PHONE A FRIEND CRISIS LINE
SUITE 420
NESLER CENTER
DUBUQUE IA 52001
Crisis Phone 1:(319)588-4016
Business Phone:(319)557-8331
Hrs Avail:24

SIOUX CITY
AID CENTER
406 5TH ST.
SIOUX CITY IA 51101
Crisis Phone 1:(712)252-1861
Business Phone:(712)252-1861
Hrs Avail:24

IOWA CITY
IOWA CITY CRISIS INTERVENTION CENTE
26 EAST MARKET
IOWA CITY IA 52240
Crisis Phone 1:(319)351-0140
Business Phone:(319)351-2726
Hrs Avail:24

WATERLOO
INTEGRATED CRISIS SERVICE
2530 UNIV. AVE.
WATERLOO IA 50701
Crisis Phone 1:(319)233-8484
Business Phone:(319)233-8484
Hrs Avail:24

IDAHO

BOISE
EMERGENCY LINE
REGION IV SERVICES/MENTAL HEALTH
1105 S. ORCHARD
BOISE ID 83705
Crisis Phone 1:(208)338-7044
Business Phone:(208)338-7020
Hrs Avail:24

IDAHO FALLS
IDAHO FALLS EMERGENCY SERVICES
REGION VII MENTAL HEALTH
150 SHOUP
IDAHO FALLS ID 83402
Crisis Phone 1:(208)525-7129
Business Phone:(208)525-7129
Hrs Avail:24

LEWISTON
YWCA CRISIS SERVICES
300 MAIN ST.
LEWISTON ID 83501
Crisis Phone 1:(208)746-9655
Business Phone:(208)746-9655
Hrs Avail:24

COEUR D' ALENE
COEUR D' ALENE EMERGENCY LINE
W. GEORGE MOODY HEALTH CENTER
2195 IRONWOOD COURT
COEUR D' ALENE ID 83814
Crisis Phone 1:(208)667-6406
Business Phone:(208)667-6406
Hrs Avail:24

KELLOGG
KELLOGG EMERGENCY LINE
HEALTH AND WELFARE SERVICE CENTER
313 W. CAMERON
KELLOGG ID 83837
Crisis Phone 1:(208)667-6406
Crisis Phone 2:(208)773-2906
Business Phone:(208)784-1351
Hrs Avail:24

ST. MARIES
ST. MARIES EMERGENCY LINE
HEALTH AND WELFARE SERVICE CENTER
128 S. 7TH STREET
ST. MARIES ID 83861
Crisis Phone 1:(208)245-2527
Business Phone:(208)245-2541
Hrs Avail:08:00AM-05:00PM

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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TWIN FALLS
TWIN FALLS EMERGENCY SERVICES
REGION 5 MENTAL HEALTH
823 HARRISON
TWIN FALLS ID 83301
Crisis Phone 1:(208)734-4000
Business Phone:(208)734-9770
Hrs Avail:24

ILLINOIS

ALTON
MADISON CO. MENTAL HEALTH CENTER
1625 EDWARDS ST.
P.O. Box 1054
ALTON IL 62002
Crisis Phone 1:(618)462-3505
EVENINGS, WEEK-ENDS
(618)463-1058
Business Phone:(618)462-3505
Hrs Avail:24

ANNA
UNION COUNTY COUNSELING SERVICE
204 SOUTH ST.
ANNA IL 62906
Crisis Phone 1:(618)833-8551
Business Phone:(618)833-8551
Hrs Avail:24

AURORA
CRISIS LINE OF THE FOX VALLEY
309 W. NEW INDIAN TRAIL CT.
AURORA IL 60506
Crisis Phone 1:(312)897-5522
Business Phone:(312)897-5531

BEARDSTOWN
CASS COUNTY MENTAL HEALTH CENTER
101 W. 15TH STREET
BEARDSTOWN IL 62618
Crisis Phone 1:(217)323-2980
Business Phone:(217)323-2980
Hrs Avail:24

BELLEVILLE
*#CALL FOR HELP
SUICIDE & CRISIS INTERV. SERVICE
500 WILSHIRE DR.
BELLEVILLE IL 62223
Crisis Phone 1:(618)397-0963
Business Phone:(618)397-0968
Hrs Avail:24

BLOOMINGTON
* EMERGENCY CRISIS INTERVENTION TEAM
MC LEAN CO. CENTER FOR HUMAN SERV.
108 W. MARKET
BLOOMINGTON IL 61701
Crisis Phone 1:(309)827-4005
Business Phone:(309)827-5351
Hrs Avail:24

BLOOMINGTON
PATH
(PERSONAL ASSISTANCE TELEPHONE HELP)
427 N. MAIN
BLOOMINGTON IL 61701
Crisis Phone 1:(309)827-4005
TOLL FREE NUMBER
(800)322-5015
Business Phone:(309)828-1922
Hrs Avail:24

CAIRO
CAIRO CRISIS LINE
MENTAL HEALTH CENTER
218 10TH STREET
CAIRO IL 62914
Crisis Phone 1:(618)734-2665
Business Phone:(618)734-2665
Hrs Avail:24

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CHAMPAIGN
CHAMPAIGN EMERGENCY SERVICE
CHAMPAIGN MENTAL HEALTH CLINIC
600 E. PARK
CHAMPAIGN IL 61820
Crisis Phone 1:(217)359-4141
Business Phone:(217)398-8080
Hrs Avail:24

CHICAGO
CHICAGO CRISIS INTERVENTION
CITY OF CHICAGO DEPT. OF HUMAN SERV.
640 N. LA SALLE
CHICAGO IL 60610
Crisis Phone 1:(312)947-8300
Business Phone:(312)744-4045
Hrs Avail:24

CLINTONN
DEWITT COUNTY HUMAN RESOURCE CENTER
109 W. JEFFERSON
CLINTONN IL 61727
Crisis Phone 1:(217)935-9496
Business Phone:(217)935-9496
Hrs Avail:24

DANVILLE
CONTACT DANVILLE
504 N. VERMILION
DANVILLE IL 61832
Crisis Phone 1:(217)443-2273
Business Phone:(217)446-8212
Hrs Avail:24

EDWARDSVILLE
EDWARDSVILLE COMM. COUNSELING SERV.
1507 TROY RD., SUITE #3
EDWARDSVILLE IL 62025
Crisis Phone 1:(618)877-4420
Business Phone:(618)656-8721
Hrs Avail:24

ELK GROVE
TALK LINE/KIDS LINE, INC.
P.O. Box 1321
ELK GROVE IL 60007
TALK LINE
(312)228-6400
KIDS LINE
(312)228-KIDS
Business Phone:(312)981-1271

CHICAGO
* SOCIETY OF SAMARITANS - CHICAGO
5638 S. WOODLAWN AVE.
CHICAGO IL 60637
Crisis Phone 1:(312)947-8300
Business Phone:(312)947-8844
Hrs Avail:24

CHICAGO
IN TOUCH HELPLINE
STUDENT COUNSELING SERVICE
UNIVERSITY OF IL
P.O. Box 4348
CHICAGO IL 60680
Crisis Phone 1:(312)996-5535
Business Phone:(312)996-5535

COLLINGSVILLE
COMMUNITY COUNSELING SERVICES
1315 VANDALIA
COLLINGSVILLE IL 62234
Crisis Phone 1:(618)877-4420
Business Phone:(618)344-0393
Hrs Avail:24

DU QUOIN
PERRY COUNTY HELP LINE
R. R. #1
P.O. Box 106
DU QUOIN IL 62832
Crisis Phone 1:(618)542-4357
Business Phone:(618)542-4357
Hrs Avail:24

ELGIN
* COMMUNITY CRISIS CENTER
P.O. Box 1390
ELGIN IL 60121
Crisis Phone 1:(312)697-2380
Business Phone:(312)742-4031
Hrs Avail:24

EVANSTON
EVANSTON HOSPITAL CRISIS INTERV.
2650 RIDGE AVE.
EVANSTON IL 60201
Crisis Phone 1:(312)492-6500
Business Phone:(312)492-6500
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION
AGENCIES IN THE UNITED STATES

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FREEPORT
CONTACT STEPHENSON CO.
P.O. Box 83
FREEPORT IL 61032
Crisis Phone 1:(815)233-4357
Business Phone:(815)233-4357
Hrs Avail:24

GALESBURG
* SPOON RIVER COMMUNITY MHC
302 E. MAIN STREET; SUITE #530
GALESBURG IL 61401
Crisis Phone 1:(800)322-7143
Business Phone:(309)343-5155
Hrs Avail:24

GRANITE CITY
MENTAL HEALTH CENTER
2024 STATE ST.
GRANITE CITY IL 62040
Crisis Phone 1:(618)877-4420
Business Phone:(618)877-4420
Hrs Avail:24

HIGHLAND
HIGHLAND COMM. COUNSELING SERVICES
508 BROADWAY
HIGHLAND IL 62249
Crisis Phone 1:(618)877-4420
Business Phone:(618)654-7232
Hrs Avail:24

HILLSBORO
HILLSBORO HELPLINE
MONTGOMERY CO. COUNSELING CENTER
200 S. MAIN ST.
HILLSBORO IL 62049
Crisis Phone 1:(217)532-9581
Crisis Phone 2:(217)532-6191
Business Phone:(217)532-9581
Hrs Avail:24

JOLIET
CRISIS LINE OF WILL COUNTY
P.O. Box 2354
JOLIET IL 60435
Crisis Phone 1:(815)722-3344
FRANKFORT
(815)469-6166
WILMINGTON
(815)476-6969
ADMINISTRATION
(815)744-5280
Business Phone:(815)744-5280
Hrs Avail:24

LIBERTYVILLE
CONNECTION TELEPHONE COUNSELING
& REFERRAL SERVICE
P.O. Box 906
LIBERTYVILLE IL 60048
Crisis Phone 1:(312)367-1080
Business Phone:(312)362-3381
Hrs Avail:24

LINCOLN
LINCOLN CRISIS CLINIC
A. LINCOLN MENTAL HEALTH CENTER
315 8TH
LINCOLN IL 62656
Crisis Phone 1:(217)732-3500
Business Phone:(217)732-2161
Hrs Avail:24

MT. VERNON
MT. VERNON CRISIS LINE
COMPREHENSIVE SERVICES
601 N. 18TH
P.O. Box 428
MT. VERNON IL 62864
Crisis Phone 1:(618)242-1512
Business Phone:(618)242-1510
Hrs Avail:24

NORTHFIELD
IRENE JOSSELYN CLINIC
405 CENTRAL
NORTHFIELD IL 60093
Crisis Phone 1:(312)441-5600
Business Phone:(312)441-5600
Hrs Avail: 8:00AM- 5:00PM

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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PARIS
HUMAN RESOURCES CENTER
P.O. Box 302
PARIS IL 61944
DAYS
(217)465-4118
EVENINGS, WEEK-ENDS
(217)465-4141
Business Phone:(217)465-4118
Hrs Avail:24

QUINCY
QUINCY SUICIDE PREV.& CRISIS SERV.
4409 MAINE
QUINCY IL 62301
Crisis Phone 1:(217)222-1166
Business Phone:(217)223-0413
Hrs Avail:24

SULLIVAN
SULLIVAN CRISIS LINE
MOULTREE CO. COUNSELING CENTER
2 W. ADAMS
SULLIVAN IL 61951
Crisis Phone 1:(217)728-7611
Business Phone:(217)728-4358
Hrs Avail:24

WOOD RIVER
* CRISIS SERVICES OF MADISON COUNTY
P.O. Box 570
WOOD RIVER IL 62095
Crisis Phone 1:(618)877-4420
Crisis Phone 2:(618)463-1058
Business Phone:(618)251-4073
Hrs Avail:24

PEORIA
PEORIA CALL FOR HELP
5407 N. UNIVERSITY
PEORIA IL 61614
Crisis Phone 1:(309)673-7373
Business Phone:(309)692-1766
Hrs Avail:24

ROCKFORD
* CONTACT ROCKFORD
P.O. Box 1976
ROCKFORD IL 61110
Crisis Phone 1:(815)964-4044
Business Phone:(815)964-0400
Hrs Avail:24

TAYLORVILLE
TAYLORVILLE HELPLINE
CHRISTIAN CO. MENTAL HEALTH CENTER
301 S. WEBSTER
TAYLORVILLE IL 62568
DAYS
(217)824-4905
EVENING, WEEK-ENDS
(217)824-3335
Business Phone:(217)824-4905
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION
AGENCIES IN THE UNITED STATES

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INDIANA

NDERSON
CONTACT/HELP
P.O. Box 303
ANDERSON IN 46015
Crisis Phone 1:(317)649-5211
Business Phone:(317)649-4939
Hrs Avail:24

T. WAYNE
SWITCHBOARD, INC.
316 W. CREIGHTON
FT. WAYNE IN 46807
Crisis Phone 1:(219)456-4561
Business Phone:(219)745-7914
Hrs Avail:24

GREENCASTLE
CONTACT PUTNAM COUNTY
P.O. Box 15
GREENCASTLE IN 46135
Crisis Phone 1:(317)653-2645
Business Phone:(317)653-5040
Hrs Avail;24

LAFAYETTE
LAFAYETTE CRISIS CENTER
803 N. 8TH ST.
LAFAYETTE IN 47904
Crisis Phone 1:(317)742-0244
Business Phone:(317)742-0244
Hrs Avail:24

LEBANON
PROJECT HELP
CRISIS INTERVENTION SERVICE
ST. PETER'S EPISCOPAL CHURCH
950 E. WASHINGTON ST.
LEBANON IN 46052
Crisis Phone 1:(317)482-1599
Business Phone:(317)482-1599
Hrs Avail:24

EVANSVILLE,
* SOUTHWESTERN INDIANA MHC, INC.
415 MULBERRY
EVANSVILLE, IN 47713
Crisis Phone 1:(812)423-7791
Business Phone:(812)423-7791
Hrs Avail:24

GARY
RAP LINE--CRISIS CENTER
215 N. GRAND BLVD.
GARY IN 46403
Crisis Phone 1:(219)980-9243
Business Phone:(219)980-4207
Hrs Avail:24

INDIANAPOLIS
* MENTAL HEALTH ASSOC. IN MARION CO.
CRISIS & SUICIDE INTERVENTION SERVICE
1433 N. MERIDIAN ST., RM. #202
INDIANAPOLIS IN 46202
Crisis Phone 1:(317)632-7575
Business Phone:(317)269-1569
Hrs Avail:24

LAWRENCEBURG
LAWRENCEBURG CRISIS LINE
COMMUNITY MENTAL HEALTH CENTER
285 BIELBY RD.
LAWRENCEBURG IN 47025
Crisis Phone 1:(812)537-1302
TOLL FREE NUMBER
(800)832-5378
Business Phone:(812)537-1302
Hrs Avail:24

MARYVILLE
CONTACT TELE. OF BLOUNT CO.
P.O. Box 0382
MARYVILLE IN 37803
Crisis Phone 1:(615)984-7689
Business Phone:(615)984-7690
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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MERRILLVILLE
CONTACT--CARES OF NW INDIANA
P.O. Box 8143
MERRILLVILLE IN 46410
Crisis Phone 1:(219)769-3141
Business Phone:(219)769-3278
Hrs Avail:24

MONTICELLO
TWIN LAKES CONTACT--HELP
P.O. Box 67
MONTICELLO IN 47960
Crisis Phone 1:(219)583-4357
Business Phone:(219)583-4357
Hrs Avail:24

KANSAS

DODGE CITY
AREA MENTAL HEALTH CENTER
W. HIGHWAY 50 BYPASS
DODGE CITY KS 67801
Crisis Phone 1:(316)227-8566
Business Phone:(316)227-8566
Hrs Avail:24

EMPORIA
EMPORIA EMERGENCY SERVICES
MH CENTER OF E. CENTRAL KANSAS
705 S. COMMERCIAL
EMPORIA KS 66801
Crisis Phone 1:(316)343-2626
Business Phone:(316)342-6116
Hrs Avail:24

FT. SCOTT
FT. SCOTT HELPLINE
MENTAL HEALTH ASSOCIATION
1ST TO SCOTT AVE.
FT. SCOTT KS 66701
Crisis Phone 1:(316)223-2420
Business Phone:(316)223-5030
Hrs Avail:24

GARDEN CITY
GARDEN CITY AREA MHC
156 GARDENDALE
GARDEN CITY KS 67846
Crisis Phone 1:(316)276-7689
Business Phone:(316)276-7689
Hrs Avail:24

KANSAS CITY
WYANDOT MENTAL HEALTH CENTER
WYANDOTTE COUNTY CRISIS LINE
36TH AND EATON
KANSAS CITY KS 66103
Crisis Phone 1:(913)831-1773
Business Phone:(913)831-9500
Hrs Avail:24

LAWRENCE
HEADQUARTERS, INC.
1419 MASSACHUSETTS
P.O. Box 999
LAWRENCE KS 66044
Crisis Phone 1:(913)841-2345
Business Phone:(913)841-2345
Hrs Avail:24

MANHATTAN
REGIONAL CRISIS CENTER
P.O. Box 164
MANHATTAN KS 66502
Crisis Phone 1:(913)539-2785
Business Phone:(913)539-2785
Hrs Avail:24

SALINA
HOTLINE CRISIS INFO. & REFERRAL
P.O. Box 1982
SALINA KS 67402-1878
Crisis Phone 1:(913)827-4747
Business Phone:(913)827-4803
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION
AGENCIES IN THE UNITED STATES

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COTT CITY
SCOTT CITY AREA MENTAL HEALTH CENTER
SCOTT CO. COURTHOUSE
SCOTT CITY KS 67871
Crisis Phone 1:(316)872-5338
Business Phone:(316)872-5338
Hrs Avail:24

LYSSES
ULYSSES AREA MENTAL HEALTH CENTER
102 W. FLOWER
ULYSSES KS 76880
Crisis Phone 1:(316)356-3198
Business Phone:(316)356-3198
Hrs Avail:24

TOPEKA
* SHAWNEE COMM. MHC EMERGENCY SERVICE
2401 W. 6TH
TOPEKA KS 66606
Crisis Phone 1:(913)233-1730
Business Phone:(913)233-1730
Hrs Avail:24

WICHITA
* SEDGWICK CO. DEPT. OF MENTAL HEALTH
1801 E. TENTH STREET
WICHITA KS 67214-3197
Crisis Phone 1:(316)686-7465
Business Phone:(316)268-8251
Hrs Avail:24

KENTUCKY

.SHLAND
ASHLAND CRISIS SERVICE
LANSDOWNE MENTAL HEALTH CENTER
P.O. Box 790
ASHLAND KY 41101
Crisis Phone 1:(606)324-1141
Business Phone:(606)324-1141
Hrs Avail:24

-ORBIN
CORBIN EMERGENCY SERVICES
CUMBERLAND RIVER COMPREH. CARE CTR.
AMERICAN GREETING RD.
P.O. Box 568
CORBIN KY 40701
Crisis Phone 1:(606)528-7010
Business Phone:(606)528-7010
Hrs Avail:24

ELIZABETH
ELIZABETHTOWN CRISIS LINE
N. CENTRAL COMPREHENSIVE CARE CTR.
907 N. DIXIE AVE.
ELIZABETH KY 42701
Crisis Phone 1:(502)769-1304
Business Phone:(502)769-1304
Hrs Avail:24

BOWLING GREEN
BOWLING GREEN HELPLINE
BARREN RIVER MENTAL HEALTH
822 WOODWAY DR.
BOWLING GREEN KY 42101
Crisis Phone 1:(502)842-5642
Business Phone:(502)843-4382
Hrs Avail:24

COVINGTON
COVINGTON EMERGENCY LINE
NORTHERN KY. COMPREHENSIVE CARE CENTER
503 FARRELL DRIVE
COVINGTON KY 41012
Crisis Phone 1:(606)331-1900
Business Phone:(606)331-6505
Hrs Avail:24

HOPKINSVILLE
HOPKINSVILLE CRISIS LINE
PENNYROYAL REGIONAL MENTAL HEALTH
735 NORTH DRIVE
HOPKINSVILLE KY 42240
Crisis Phone 1:(502)886-5163
Business Phone:(502)886-5163
Hrs Avail:24

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JACKSON
HAZARD/JACKSON CRISIS LINE
KENTUCKY RIVER COMMUNITY CARE
P.O. Box 603
JACKSON KY 41339
TOLL FREE NUMBER
(800)262-7491
Business Phone:(606)666-4904
Hrs Avail:24

LEXINGTON
CRISIS INTERVENTION MENTAL HEALTH
201 MECHANIC STREET
LEXINGTON KY 40507
Crisis Phone 1:(606)254-3844
Business Phone:(606)254-3844
Hrs Avail:24

LOUISVILLE
*#SEVEN COUNTIES SERVICES
CRISIS & INFORMATION CENTER
600 S. PRESTON ST.
LOUISVILLE KY 40202
Crisis Phone 1:(502)589-4313
Business Phone:(502)583-3951 x284
Hrs Avail:24

MAYSVILLE
MAYSVILLE CRISIS LINE
COMPREHEND, INC. DISTRICT MH
P.O. Box G
MAYSVILLE KY 51056
Crisis Phone 1:(606)564-4016
Business Phone:(606)564-4016
Hrs Avail:24

MOREHEAD
MOREHEAD CRISIS CENTER
CAVE RUN COMPREHENSIVE CARE CENTER
325 E. MAIN STREET
MOREHEAD KY 40351
Crisis Phone 1:(800)262-7470
Business Phone:(606)784-4161
Hrs Avail:24

OWENSBORO
OWENSBORO CRISIS LINE
GREEN RIVER COMPREH. CARE CTR.
1001 FREDERICKA ST.
OWENSBORO KY 42301
Crisis Phone 1:(502)684-9466
Business Phone:(502)683-0277
Hrs Avail:24

PADUCAH
PADUCAH CRISIS LINE
WESTERN KENTUCKY REGIONAL MH/MR BD.
1530 LONE OAK RD.
PADUCAH KY 42001
Crisis Phone 1:(800)592-3980
Business Phone:(502)442-7121
Hrs Avail:24

PRESTONSBURG
PRESTONBURG HELPLINE
MOUNTAIN COMPREHENSIVE CARE CENTER
18 S. FRONT AVE.
PRESTONSBURG KY 41653
Crisis Phone 1:(800)422-1060
Business Phone:(606)886-8572
Hrs Avail:24

SOMERSET
SOMERSET EMERGENCY SERVICES
COMMUNITY MENTAL HEALTH SERVICES
324 CUNDIFF SQ.
SOMERSET KY 42501
Crisis Phone 1:(800)632-8581
Business Phone:(606)679-7348
Hrs Avail:24

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LOUISIANA

ALEXANDRIA
ALEXANDRIA HELPLINE
P.O. Box 749
ALEXANDRIA LA 71301
Crisis Phone 1:(318)445-4357
Business Phone:(318)445-4357
Hrs Avail:24

BATON ROUGE
*#BATON ROUGE CRISIS INTERV. CENTER
P.O. Box 80738
BATON ROUGE LA 70898
Crisis Phone 1:(504)924-3900
Business Phone:(504)924-1595
Hrs Avail:24

DE RIDDER
* BEAUREGARD DE RIDDER COMM. HELP-LINE
P.O. Box 815
DE RIDDER LA 70634
Crisis Phone 1:(318)462-0609
Crisis Phone 2:(318)239-6196
Business Phone:(318)462-1452
Hrs Avail:8AM-5PM 7-10PM

HAMMOND
* TANGIPAHOA CRISIS PHONE, INC.
P.O. Box 153
HAMMOND LA 70404
Crisis Phone 1:(504)345-6120
Business Phone:(504)345-5335
Hrs Avail:24

HOUMA,
HOUMA-TERREBONNE CRISIS LINE
341 LEVRON
HOUMA, LA 70360
Crisis Phone 1:(504)872-1111
Business Phone:(504)851-5950
Hrs Avail:24

LAFAYETTE
SW LOUISIANA EDUC. & REFERRAL CENTER
P.O. Box 3844
LAFAYETTE LA 70502
Crisis Phone 1:(318)232-help
Business Phone:(318)232-4357
Hrs Avail:24

LAKE CHARLES
* CRISIS PHONE (439-CARE)
ETC COUNSELING CENTER
1146 HODGES
LAKE CHARLES LA 70601
Crisis Phone 1:(318)439-2273
Business Phone:(318)433-1062
Hrs Avail:24

MONROE,
MAIN LINE
P.O. Box 1322
MONROE, LA 71201
Crisis Phone 1:(318)387-5690
Business Phone:(318)387-5683
Hrs Avail:24

NEW ORLEANS
*#MENTAL HEALTH ASSOC. OF N.O.
CRISIS LINE PROGRAM
2515 CANAL ST STE-200
NEW ORLEANS LA 70119
Crisis Phone 1:(504)523-2673
Business Phone:(504)821-1024
Hrs Avail:24

NEW ORLEANS
* RIVER OAKS CRISIS CENTER
1525 RIVER OAKS ROAD W.
NEW ORLEANS LA 70123
Crisis Phone 1:(504)733-2273
Business Phone:(504)734-1740
Hrs Avail:24

SHREVEPORT
OPEN EAR
CENTENARY COLLEGE
P.O. Box 247
SHREVEPORT LA 71106
Crisis Phone 1:(318)869-1228
Business Phone:(318)869-1228
Hrs Avail:08:00PM-12:00AM

SLIDELL
SLIDELL CRISIS LINE, INC.
360 ROBERT RD.
SLIDELL LA 70458
Crisis Phone 1:(504)643-6832
Business Phone:(504)643-6832
Hrs Avail:24

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VILLE PLATTE,
VILLE PLATTE M.H.C.I.C.
520 DE MONCHERVEAUX BLVD.
VILLE PLATTE, LA 70586
Crisis Phone 1:(318)363-5579
Business Phone:(318)363-5525
Hrs Avail:24

MASSACHUSETTS

ACTON
CODE HOTLINE
481 GREAT RD.
ACTON MA 01720
Crisis Phone 1:(617)263-8777
Crisis Phone 2:(617)486-3130
Business Phone:(617)263-8777
Hrs Avail:24

ATTLEBORO,
NEW HOPE/ATTLEBORO
P.O. Box 48
ATTLEBORO, MA 02703
Crisis Phone 1:(617)695-2113
Crisis Phone 2:(617)226-4015
Crisis Phone 3:(617)762-1350
Business Phone:(617)824-4757
Hrs Avail:24

BEVERLY,
PROJECT RAP, INC.
9 HIGHLAND AVE.
BEVERLY, MA 01915
Crisis Phone 1:(617)922-0000
Business Phone:(617)927-4506
Hrs Avail:24

BOSTON
*#THE SAMARITANS
500 COMMONWEALTH AVE.
BOSTON MA 02215
Crisis Phone 1:(617)247-0220
Business Phone:(617)536-2460
Hrs Avail:24

BROCKTON,
BROCKTON, CANTON HELPLINE
837 N. MAIN ST.
BROCKTON, MA 02401
Crisis Phone 1:(617)828-6666
Business Phone:(617)584-4357
Hrs Avail:24

FALL RIVER,
* SAMARITANS OF FALL RIVER-NEW BEDFORD,
386 STANLEY ST.
FALL RIVER, MA 02720
Crisis Phone 1:(617)636-6111
Business Phone:(617)636-6111
Hrs Avail:24

FALMOUTH,
* SAMARITANS ON CAPE COD
P.O. Box 65
FALMOUTH, MA 02540
Crisis Phone 1:(617)548-8900
Crisis Phone 2:(617)548-8901
Business Phone:(617)548-8900
Hrs Avail:24

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FITCHBURG
LUK CRISIS CENTER, INC.
9 DAY ST.
FITCHBURG MA 01420
Crisis Phone 1:(617)345-7353
Crisis Phone 2:(617)632-7374
Crisis Phone 3:(617)772-2203
Crisis Phone 4:(617)365-6750
Business Phone:(617)345-0685
Hrs Avail:24

GREENFIELD
GREENFIELD EMERGENCY SERVICES
196 FEDERAL ST.
GREENFIELD MA 01030
Crisis Phone 1:(413)774-2758
Business Phone:(413)774-2758
Hrs Avail:24

LAWRENCE
* GREATER LAWRENCE MHC
351 ESSEX ST.
LAWRENCE MA 01840
Crisis Phone 1:(617)683-3128
Business Phone:(617)683-6303
Hrs Avail:24

MELROSE,
EASTERN MIDDLESEX CIS
150 GREEN ST.
MELROSE, MA 01880
Crisis Phone 1:(617)662-6623
Business Phone:(617)662-6623
Hrs Avail:24

NEWTONVILLE/BOSTON AREA
CONTACT BOSTON
P.O. Box 287
NEWTONVILLE MA 02160
Crisis Phone 1:(617)244-4350
Business Phone:(617)244-4353
Hrs Avail:24

FRAMINGHAM
* SAMARITANS OF SOUTH MIDDLESEX, INC.
73 UNION AVE.
FRAMINGHAM MA 01701
Crisis Phone 1:(617)875-4500
Business Phone:(617)875-4500
Hrs Avail:24

LAWRENCE
* PSYCHIATRIC ASSOCIATES OF LAWRENCE
42 FRANKLIN ST.
LAWRENCE MA 01840
Crisis Phone 1:(617)682-7442
Business Phone:(617)682-7442
Hrs Avail:24

LAWRENCE,
* SAMARITANS OF THE MERRIMACK VALLEY
55 JACKSON ST.
LAWRENCE, MA 01840
Crisis Phone 1:(617)688-6607
Crisis Phone 2:(617)452-6733
Crisis Phone 3:(617)372-7200
Business Phone:(617)688-6607
Hrs Avail:24

NEWBURYPORT
TURNING POINT HOT LINE
5 MIDDLE ST.
NEWBURYPORT MA 01950
Crisis Phone 1:(617)465-8800
Business Phone:(617)462-8251
Hrs Avail:24

NORTH ADAMS
HELP LINE, INC.
111 MAIN ST.
NORTH ADAMS MA 01247
Crisis Phone 1:(413)664-6391
Business Phone:(413)663-5244
Hrs Avail:24

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NORTHAMPTON
NORTHAMPTON EMERGENCY SERVICES
48 PLEASANT ST.
NORTHAMPTON MA 01060
Crisis Phone 1:(413)586-5555
Business Phone:(413)586-5555
Hrs Avail:24

NORWOOD,
PULSE HOTLINE
P.O. Box 273
NORWOOD, MA 02062
Crisis Phone 1:(617)762-5144
Business Phone:(617)762-5144
Hrs Avail:7 PM-11PM

SALEM,
SAMARITANS OF SALEM
P.O. Box 8133
SALEM, MA 01970
Crisis Phone 1:(617)744-5000
Business Phone:(617)744-5000
Hrs Avail:5:30PM-10:30PM

WORCESTER
* CRISIS CENTER, INC.
P.O. Box 652
WORCESTER MA 01602
Crisis Phone 1:(617)791-6562
Business Phone:(617)791-7205
Hrs Avail:24

NORWOOD
*#SO. NORFOLK SCREENING & EMERG. TEAM
91 CENTRAL ST.
NORWOOD MA 02062
Crisis Phone 1:(617)769-6060
Business Phone:(617)769-6060
Hrs Avail:24

SAGUS,
LISTEN, INC
28 TAYLOR ST.
SAGUS, MA 01906
Crisis Phone 1:(617)233-8911
Business Phone:(617)233-8911
Hrs Avail:24

WARE
WARE HELPLINE
VALLEY HUMAN SERVICES
96 SOUTH ST.
WARE MA 01082
Crisis Phone 1:(413)283-3473
Business Phone:(413)967-6241
Hrs Avail:24

MARYLAND

BALTIMORE
CONTACT BALTIMORE
710 N. CHARLES ST.
BALTIMORE MD 21201
Crisis Phone 1:(301)332-1114
Business Phone:(301)332-0567
Hrs Avail:24

BALTIMORE
BALTIMORE CRISIS CENTER
WALTER P. CARTER MHC
630 W. FAYETTE ST.
BALTIMORE MD 21201
Crisis Phone 1:(301)528-2200
Business Phone:(301)528-2200
Hrs Avail:24

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BALTIMORE
BALTIMORE CRISIS LINE
SINAI HOSPITAL
BELVEDERE AND GREENSPRING AVE.
BALTIMORE MD 21215
WEEKDAYS
(301)578-5457
EVENINGS & WEEKENDS
(301)578-5000
Business Phone:(301)578-5457
Hrs Avail:24

BOWIE
BOWIE HOTLINE
P.O. Box 535
BOWIE MD 20715
Crisis Phone 1:(301)262-2433
Business Phone:(301)262-2433
Hrs Avail:04:00PM-12:00AM

COLUMBIA
GRASS ROOTS
8045 RT. 32
COLUMBIA MD 21044
Crisis Phone 1:(301)531-6677
Business Phone:(301)351-6006or6080
Hrs Avail:24

KENSINGTON
*#MONTGOMERY COUNTY HOTLINE
10920 CONNECTICUT AVE.
KENSINGTON MD 20795
Crisis Phone 1:(301)949-6603
Business Phone:(301)949-1255
Hrs Avail:24

RIVERDALE,,
* PRINCE GEORGE'S COUNTY HOTLINE
6607 RIVERDALE RD.
RIVERDALE, MD 20737
Crisis Phone 1:(301)441-8384
Business Phone:(301)577-3140
Hrs Avail:4PM-MID.7 DAYS

MAINE

BANGOR
DIAL HELP
43 ILLINOIS AVE.
BANGOR ME 04401
Crisis Phone 1:(207)947-6143
TOLL FREE NUMBER
(800)431-7810
Business Phone:(207)947-6143
Hrs Avail:24

PORTLAND
* INGRAHAM VOLUNTEERS, INC.
142 HIGH ST.
PORTLAND ME 04101
Crisis Phone 1:(207)774-HELP
TTY/TDD
(207)773-7321
Business Phone:(207)773-4830
Hrs Avail:24

SKOWHEGAN
* CRISIS STABILIZATION UNIT
147 WATER ST.
SKOWHEGAN ME 04976
AGUSTA
(207)623-4511
WATERVILLE
(207)872-2276
SKOWHEGAN
(800)452-1933
Business Phone:(207)474-2506
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION
AGENCIES IN THE UNITED STATES

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MICHIGAN

ADRIAN
CALL SOMEONE CONCERNED
227 N. WINTER #215
ADRIAN MI 49221
Crisis Phone 1:(517)263-6737
TOLL FREE NUMBER
(800)322-0044
Business Phone:(517)263-6739
Hrs Avail:24

ANN ARBOR
WASHTENAW COUNTY COMMUNITY MHC
2929 PLYMOUTH RD.
ANN ARBOR MI 48105
Crisis Phone 1:(313)996-4747
Business Phone:(313)994-2285
Hrs Avail:24

BIRMINGHAM
COMMON GROUND
1090 S. ADAMS
BIRMINGHAM MI 48011
Crisis Phone 1:(313)645-9676
Business Phone:(313)645-1173
Hrs Avail:24

DETROIT
*#SUICIDE PREVENTION CENTER/DETROIT
220 BAGLEY SUITE 626
DETROIT MI 48226
Crisis Phone 1:(313)224-7000
Business Phone:(313)963-7890

DETROIT
CONTACT LIFE LINE
7430 2ND ST., RM. #428
DETROIT MI 48202
Crisis Phone 1:(313)894-5555
Business Phone:(313)875-0426
Hrs Avail:24

EAST LANSING
LISTENING EAR OF EAST LANSING
547 1/2 E. GRAND RIVER
EAST LANSING MI 48823
Crisis Phone 1:(517)337-1717
Business Phone:(517)337-1717
Hrs Avail:24

FLINT
FLINT EMERGENCY SERVICE
GENESEE CO. MENTAL HEALTH
420 W. 5TH AVE.
FLINT MI 48503
Crisis Phone 1:(313)257-3740
Business Phone:(313)257-3742
Hrs Avail:24

GRAND HAVEN
GRAND HAVEN HELPLINE
OTTAWA COUNTY MENTAL HEALTH CENTER
1111 FULTON ST.
GRAND HAVEN MI 49417
Crisis Phone 1:(616)842-4357
Business Phone:(616)842-5350
Hrs Avail:24

HART
* OCEANA CO. COMMUNITY MENTAL HEALTH
P.O. Box 127
HART MI 49420
Crisis Phone 1:(616)873-2108
Business Phone:(616)873-2108
Hrs Avail:24

HOLLAND
HOLLAND HELPLINE
12265 JAMES ST.
HOLLAND MI 49423
Crisis Phone 1:(616)396-4357
Business Phone:(616)392-1873
Hrs Avail:24

JACKSON
HELP LINE/JACKSON
P.O. Box 1526
JACKSON MI 49204
Crisis Phone 1:(517)783-2671
Business Phone:(517)783-2861
Hrs Avail:24

KALAMAZOO
* GRYPHON PLACE
1104 S. WESTNEDGE
KALAMAZOO MI 49008
Crisis Phone 1:(616)381-4357
Business Phone:(616)381-1510
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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LAPEER
* LAPEER CO. COMM. MHC
1575 SUNCREST DR.
LAPEER MI 48446
Crisis Phone 1:(313)667-0500
Business Phone:(313)667-0500
Hrs Avail:24

MT. CLEMENS
MACOMB COUNTY CRISIS CENTER
5TH FLOOR, COUNTY BUILDING
MT. CLEMENS MI 48043
Crisis Phone 1:(313)573-8700
Business Phone:(313)573-8700
Hrs Avail:24

MUSKEGON
* COMM. MH SERVICES OF MUSKEGON CO.
125 E. SOUTHERN
MUSKEGON MI 49442
Crisis Phone 1:(616)722-4357
Business Phone:(616)726-5266
Hrs Avail:24

PORT HURON
* BLUE WATER MH & CHILD GUIDANCE CLINIC
1501 KRAFFT RD.
PORT HURON MI 48060
Crisis Phone 1:(313)985-5125
Business Phone:(313)985-5125
Hrs Avail:24

PORT HURON
* ST. CLAIR CO. COMM MH SERVICES
3415 28TH ST.
PORT HURON MI 48060
Crisis Phone 1:(313)985-7161
Crisis Phone 2:(800)462-5350
Business Phone:(313)985-9618
Hrs Avail:24

TRAVERSE CITY
THIRD LEVEL CRISIS INTERV. CENTER
908 W. FRONT ST.
TRAVERSE CITY MI 49684
Crisis Phone 1:(616)941-2280
TOLL FREE NUMBER
(800)442-7315
Business Phone:(616)941-2282
Hrs Avail:24

LIVONIA
TELEPHONE LISTENING CENTER
P.O. Box 9391
LIVONIA MI 48150
Crisis Phone 1:(313)422-4852
Business Phone:(313)422-4854
Hrs Avail:24

MT. PLEASANT
LISTENING EAR CRISIS CENTER, INC.
P.O. Box 65
MT. PLEASANT MI 48858
Crisis Phone 1:(517)772-2918
Business Phone:(517)772-2918
Hrs Avail:24

PLYMOUTH
TURNING POINT CRISIS CENTER
P.O. Box 115
PLYMOUTH MI 48170
Crisis Phone 1:(313)455-4900
Business Phone:(313)455-4902
Hrs Avail:06:30PM-10:30PM

PORT HURON
* CENTER FOR HUMAN RESOURCES
1113 MILITARY ST.
PORT HURON MI 48060
Crisis Phone 1:(313)985-7161
Business Phone:(313)985-5168
Hrs Avail:24

ST. JOSEPH
ST. JOSEPH HELPLINE
RIVERWOOD COMMUNITY MHC
MEMORIAL HOSPITAL
2681 MORTON AVE.
ST. JOSEPH MI 49085
Crisis Phone 1:(616)927-4447
TOLL FREE NUMBER
(800)422-0757
Business Phone:(616)983-7781
Hrs Avail:24

YPSILANTI
SOS CRISIS CENTER
114 NORTH RIVER ST.
YPSILANTI MI 48198
Crisis Phone 1:(313)485-3222
Business Phone:(313)485-8730
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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MINNESOTA

ALEXANDRIA
LISTENING EAR CRISIS CENTER
111 17TH AVE. EAST
ALEXANDRIA MN 56308
Crisis Phone 1:(612)763-6638
Business Phone:(612)762-1511 x283
Hrs Avail:24

GRAND RAPIDS
NIGHTINGALE HELP PHONE
INFORMATION AND REFERRAL SERVICE
P.O. Box 113
GRAND RAPIDS MN 55744
Crisis Phone 1:(218)326-8565
Business Phone:(218)326-8565
Hrs Avail:24

MINNEAPOLIS
CONTACT TWIN CITIES
83 S. 12TH ST.
MINNEAPOLIS MN 55403
Crisis Phone 1:(612)341-2896
Business Phone:(612)341-2212
Hrs Avail:24

WORTHINGTON /LUVERNE/PIPESTONE/WINDOM
* 24 HOUR CRISIS HOTLINE
SOUTHWESTERN MENTAL HEALTH CENTER
1224 FOURTH AVE.
WORTHINGTON MN 56187
Crisis Phone 1:(800)642-1525
Business Phone:(507)372-7671
Hrs Avail:24

AUSTIN
VICTIMS CRISIS CENTER
908 N.W. 1ST DRIVE
AUSTIN MN 55912
Crisis Phone 1:(507)437-6680
Business Phone:(507)437-6680
Hrs Avail:24

MINNEAPOLIS
*#CRISIS INTERV. CENTER
HENNEPIN COUNTY MEDICAL CENTER
701 PARK AVE. SOUTH
MINNEAPOLIS MN 55415
CRISIS
(612)347-3161
SUICIDE
(612)347-2222
CRISIS HOME PROGRAM
(612)347-3170
SEXUAL ASSAULT SERV.
(612)347-5838
Business Phone:(612)347-3164
Hrs Avail:24

OWATONNA
OWATONNA--STEELE CO. CONTACT
P.O. Box 524
OWATONNA MN 55060
Crisis Phone 1:(507)451-9100
Business Phone:(507)451-1897
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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MISSOURI

COLUMBIA
EVERYDAY PEOPLE, INC.
209 PRICE AVE.
COLUMBIA MO 65201
Crisis Phone 1:(314)443-
Business Phone:(314)443-
Hrs Avail:24

JOPLIN
JOPLIN CRISIS INTERVENTION, INC.
P.O. Box 582
JOPLIN MO 64801
Crisis Phone 1:(417)781-2255
Business Phone:(417)781-2255
Hrs Avail:24

KANSAS CITY
K.C. SUICIDE PREVENTION LINE
WESTERN MO. MENTAL HEALTY CENTER
600 E. 22ND ST.
KANSAS CITY MO 64108
Crisis Phone 1:(816)471-3939
Crisis Phone 2:(816)471-3940
Business Phone:(816)471-3000
Hrs Avail:24

ST. JOSEPH
ST. JOSEPH CRISIS SERVICE
ST. JOSEPH STATE HOSPITAL
ST. JOSEPH MO 64506
Crisis Phone 1:(816)232-8431
Business Phone:(816)232-8431
Hrs Avail:24

ST. LOUIS
*#LIFE CRISIS SERVICES, INC.
1423 S. BIG BEND BLVD.
ST. LOUIS MO 63117
Crisis Phone 1:(314)647-4357
Business Phone:(314)647-3100
Hrs Avail:24

ST. LOUIS
CONTACT ST. LOUIS
P.O. Box 160070
ST. LOUIS MO 63116
Crisis Phone 1:(314)771-8181
Business Phone:(314)771-0404
Hrs Avail:24

MISSISSIPPI

COLUMBUS
GOLDEN TRIANGLE CONTACT
P.O. Box 1304
COLUMBUS MS 39703-1304
Crisis Phone 1:(601)328-0200
Business Phone:(601)328-0200
Hrs Avail:24

HATTIESBURG
HATTIESBURG HELP LINE, INC.
P.O. Box 183
HATTIESBURG MS 39401
Crisis Phone 1:(601)545-help
Business Phone:(601)545-help
Hrs Avail:24

JACKSON
CONTACT JACKSON
P.O. Box 5192
JACKSON MS 39216
Crisis Phone 1:(601)969-2077
Business Phone:(601)969-2077
Hrs Avail:24

MERIDIAN
WEEMS MENTAL HEALTH CENTER
P.O. Box 4376 WS
MERIDIAN MS 39301
Crisis Phone 1:(601)483-4821
Business Phone:(601)483-4821
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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UNIVERSITY
RAPLINE
P.O. Box 5923
UNIVERSITY MS 38677
Crisis Phone 1:(601)232-6439
Business Phone:(601)232-6439

MONTANA

BILLINGS
BILLINGS HELPLINE
YELLOWSTONE CO. WELFARE
3021 3RD AVENUE N
BILLINGS MT 59191
Crisis Phone 1:(406)248-1691
Business Phone:(406)248-1691
Hrs Avail:24

BOZEMAN
BOZEMAN HELP CENTER
323 S. WALLACE
BOZEMAN MT 59715
Crisis Phone 1:(406)248-1691
Business Phone:(406)248-1691
Hrs Avail:24

GREAT FALLS
GREAT FALLS CRISIS CENTER
P.O. Box 124
GREAT FALLS MT 59403
Crisis Phone 1:(406)453-6512
Business Phone:(406)453-6512
Hrs Avail:24

HELENA,
SOUTHWEST MONTANA MHC
572 LOGAN
HELENA, MT 59601
Crisis Phone 1:(406)443-9667
Business Phone:(406)443-9667
Hrs Avail:24

MISSOULA
MISSOULA CRISIS CENTER, INC.
P.O. Box 9345
MISSOULA MT 59807
Crisis Phone 1:(406)543-4555
Business Phone:(406)543-4555
Hrs Avail:24

N. CAROLINA

ASHVILLE
CONTACT-ASHVILLE/BUNCOMBE
P.O. Box 6747
ASHVILLE NC 28816
Crisis Phone 1:(704)253-4357
Business Phone:(704)252-7703
Hrs Avail:24

BURLINGTON
*#SUICIDE & CRISIS SERV/ALAMANCE CO.
P.O. Box 2573
BURLINGTON NC 27215
Crisis Phone 1:(919)227-6220
Business Phone:(919)228-1720
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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CHAPEL HILL
CHAPEL HILL HELPLINE
333 MC MASTERS ST.
CHAPEL HILL NC 27514
Crisis Phone 1:(919)929-0479
Business Phone:(919)929-0479
Hrs Avail:24

CHARLOTTE,
THE RELATIVES, INC.
1000 E. BOULVEVARD
CHARLOTTE, NC 28203
Crisis Phone 1:(704)377-0602
Business Phone:(704)377-0602
Hrs Avail:24

DURHAM
* HELPLINE OF DURHAM
414 E. MAIN ST.
DURHAM NC 27701
Crisis Phone 1:(919)683-8628
Business Phone:(919)683-2392
Hrs Avail:24

FRANKLYN,
RESPECT, INC.
431 WIDE HORIZON DR.
FRANKLYN, NC 28734
Crisis Phone 1:(704)369-6143
Business Phone:(704)369-7333
Hrs Avail:24

GREENSBORO
CRISIS CONTROL CENTER, INC.
P.O. Box 735
GREENSBORO NC 27402
Crisis Phone 1:(919)852-4444
Business Phone:(919)852-6366
Hrs Avail:24

GREENVILLE,
REAL CRISIS INTERV., INC.
312 E. 10TH ST.
GREENVILLE, NC 28203
Crisis Phone 1:(919)758-HELP
Crisis Phone 2:(919)758-0787
Business Phone:(704)377-0602
Hrs Avail:24

CHARLOTTE,
CONTACT TELE. COUNSELING
501 N. TYRON ST.
CHARLOTTE, NC 28202
Crisis Phone 1:(704)333-6121
Business Phone:(919)333-6121
Hrs Avail:24

DURHAM
CONTACT DURHAM
806 A CLARENDON ST.
DURHAM NC 27705
Crisis Phone 1:(919)683-1595
Business Phone:(919)286-4175
Hrs Avail:24

FAYETTEVILLE,
CONTACT OF FAYETTEVILLE, INC.
P.O. Box 456
FAYETTEVILLE, NC 28302
Crisis Phone 1:(919)485-4134
Business Phone:(919)483-8970
Hrs Avail:24

GOLDSBORO
WAYNE CO. MHC HOTLINE
301 N. HERMAN ST.
GOLDSBORO NC 27514
Crisis Phone 1:(919)735-4357
Business Phone:(919)736-7330
Hrs Avail:24

GREENSBORO
SWITCHBOARD CRISIS CENTER
330 S. GREENE
GREENSBORO NC 27402
Crisis Phone 1:(919)275-0896
Business Phone:(919)275-9341
Hrs Avail:24

HARRELLSVILLE,
ROANOKE-CHOWAN
HUMAN SERVICES CENTER
WICCACON CENTER
P.O. Box 407
HARRELLSVILLE, NC 27942
Crisis Phone 1:(919)332-4442
Business Phone:(919)356-2938
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION
AGENCIES IN THE UNITED STATES

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HIGH POINT
CONTACT HIGH POINT
463 S. MAIN ST.
HIGH POINT NC 27260
Crisis Phone 1:(919)882-8121
Business Phone:(919)885-0191
Hrs Avail:24

LEXINGTON
CONTACT LEXINGTON
P.O. Box 924
LEXINGTON NC 27292
Crisis Phone 1:(704)249-8974
Business Phone:(704)249-8824
Hrs Avail:24

MANTEO
OUTER BANKS HOTLINE
P.O. Box 1417
MANTEO NC 27954
Crisis Phone 1:(919)473-3366
Crisis Phone 2:(919)995-5104
Crisis Phone 3:(919)338-2829
Business Phone:(919)473-5121
Hrs Avail:24

MOREHEAD,
HELPLINE OF MOREHEAD
P.O. Box 3537
MOREHEAD, NC 28557
Crisis Phone 1:(919)247-3023
Business Phone:(919)247-3023
Hrs Avail:24

RALEIGH
HOPELINE, INC.
P.O. Box 6036
RALEIGH NC 27628
Crisis Phone 1:(919)755-6555
Business Phone:(919)755-6555
Hrs Avail:24

ROANOKE RAPIDS
ROANOKE RAPIDS CRISIS LINE
HALIFAX CO. MENTAL HEALTH
P.O. Box 1199
ROANOKE RAPIDS NC 27870
Crisis Phone 1:(919)537-2909
Business Phone:(919)537-2909
Hrs Avail:24

SALISBURY
SALISBURY DIAL HELP
165 MAHALEY
SALISBURY NC 28144
Crisis Phone 1:(704)636-9222
Business Phone:(704)633-3616
Hrs Avail:24

SANFORD
LEE COUNTY MH CRISIS LINE
130 CARBONTON RD.
SANFORD NC 27330
Crisis Phone 1:(919)774-4520
Business Phone:(919)774-6521
Hrs Avail:24

SMITHFIELD
CONTACT JOHNSTON CO.
140 MARKET ST.
SMITHFIELD NC 27577
Crisis Phone 1:(919)934-6161
Business Phone:(919)934-6979
Hrs Avail:24

STATESVILLE
THE CUP OF WATER, INC.
125 W. BELL ST.
STATESVILLE NC 28677
Crisis Phone 1:(704)872-7638
Business Phone:(704)872-7638
Hrs Avail:24

WILMINGTON
CRISIS LINE/OPEN HOUSE
419 CHESTNUT ST.
WILMINGTON NC 28401
Crisis Phone 1:(919)763-3695
Business Phone:(919)343-0145
Hrs Avail:24

WILSON,
WILSON CRISIS CENTER
P.O. Box 593
WILSON, NC 27893
Crisis Phone 1:(919)237-5156
Business Phone:(919)237-5156
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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WINSTON-SALEM
CONTACT: WINSTON-SALEM
1111 W. FIRST ST.
WINSTON-SALEM NC 27101
Crisis Phone 1:(919)722-5153
Business Phone:(919)723-4338
Hrs Avail:24

N. DAKOTA

BEULAH,
* MERCER COUNTY WOMEN`S RESOURCE CENTER
HILLSIDE OFFICE COMPLEX
HIGHWAY 49 NW.
BEULAH, ND 58523
Crisis Phone 1:(701)748-2274
Business Phone:(701)873-2274
Hrs Avail:24

BISMARK
CRISIS AND EMERGENCY SERVICES
WEST CENTRAL HUMAN SERVICE CENTER
600 S. 2ND ST.
BISMARK ND 58501
Crisis Phone 1:(701)255-3090
Business Phone:(701)255-3090
Hrs Avail:24

FARGO,
FARGO HOTLINE
P.O. Box 447
FARGO, ND 58107
Crisis Phone 1:(701)235-7335
Crisis Phone 2:(701)232-4357
Business Phone:(701)293-6462
Hrs Avail:24

GRAND FORKS
GRAND FORKS MH CRISIS LINE
1407 24TH AVE. S.
GRAND FORKS ND 58201
Crisis Phone 1:(701)775-0525
Business Phone:(701)746-9411
Hrs Avail:24

MINOT
MINOT SUICIDE PREVENTION SERVICE
ST. JOSEPH'S HOSPITAL
MINOT ND 58701
Crisis Phone 1:(701)839-2222
Business Phone:(701)857-2000
Hrs Avail:24

NEBRASKA

LINCOLN
PERSONAL CRISIS SERVICE
P.O. Box 80083
LINCOLN NE 68506
Crisis Phone 1:(402)475-5171
Business Phone:(402)475-5171
Hrs Avail:24

NORFOLK
24 HOUR HOTLINE
NORTHERN NEBRASKA COMP. MHC
201 MILLER AVE.
NORFOLK NE 68701
Crisis Phone 1:(800)672-8323
Business Phone:(402)371-7530
Hrs Avail:24

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AGENCIES IN THE UNITED STATES

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NORTH PLATTE
NORTH PLATTE EMERGENCY SERVICES
GREAT PLAINS MENTAL HEALTH CENTER
P.O. Box 1209
NORTH PLATTE NE 69103
Crisis Phone 1:(308)532-9332
Business Phone:(308)532-4050
Hrs Avail:24

OMAHA
OMAHA PERSONAL CRISIS SERVICE, INC.
4102 WOOLWORTH AVENUE
OMAHA NE 68105
Crisis Phone 1:(402)444-7335
Business Phone:(402)444-7335
Hrs Avail:24

NEW HAMPSHIRE

CLAREMONT
*#INTAKE/CRISIS/EVALUATION UNIT
COUNSELING CENTER OF SULLIVAN CO.
18 BAILEY AVE.
CLAREMONT NH 03743
Crisis Phone 1:(603)542-2578
Business Phone:(603)542-2578
Hrs Avail:24

CONCORD
*#EMERGENCY SERVICES/CONCORD
CNHCMS, INC.
P.O. Box 2032
CONCORD NH 03301
Crisis Phone 1:(603)228-1551
Business Phone:(603)228-1551
Hrs Avail:24

DOVER
* STRAFFORD GUIDANCE CENTER, INC.
EMERGENCY CRISIS TEAM
180 WASHINGTON ST.
DOVER NH 03820
Crisis Phone 1:(603)742-0630
Crisis Phone 2:(603)332-8090
Business Phone:(603)742-0630
Hrs Avail:24

KEENE
THE SAMARITANS OF KEENE
25 LAMSON ST.
KEENE NH 03431
Crisis Phone 1:(603)357-5505
Business Phone:(603)357-5505
Hrs Avail:24

LEBANON
* HEADREST INC.
14 CHURCH ST.
P.O. Box 221
LEBANON NH 03766
Crisis Phone 1:(603)448-4400
Business Phone:(603)448-4872
Hrs Avail:24

MANCHESTER
*#GREATER MANCHESTER MHC
401 CYPRESS ST.
MANCHESTER NH 03103
Crisis Phone 1:(603)668-4111
Business Phone:(603)668-4111

PORTSMOUTH
* SEACOAST MENTAL HEALTH CENTER
1145 SAGAMORE AVE.
PORTSMOUTH NH 03801
Crisis Phone 1:(603)431-6703
Business Phone:(603)431-6703
Hrs Avail:24

SALEM
*#CENTER FOR LIFE MANAGEMENT
SALEM PROF PARK
44 STILES RD.
SALEM NH 03079
Crisis Phone 1:(603)432-2253
Business Phone:(603)893-3548
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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NEW JERSEY

ATLANTIC CITY
CRISIS INTERVENTION PROGRAM/AC
ATLANTIC CITY MEDICAL CENTER
1925 PACIFIC AVE.
ATLANTIC CITY NJ 08401
Crisis Phone 1:(609)344-1118
Business Phone:(609)344-1118
Hrs Avail:24

CAMDEN,
* EMERGENCY AND ADVOCACY SERVICES
GUIDANCE CENTER OF CAMDEN CO. INC.
1600 HADDON AVE.
CAMDEN, NJ 08103
Crisis Phone 1:(609)428-4357
Crisis Phone 2:(609)541-2222
Business Phone:(609)428-1300
Hrs Avail:24

FLEMINGTON
HUNTERDON HELPLINE
RT. #31, BOX 36
FLEMINGTON NJ 08822
Crisis Phone 1:(201)782-4357
Business Phone:(201)782-4357
Hrs Avail:24

HACKENSACK
* SO. BERGEN MENTAL HEALTH CENTER
BERGEN REGIONAL COUNS. CENTER
395 MAIN ST.
HACKENSACK NJ 07601
Crisis Phone 1:(201)460-0160
Business Phone:(201)460-0160
Hrs Avail:24

MANCHESTER
GREATER MANCHESTER MHC
401 CYPRESS ST.
MANCHESTER NJ 03103
Crisis Phone 1:(603)688-4111
Business Phone:(603)688-4111
Hrs Avail:24

BRIDGEWATER
GUIDELINE
500 N.BRIDGE.
BRIDGEWATER NJ 08807
Crisis Phone 1:(201)526-4100
Business Phone:(201)725-2800
Hrs Avail:24

CHERRY HILL
CONTACT "609"
1050 N. KINGS HIGHWAY
CHERRY HILL NJ 08034
Crisis Phone 1:(609)667-3000
Crisis Phone 2:(609)428-2900
Business Phone:(609)667-0285
Hrs Avail:24

GLASSBORO
TOGETHER, INC.
7 STATE ST.
GLASSBORO NJ 08028
Crisis Phone 1:(609)881-4040
Business Phone:(609)881-7045
Hrs Avail:24

LINWOOD
CONTACT ATLANTIC COUNTY
P.O. Box 181
LINWOOD NJ 08221
Crisis Phone 1:(609)646-6616
Business Phone:(609)646-2101
Hrs Avail:24

MILLVILLE
MILLVILLE HOTLINE
CUMBERLAND CO. GUIDANCE CENTER
R D 1, CARMEL RD.
P.O. Box 808
MILLVILLE NJ 08332
Crisis Phone 1:(609)327-2222
Business Phone:(609)825-6810
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION
AGENCIES IN THE UNITED STATES

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MONTCLAIR
NORTH ESSEX HELP LINE
MENTAL HEALTH RESOURCE CENTER
60 S. FULLERTON AVE.
MONTCLAIR NJ 07042
Crisis Phone 1:(201)744-1954
Business Phone:(201)744-6522
Hrs Avail:24

MOORESTOWN
CONTACT BURLINGTON CO.
P.O. Box 333
MOORESTOWN NJ 08057
Crisis Phone 1:(609)234-8888
Business Phone:(609)234-5484
Hrs Avail:24

MORRISTOWN
MEMO HELPLINE
100 MADISON AVE.
MORRISTOWN NJ 07960
Crisis Phone 1:(201)540-5045
Business Phone:(201)540-5168
Hrs Avail:24

MT. HOLLY
SCREENING AND CRISIS INTERV. PROGRAM
CO. MEMORIAL HOSPITAL
175 MADISON AVE.
MT. HOLLY NJ 08060
Crisis Phone 1:(609)261-8000
Business Phone:(609)267-0700 x609
Hrs Avail:24

NEWARK
NEWARK EMERGENCY SERVICES
MT. CARMEL GUILD COMMUNITY MHC
17 MULBERRY ST.
NEWARK NJ 07102
Crisis Phone 1:(201)596-4100
Business Phone:(201)596-4100
Hrs Avail:24

PEQUANNOCK
CONTACT [illegible]RIS-PASSAIC
P.O. Box [illegible]9
PEQUANNOCK NJ 07440
Crisis Phone 1:(201)831-1870
Business Phone:(201)831-1870
Hrs Avail:24

RED BANK
HELPLINE - CRISIS UNIT
RIVERVIEW MEDICAL CENTER/
CHILDREN'S PSYCH. CENTER
35 UNION STREET
RED BANK NJ 07701
Crisis Phone 1:(201)671-5250
Business Phone:(201)530-2438
Hrs Avail:24

RICHWOOD
CONTACT GLOUCESTER CO.
P.O. Box 222
RICHWOOD NJ 08074
Crisis Phone 1:(609)881-6200
Business Phone:(609)881-6200
Hrs Avail:24

ROSELLE
CONTACT UNION-ESSEX
P.O. Box 225
ROSELLE NJ 07203
Crisis Phone 1:(201)527-0555
Business Phone:(201)241-9350
Hrs Avail:24

SALEM
CONTACT HELP OF SALEM CO.
P.O. Box 36
SALEM NJ 08079
Crisis Phone 1:(609)935-4357
Business Phone:(609)935-4484
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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TOMS RIVER
CONTACT OF OCEAN COUNTY
P.O. Box 1121
TOMS RIVER NJ 08753
Crisis Phone 1:(201)240-6100
Business Phone:(201)240-6104
Hrs Avail:24

UNION
COMMUNICATION--HELP CENTER
KEAN COLLEGE OF NEW JERSEY
MORRIS AVENUE
UNION NJ 07083
Crisis Phone 1:(201)527-2360
Crisis Phone 2:(201)527-2330
Crisis Phone 3:(201)289-2101
Business Phone:(201)289-2100
Hrs Avail:09:00AM-01:00AM

W. TRENTON
CONTACT OF MERCER COUNTY, NJ, INC.
KATZENBACH SCHOOL FOR THE DEAF.
320 SULLIVAN WAY
W. TRENTON NJ 08628
Crisis Phone 1:(609)883-2880
TTY
(609)587-3050
TTY
(609)452-1919
Business Phone:(609)883-2880
Hrs Avail:24

WESTFIELD
CONTACT--WE CARE
P.O. Box 37
WESTFIELD NJ 07090
Crisis Phone 1:(201)232-2880
Crisis Phone 2:(201)132-3333
Business Phone:(201)232-2936
Hrs Avail:24

NEW MEXICO

ALBUQUERQUE
CRISIS UNIT
BERNALILLO CO. MENTAL HEALTH CENTER
2600 MARBLE N.E.
ALBUQUERQUE NM 87106
Crisis Phone 1:(505)843-2800
Business Phone:(505)843-2800
Hrs Avail:24

ALBUQUERQUE
AGORA
THE UNIV. OF NEW MEXICO CRISIS CTR.
STUDENT UNION
P.O. Box 29
ALBUQUERQUE NM 87131
Crisis Phone 1:(505)277-3013
Business Phone:(505)277-3013
Hrs Avail:24

NEVADA

LAS VEGAS
LAS VEGAS SUICIDE PREVENTION CENTER
2408 SANTA CLARA DR.
LAS VEGAS NV 89104
Crisis Phone 1:(702)732-1622
Business Phone:(702)732-1622
Hrs Avail:24

RENO
* SUICIDE PREV. & CRISIS CALL CENTER
P.O. Box 8016
RENO NV 89507
Crisis Phone 1:(702)323-6111
Business Phone:(702)323-4533
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION
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NEW YORK

ALBANY
REFER SWITCHBOARD
PROJECT EQUINOX
70 CENTRAL AVENUE
ALBANY NY 12210
Crisis Phone 1:(518)434-1200
Business Phone:(518)434-1200
Hrs Avail:24

ALBANY
CAPITOL DIST. PSYCHIATRIC CENTER
75 NEW SCOTLAND AVE.
ALBANY NY 12208
Crisis Phone 1:(518)447-9650
Business Phone:(518)844-79650
Hrs Avail:24

ALBANY,
SAMARITANS OF CAPITOL DIST.
200 CENTRAL AVE.
ALBANY, NY 12206
Crisis Phone 1:(518)463-2323
Business Phone:(518)463-0861
Hrs Avail:24

BELLMORE
MIDDLE EARTH CRISIS COUNSELING &
REFERRAL CENTER
2740 MARTIN AVE.
BELLMORE NY 11710
Crisis Phone 1:(516)826-0600
Business Phone:(516)826-0244
Hrs Avail:24

BERLIN
BERLIN EMERGENCY SERVICES
ANDROSCOGGIN VALLEY MH CLINIC
PAGEVILLE RD.
BERLIN NY 03570
Crisis Phone 1:(603)752-7404
Business Phone:(603)752-7404
Hrs Avail:24

BUFFALO
BUFFALO SUICIDE PREV. & CRISIS SERV
3258 MAIN ST.
BUFFALO NY 14214
Crisis Phone 1:(716)834-3131
Business Phone:(716)834-3131
Hrs Avail:24

ELLENVILLE
FAMILY OF WOODSTOCK, INC.
ELLENVILLE NY 12428
Crisis Phone 1:(914)626-8109
Business Phone:(914)626-8109
Hrs Avail:24

GOSHEN
ORANGE COUNTY HELP LINE
MENTAL HEALTH ASSOCIAITON
255 GREENWICH AVE.
GOSHEN NY 10924
Crisis Phone 1:(914)343-6906
Crisis Phone 2:(914)294-9355
Crisis Phone 3:(914)294-9445
Crisis Phone 4:(914)342-5871
Crisis Phone 5:(914)565-6381
Business Phone:(914)294-7411
Hrs Avail:24

ISLIP
ISLIP HOTLINE
TOWN HALL
ISLIP NY 11751
Crisis Phone 1:(516)277-4700
Business Phone:(516)277-4700
Hrs Avail:09:00AM-12:00AM

ITHACA
*#SUICIDE PREVENTION & CRISIS SERVICE
P.O. Box 312
ITHACA NY 14850
Crisis Phone 1:(607)272-1616
Business Phone:(607)272-1505
Hours Avail: 24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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JAMESTOWN
JAMESTOWN CRISIS LINE
JAMESTOWN GENERAL HOSPITAL
JAMESTOWN NY 14701
Crisis Phone 1:(716)484-1314
Business Phone:(716)484-1161 x321
Hrs Avail:24

LINCROFT
CONTACT MONMOUTH COUNTY
P.O. Box 137
LINCROFT NY 07738
Crisis Phone 1:(201)544-1444
Business Phone:(201)544-1444
Hrs Avail:24

NEW PALTZ
FAMILY OF NEW PALTZ
2 CHURCH ST.
NEW PALTZ NY 12561
Crisis Phone 1:(914)255-8801
Business Phone:(914)255-8801
Hrs Avail:24

NEW PLATZ
OASIS
COUNSELING CENTER
STATE UNIV. COLLEGE
NEW PLATZ NY 12561
Crisis Phone 1:(914)257-2141
Business Phone:(914)257-2250
Hrs Avail:24

NEW YORK
HELP-LINE TELEPHONE SERVICES
3 W. 19TH STREET, SUITE #1010
NEW YORK NY 10001
Crisis Phone 1:(212)532-2400
TTY
(212)532-0942
Business Phone:(212)684-4480
Hrs Avail:24

NIAGARA FALLS
NIAGARA HOTLINE/CRISIS INTERV. SERV.
775 3RD ST.
NIAGARA FALLS NY 14302
Crisis Phone 1:(716)285-3515
Business Phone:(716)285-9636
Hrs Avail:24

ONEONTA
PROJECT 85
259 CHESTNUT ST.
ONEONTA NY 14302
Crisis Phone 1:(607)432-2111
Business Phone:(607)432-2111
Hrs Avail:24

PEEKSKILL
PEEKSKILL CRISIS INTERVENTION
1137 MAIN ST.
PEEKSKILL NY 10566
Crisis Phone 1:(914)739-6403
Business Phone:(914)739-6403
Hrs Avail:24

PLATTSBURGH
PLATTSBURGH COMM. CRISIS CENTER
29 PROTECTION AVE.
PLATTSBURGH NY 12901
Crisis Phone 1:(518)561-2330
Business Phone:(518)561-2331
Hrs Avail:24

QUEENS VILLAGE
DIAL-FOR-HELP
CREEDMOR PSYCHIATRIC CENTER
80-45 WINCHESTER BLVD.
QUEENS VILLAGE NY 11427
Crisis Phone 1:(212)464-7515
Business Phone:(212)464-7500 x3111
Hrs Avail:24

ROCHESTER
* LIFE LINE/HEALTH ASSN. OF ROCHESTER
973 EAST AVE.
ROCHESTER NY 14607
Crisis Phone 1:(716)275-5151
Business Phone:(716)271-3540
Hrs Avail:24

STONY BROOK
* RESPONSE OF SUFFOLK CO. INC.
P.O. Box 300
STONY BROOK NY 11790
Crisis Phone 1:(516)751-7500
Business Phone:(516)751-7620
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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SYRACUSE
SUICIDE PREV/CRISIS COUNSEL. SERV.
ST. JOSEPH'S HOSPITAL HEALTH CENTER
301 PROSPECT AVE.
SYRACUSE NY 13203
Crisis Phone 1:(315)474-1333
Business Phone:(315)474-1333
Hrs Avail:24

SYRACUSE
CONTACT SYRACUSE
958 SALT SPRINGS RD.
SYRACUSE NY 13224
Crisis Phone 1:(315)445-1500
Business Phone:(315)446-2610
Hrs Avail:24

UTICA
UTICA CRISIS INTERVENTION
1213 COURT ST., COTTAGE 46
UTICA NY 13502
Crisis Phone 1:(315)736-0883
ROME
(315)337-7299
HERKIMER
(315)866-0123
Business Phone:(315)797-6800 x4210
Hrs Avail:24

VALHALLA
CRISIS INTERVENTION UNIT
WESTCHESTER COUNTY MEDICAL CENTER
GRASSLANDS ROAD
VALHALLA NY 10595
Crisis Phone 1:(914)347-7075
Business Phone:(914)347-7075
Hrs Avail:24

WHITE PLAINS
SUICIDE PREVEN/CRISIS INTERV. SERV.
MHA OF WESTCHESTER CO., INC.
29 STERLING AVE.
WHITE PLAINS NY 10606
SUICIDE PREV. SERV.
(914)946-0121
CRISIS INTERV. SERV.
(914)949-6741
Business Phone:(914)949-6741
Hrs Avail:24

WOODSTOCK
FAMILY OF WOODSTOCK
16 ROCK CITY RD.
WOODSTOCK NY 12498
Crisis Phone 1:(914)338-2370
Business Phone:(914)338-2370
Hrs Avail:24

OHIO

AKRON
*#SUPPORT, INC.
1361 W. MARKET ST.
AKRON OH 44313
Crisis Phone 1:(216)434-9144
Business Phone:(216)864-7743
Hrs Avail:24

ASHTABULA
CONTACT ASHTABULA
P.O. Box 674
ASHTABULA OH 44004
Crisis Phone 1:(216)998-2607
Business Phone:(216)998-2609
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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ATHENS
CARE LINE, INC.
28 W. STIMSON
ATHENS OH 45701
Crisis Phone 1:(614)593-3344
Business Phone:(614)593-3346
Hrs Avail:24

BUCYRUS
CONTACT CRAWFORD CO.
P.O. Box 631
BUCYRUS OH 44820
Crisis Phone 1:(419)562-9010
ENTERPRISE
(419)468-9081
Business Phone:(419)562-9099
Hrs Avail:24

CANTON
*#CRISIS INTERV. CENTER OF STARK CO.
2421 13TH ST., N.W.
CANTON OH 44708
Crisis Phone 1:(216)452-6000
Business Phone:(216)452-9812
Hrs Avail:24

CHILLICOTHE
CHILLICOTHE CRISIS CENTER
SCIOTO-PAINT VALLEY MH CENTER
425 CHESTNUT ST.
CHILLICOTHE OH 45601
Crisis Phone 1:(614)773-4357
Business Phone:(614)773-0760
Hrs Avail:24

CINCINNATI
* 281-CARE/TALBERT HOUSE
3891 READING RD.
CINCINNATI OH 45206
Crisis Phone 1:(513)281-2273
Business Phone:(513)281-2866
Hrs Avail:24

CINCINNATI
CONTACT QUEEN CITY
P.O. Box 42071
CINCINNATI OH 45242
Crisis Phone 1:(513)791-4673
Business Phone:(513)791-5673
Hrs Avail:24

COLUMBUS
* SUICIDE PREVENTION SERVICES
1301 HIGH
COLUMBUS OH 43201
Crisis Phone 1:(614)221-5445
Business Phone:(614)299-6600

DAYTON
*#SUICIDE PREVENTION CENTER, INC.
184 SALEM AVE.
DAYTON OH 45406
Crisis Phone 1:(513)223-4777
Business Phone:(513)223-9096
Hrs Avail:24

DAYTON
CONTACT DAYTON
P.O. Box 125
DAYTON OH 45459
Crisis Phone 1:(513)434-6684
Business Phone:(513)434-1798
Hrs Avail:24

DELAWARE
* HELP ANONYMOUS, INC.
11 E. CENTRAL AVE.
DELAWARE OH 43015
Crisis Phone 1:(614)369-3316
Crisis Phone 2:(614)548-7324
Business Phone:(614)363-1835
Hrs Avail:24

DOVER,
CRISIS HELP LINE
201 HOSPITAL DR.
DOVER, OH 44622
Crisis Phone 1:(216)343-1811
Business Phone:(216)343-6631
Hrs Avail:24

EATON,
PREBLE COUNSELING CENTER HOTLINE
101 NORTH BARRON ST.
EATON, OH 45320
Crisis Phone 1:(513)456-1166
Business Phone:(513)456-1166
Hrs Avail:24

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FOSTORIA,
BUREAU OF CONCERN
716 N. COUNTY LINE ST.
FOSTORIA, OH 44830
Crisis Phone 1:(419)435-4357
Business Phone:(419)435-4357
Hrs Avail:8:30-5 PM M-F

KENT
TOWNHALL II HELPLINE
225 E. COLLEGE ST.
KENT OH 44240
Crisis Phone 1:(216)678-4357
Business Phone:(216)678-3006
Hrs Avail:24

MANSFIELD
HELP LINE/ADAPT
741 SHOLL RD.
MANSFIELD OH 44907
Crisis Phone 1:(419)522-4357
Business Phone:(419)526-4332
Hrs Avail:24

MARYSVILLE
MARYSVILLE CRISIS HOTLINE
CHARLES B. MILLS CENTER
715 PLUM ST.
MARYSVILLE OH 43040
Crisis Phone 1:(513)644-6363
PLAIN CITY
(614)873-8610
RICHWOOD
(614)943-2916
Business Phone:(513)644-9192
Hrs Avail:24

MT. GILEAD
* HOPE LINE, INC.
P.O. Box 142
MT. GILEAD OH 43338
Crisis Phone 1:(419)947-2520
Business Phone:(419)947-2520
Hrs Avail:24

GREENVILLE
CRISIS HOTLINE
DARKE COUNTY MENTAL HEALTH CLINIC
212 E. MAIN
GREENVILLE OH 45331
Crisis Phone 1:(513)548-1635
Business Phone:(513)548-1635
Hrs Avail:24

LANCASTER
INFO. & CRISIS SERV./FAIRFIELD CO.
P.O. Box 1054
LANCASTER OH 43130
Crisis Phone 1:(614)687-0500
Business Phone:(614)687-0500
Hrs Avail:24

MARION
CARE LINE
320 EXECUTIVE DR.
MARION OH 43302
Crisis Phone 1:(614)387-7200
Business Phone:(614)387-7200
Hrs Avail:24

MEDINA
MEDINA CRISIS INTERVENTION HELP LIN
CATHOLIC SOCIAL SERVICES
246 NORTHLAND DR.
MEDINA OH 44256
Crisis Phone 1:(216)725-4357
Crisis Phone 2:(216)225-4357
Crisis Phone 3:(216)336-4357
Business Phone:(216)725-4923
Hrs Avail:24

OXFORD
OXFORD CRISIS & REFERRAL CENTER
111 E. WALNUT ST.
OXFORD OH 45056
Crisis Phone 1:(513)523-4146
Business Phone:(513)523-4148
Hrs Avail:24

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SHELBY,
SHELBY HELPLINE
60 1/2 WEST MAIN ST.
SHELBY, OH 44875
Crisis Phone 1:(419)347-6307
Business Phone:(419)347-6307
Hrs Avail:7 A.M.-7 P.M.

TOLEDO
* THE NEW RESCUE CRISIS SERVICE
3314 COLLINGWOOD AVE.
TOLEDO OH 43610
Crisis Phone 1:(419)255-5500
Business Phone:(419)255-5500
Hrs Avail:24

WARREN
* CONTACT COMMUNITY CONNECTION
P.O. Box 1403
WARREN OH 44482
Crisis Phone 1:(216)393-1565
Crisis Phone 2:(216)545-4371
Business Phone:(216)395-5255
Hrs Avail:24

XENIA
GREENE COUNTY CRISIS CENTER
452 W. MARKET.
XENIA OH 45385
Crisis Phone 1:(513)429-0679
Crisis Phone 2:(513)429-0933
Business Phone:(513)376-8700
Hrs Avail:24

ZANESVILLE
* SIX COUNTY, INC. CRISIS HOTLINE
2845 BELL STREET
ZANESVILLE OH 43701
Crisis Phone 1:(614)452-8403
Business Phone:(614)454-9766
Hrs Avail:24

SPRINGFIELD,
SUICIDE PREV. CENTER LIFE-LINE
1101 EAST HIGH ST
SPRINGFIELD, OH 45505
Crisis Phone 1:(513)322-5433
Business Phone:(513)328-5300
Hrs Avail:24

TOLEDO,
TOLEDO FIRST CALL FOR HELP
1 STRANAHAN SQ.#141
TOLEDO, OH 43604
Crisis Phone 1:(419)244-3728
Business Phone:(419)244-3728
Hrs Avail:24

WOOSTER
DIAL A FRIEND
P.O. Box 303
WOOSTER OH 44691
Crisis Phone 1:(216)262-9999
Business Phone:(216)262-9499
Hrs Avail:2PM TO 12PM

YOUNGSTOWN
*#HELP HOTLINE, INC.
P.O. Box 46
YOUNGSTOWN OH 44501
Crisis Phone 1:(216)747-2696
Crisis Phone 2:(216)424-7767
Crisis Phone 3:(216)426-9355
TTY
(216)744-0579
Business Phone:(216)747-5111
Hrs Avail:24

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OKLAHOMA

CLINTON
CONTACT WESTERN OKLAHOMA
P.O. Box 572
CLINTON OK 73601
Crisis Phone 1:(405)323-1064
Business Phone:(405)323-1064
Hrs Avail:24

ENID
CONTACT NORTHWEST OKLAHOMA
P.O. Box 3165
ENID OK 73702
Crisis Phone 1:(405)234-1111
Business Phone:(405)237-8400
Hrs Avail:11:00AM-11:00PM

LAWTON
CRISIS TELEPHONE SERVICE
P.O. Box 2011
LAWTON OK 73502
Crisis Phone 1:(405)355-7575
Business Phone:(405)355-7575
Hrs Avail:24

NORMAN
UNITED WAY HELPLINE
319 W. MAIN ST.
NORMAN OK 73069
Crisis Phone 1:(405)364-3800
Business Phone:(405)364-3800

OKLAHOMA CITY
* CONTACT OF METRO. OKLAHOMA CITY
P.O. Box 12832
OKLAHOMA CITY OK 73157
Crisis Phone 1:(405)848-2273
Business Phone:(405)840-9396
Hrs Avail:24

PONCA CITY
HELPLINE/PONCA CITY
P.O. Box 375
PONCA CITY OK 74602
Crisis Phone 1:(405)765-5551
Business Phone:(405)765-5551
Hrs Avail:24

TULSA
TULSA HELPLINE
P.O. Box 52847
TULSA OK 74152
Crisis Phone 1:(918)583-4357
Business Phone:(918)585-1144
Hrs Avail:24

OREGON

ALBANY
LINN COUNTY MENTAL HEALTH
P.O. Box 100
ALBANY OR 97321
Crisis Phone 1:(503)757-2299
Business Phone:(503)967-3866
Hrs Avail:24

CORVALLIS
BENTON COUNTY MENTAL HEALTH
530 N. W. 27TH
CORVALLIS OR 97330
Crisis Phone 1:(503)757-2299
Business Phone:(503)757-6846
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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EUGENE
MENTAL HEALTH EMERGENCY CENTER/CIRT
151 W. 5TH ST.
EUGENE OR 97401
Crisis Phone 1:(503)687-4000
Business Phone:(503)687-3608
Hrs Avail:24

EUGENE
WHITEBIRD CLINIC MED. AID STATION
341 E. 12TH
EUGENE OR 97401
Crisis Phone 1:(503)342-8255
Business Phone:(503)342-8255
Hrs Avail:24

GRANTS PASS
JOSEPHINE CNTY INFO &REF SERV.-H.L.
P.O. Box 670
GRANTS PASS OR 97526
Crisis Phone 1:(503)479-help
Business Phone:(503)479-2349
Hrs Avail:24

KLAMATH FALLS
HOPE IN CRISIS
P.O. Box 951
KLAMATH FALLS OR 97601
Crisis Phone 1:(503)884-0636
Business Phone:(503)882-8974
Hrs Avail:24

MEDFORD
CRISIS INTERVENTION SERVICES
P.O. Box 819
MEDFORD OR 97501
Crisis Phone 1:(503)779-4357
Business Phone:(503)779-4490
Hrs Avail:24

PORTLAND
* METRO CRISIS INTERVENTION SERVICE
P.O. Box 637
PORTLAND OR 97207
Crisis Phone 1:(503)223-6161
Business Phone:(503)226-3099

SALEM
NORTHWEST HUMAN SERVICES, INC.
674 CHURCH ST.N.
SALEM OR 97303
Crisis Phone 1:(503)581-5535
Business Phone:(503)588-5828
Hrs Avail:24

PENNSYLVANIA

ALLENTOWN
LEHIGH VALLEY
LIFELINE-VALLEY WIDE HELP
1244 HAMILTON ST.
ALLENTOWN PA 18102
Crisis Phone 1:(215)435-7111
Business Phone:(215)435-7111
Hrs Avail:24

ALLENTOWN
CRISIS INTERVENTION TEAM
LEHIGH COUNTY
512 HAMILTON ST., SUITE #300
ALLENTOWN PA 18101
Crisis Phone 1:(215)820-3127
Business Phone:(215)820-3127
Hrs Avail:24

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ALTOONA,
CONTACT ALTOONA
P.O. Box 11
ALTOONA, PA 16603
Crisis Phone 1:(814)946-9050
Business Phone:(814)946-0531
Hrs Avail:24

BETHLEHEM
CRISIS INTERVENTION TEAM (MH/MR)
NORTHAMPTON COUNTY
BROAD & NEW STREETS
BETHLEHEM PA 18018
Crisis Phone 1:(215)865-0944
Business Phone:(215)865-0944
Hrs Avail:24

CHAMBERSBURG
CONTACT CHAMBERSBURG
221 N. MAIN ST.
CHAMBERSBURG PA 17201
Crisis Phone 1:(717)264-7799
Business Phone:(717)263-8007
Hrs Avail:24

DARBY
* PSYCH CRISIS CENTER
FITZGERALD MERCY HOSPITAL
DARBY PA 19023
Crisis Phone 1:(215)565-4300
Business Phone:(215)565-2041
Hrs Avail:24

ERIE,
INFO. & REFERRAL DIVISION
UNITED WAY OF ERIE COUNTY
110 W. 10TH ST.
ERIE, PA 16501-1466
ERIE HOTLINE
(814)453-5656
Business Phone:(814)456-2937
Hrs Avail:24

GETTYSBURG
ADAMS/HANOVER COUNSELING SERVICE
37 WEST ST.
GETTYSBURG PA 17325
Crisis Phone 1:(717)334-9111
Business Phone:(717)334-9111
Hrs Avail:24

GLENSHAW/PITTSBURGH
*#CONTACT PITTSBURGH, INC.
P.O. Box 30
GLENSHAW PA 15116
Crisis Phone 1:(412)782-4023
Business Phone:(412)487-7712

HARRISBURG
CONTACT HARRISBURG
P.O. Box 6270
HARRISBURG PA 17112
Crisis Phone 1:(717)652-4400
Business Phone:(717)652-4987
Hrs Avail:24

INDIANA
THE OPEN DOOR
1008 PHILADELPHIA ST.
INDIANA PA 15701
Crisis Phone 1:(412)465-2605
Business Phone:(412)465-2605
Hrs Avail:24

LANCASTER
CONTACT LANCASTER
447 E. KING ST.
LANCASTER PA 17602
Crisis Phone 1:(717)299-4855
Business Phone:(717)291-2261
Hrs Avail:24

MEDIA
DELAWARE CO. CRISIS INTERVENTION/SPS
600 N. OLIVE ST.
MEDIA PA 19063
Crisis Phone 1:(215)565-4300
Business Phone:(215)565-2041
Hrs Avail:24

NANCICOKE
HAZELTON-NANCICOKE CRISIS SERVICES
HAZELTON-NANCICOKE MHC
W. WASHINGTON ST.
NANCICOKE PA 18634
Crisis Phone 1:(717)735-7590
Business Phone:(717)735-7590
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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NEW BLOOMFIELD
PERRY COUNTY HOTLINE
PERRY HUMAN SERVICES
COURTHOUSE ANNEX
NEW BLOOMFIELD PA 17068
Crisis Phone 1:(717)582-8052
Business Phone:(717)582-8703
Hrs Avail:24

NEW CASTLE
CONTACT E.A.R.S.
P.O. Box 7804
NEW CASTLE PA 16107
Crisis Phone 1:(412)658-5529
Business Phone:(412)652-0333
Hrs Avail:24

NORRISTOWN
MONTGOMERY CO. MH/MR EMERG. SERV.
BLDG 16 STANBRIDGE&STERIGERE
NORRISTOWN PA 19401
Crisis Phone 1:(215)279-6100
Business Phone:(215)277-6225
Hrs Avail:24

PHILADELPHIA
CONTACT PHILADELPHIA
P.O. Box 12586
PHILADELPHIA PA 19151
Crisis Phone 1:(215)879-4402
Business Phone:(215)877-9099
Hrs Avail:24

SCRANTON
FREE INFO & REFERRAL SYSTEM TELEPH.
200 ADAMS AVE.
SCRANTON PA 18503
Crisis Phone 1:(717)961-1234
Business Phone:(717)961-1234
Hrs Avail:24

NEW BRIGHTON
CONTACT BEAVER VALLEY
P.O. Box 75
NEW BRIGHTON PA 15066
Crisis Phone 1:(412)728-3650
Business Phone:(412)728-3650
Hrs Avail:24

NEWTOWN
CONTACT LOWER BUCKS
P.O. Box 376
NEWTOWN PA 18940
Crisis Phone 1:(215)752-1850
Business Phone:(215)860-1803
Hrs Avail:24

PHILADELPHIA
PHILADELPHIA SUICIDE & C.I. CENTER
1 READING CENTER
1101 MARKET 7TH FLOOR
PHILADELPHIA PA 19107
Crisis Phone 1:(215)686-4420
Business Phone:(215)592-5565
Hrs Avail:24

PITTSBURGH: see Glenshaw

PITTSBURGH
* HELPLINE/PITTSBURGH
200 ROSS ST.
PITTSBURGH PA 15219
Crisis Phone 1:(412)255-1155
Business Phone:(412)255-1133
Hrs Avail:24/7 DAYS

SHAMOKIN DAM
S.U.N. CONTACT
P.O. Box 442
SHAMOKIN DAM PA 17862
SNYDER, UNION
(717)743-4357
NORTHUMBERLAND
(717)286-2800
Business Phone:(717)743-5534
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION
AGENCIES IN THE UNITED STATES

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SHARPSVILLE,
CONTACT PENN-OHIO
P.O. Box 91
SHARPSVILLE, PA
Crisis Phone 1:(412)962-5777
Business Phone:(412)962-5777
Hrs Avail:8 A.M.-MIDNIGHT

WILLIAMSPORT
WILLIAMSPORT HELPLINE
815 W. 4TH ST.
WILLIAMSPORT PA 17701
Crisis Phone 1:(717)323-8555
Crisis Phone 2:(800)624-4636
Business Phone:(717)323-8555
Hrs Avail:24

WILKES BARRE
LUZERNE/WYOMING CO. MH/MR CENTER #1
103 S. MAIN ST.
WILKES BARRE PA 18702
Crisis Phone 1:(717)823-2155
Business Phone:(717)823-2155
Hrs Avail:24

YORK
CONTACT YORK
145 S. DUKE ST.
YORK PA 17403
Crisis Phone 1:(717)845-3656
Business Phone:(717)845-9125
Hrs Avail:24

RHODE ISLAND

PROVIDENCE
* THE SAMARITANS OF PROVIDENCE
33 CHESTNUT ST.
PROVIDENCE RI 02903
Crisis Phone 1:(401)272-4044
Business Phone:(401)272-4044
Hrs Avail:24

WAKEFIELD
SYMPATICO
29 COLUMBIA ST.
WAKEFIELD RI 02879
Crisis Phone 1:(401)783-0650
Business Phone:(401)783-0782
Hrs Avail:24

S. CAROLINA

AIKEN
AIKEN COUNTY CRISIS LINE
P.O. Box 2712
AIKEN SC 29801
Crisis Phone 1:(803)648-9900
Business Phone:(803)648-0000
Hrs Avail:24

CHARLESTON HTS.
CHARLESTON HOTLINE
P.O. Box 71583
CHARLESTON HTS. SC 29415-1583
Crisis Phone 1:(803)744-4357
Business Phone:(803)747-3007
Hrs Avail:24

CHESNEE
HEARTLINE, INC.
RT. #3 BOX 442
CHESNEE SC 29323
Crisis Phone 1:(803)461-7301
Business Phone:(803)461-7301
Hrs Avail:24

COLUMBIA
* HELPLINE OF MIDLAND, INC.
P.O. Box 6336
COLUMBIA SC 29260
Crisis Phone 1:(803)771-4357
Business Phone:(803)799-6329
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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GREENVILLE
HELP-LINE/GREENVILLE
P.O. Box 1085
GREENVILLE SC 29602
Crisis Phone 1:(803)233-HELP
Business Phone:(803)242-0955
Hrs Avail:24

S. DAKOTA

ABERDEEN
NEW BEGINNINGS CENTER
1206 NORTH THIRD
ABERDEEN SD 57401
Crisis Phone 1:(605)229-1239
Business Phone:(605)229-1239
Hrs Avail:24

SIOUX FALLS
COMMUNITY CRISIS LINE
313 S. 1ST AVE.
SIOUX FALLS SD 57102
Crisis Phone 1:(605)334-7022
Business Phone:(605)334-7022
Hrs Avail:24

HURON
OUR HOME, INC.
510 NEBRASKA
HURON SD 57350
Crisis Phone 1:(605)352-9449
Business Phone:(605)352-9098
Hrs Avail:24

TENNESSEE

ATHENS
MC MINN/MEIGS CONTACT
P.O. Box 69
ATHENS TN 37303
Crisis Phone 1:(615)745-9111
Business Phone:(615)745-1042
Hrs Avail:24

CLEVELAND
CONTACT OF CLEVELAND
P.O. Box 962
CLEVELAND TN 37311
Crisis Phone 1:(615)479-9666
Business Phone:(615)472-1916
Hrs Avail:24

CHATTANOOGA
CONTACT OF CHATTANOOGA
1202 DUNCAN
CHATTANOOGA TN 37404
Crisis Phone 1:(615)266-8228
Crisis Phone 2:(615)622-5193
Business Phone:(615)629-0039
Hrs Avail:24

JOHNSON CITY
CONTACT MINISTRIES
P.O. Box 1403
JOHNSON CITY TN 37601
Crisis Phone 1:(615)926-0144
Business Phone:(615)926-0140
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION
AGENCIES IN THE UNITED STATES

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KINGSPORT
CONTACT--CONCERN
P.O. Box 798
KINGSPORT TN 37662
Crisis Phone 1:(615)246-2273
Business Phone:(615)247-7761
Hrs Avail:24

KNOXVILLE
CONTACT TELE. OF KNOXVILLE
P.O. Box 11234
KNOXVILLE TN 37939-1234
Crisis Phone 1:(615)523-9124
Business Phone:(615)523-9108
Hrs Avail:24

MEMPHIS
* SUICIDE/CRISIS INTERV. SERV./MEMPHIS
P.O. Box 40068
MEMPHIS TN 38104
Crisis Phone 1:(901)274-7477
Business Phone:(901)276-1111
Hrs Avail:24

OAK RIDGE
CONTACT OF OAK RIDGE
P.O. Box 641
OAK RIDGE TN 37830
Crisis Phone 1:(615)482-4949
Business Phone:(615)482-4940
Hrs Avail:24

KNOXVILLE
HELEN ROSS MC NABB CENTER
1520 CHEROKEE TRAIL
KNOXVILLE TN 37920
Crisis Phone 1:(615)637-9711
Business Phone:(615)637-9711
Hrs Avail:24

MARYVILLE,
CONTACT OF BLOUNT COUNTY
P.O. Box 0382
MARYVILLE, TN 37803
Crisis Phone 1:(615)984-7689
Business Phone:(615)984-7690
Hrs Avail:24

NASHVILLE
*#CRISIS INTERVENTION CENTER, INC.
P.O. Box 120934
NASHVILLE TN 37212
Crisis Phone 1:(615)244-7444
Business Phone:(615)298-3359
Hrs Avail:24

TULLAHOMA
TULLAHOMA CONTACT--LIFE LINE
P.O. Box 1614
TULLAHOMA TN 37388
COFFEE COUNTY
(615)455-7133
FRANKLIN CO.
(615)967-7133
BEDFORD CO.
(615)684-7133
MOORE CO.
(615)759-7133
Business Phone:(615)967-7133
Hrs Avail:24

TEXAS

AMARILLO
* SUICIDE PREV/CRISIS INT. CENTER
P.O. Box 3250
AMARILLO TX 79106
Crisis Phone 1:(806)376-4251
TOLL FREE IN-STATE
(800)692-4039
Business Phone:(806)353-7235
Hrs Avail:24

ARLINGTON
CONTACT TARRANT COUNTY
P.O. Box 1431
ARLINGTON TX 76010
Crisis Phone 1:(817)277-2233
Business Phone:(817)277-0071
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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AUSTIN
INFORMATION HOTLINE & CRISIS CENTER
102 NECHES
AUSTIN TX 78705
Crisis Phone 1:(512)472-help
Business Phone:(512)475-5695
Hrs Avail:24

BEAUMONT
* RAPE & SUICIDE CRISIS OF SE TEXAS
P.O. Box 5011
BEAUMONT TX 77706
Crisis Phone 1:(409)835-3355
Business Phone:(409)832-6530
Hrs Avail:24

DALLAS
*#SUICIDE & CRISIS CENTER
2808 SWISS AVE.
DALLAS TX 75204
Crisis Phone 1:(214)828-1000
Business Phone:(214)824-7020
Hrs Avail:24

DEL RIO
DEL RIO CRISIS LINE
YOUTH COUNSELING CENTER
609 GRINER ST.
DEL RIO TX 78840
Crisis Phone 1:(512)775-0571
Business Phone:(512)774-2585
Hrs Avail:24

EL PASO
EL PASO CRISIS INTERVENTION SERVICES
5308 E; PASO DR.
EL PASO TX 79905
Crisis Phone 1:(915)779-1800
Business Phone:(915)779-7383
Hrs Avail:24

HOUSTON
HOUSTON-BAY AREA CRISIS HELPLINE
16811 EL CAMINO REAL #126
HOUSTON TX 77058
Crisis Phone 1:(713)488-7222
Business Phone:(713)486-9683
Hrs Avail:24

BEAUMONT
SUICIDE RESCUE, INC.
2750 I-10E
BEAUMONT TX 77703
Crisis Phone 1:(713)833-2311
Business Phone:(713)833-2311
Hrs Avail:24

CORPUS CHRISTI
* CRISIS SERVICES/CORPUS CHRISTI
4906-B EVERHART
CORPUS CHRISTI TX 78411
Crisis Phone 1:(512)993-7410
Business Phone:(512)993-7416
Hrs Avail:24

DALLAS
CONTACT-DALLAS/TELEPH. COUNSEL.
P.O. Box 742224
DALLAS TX 75374
Crisis Phone 1:(214)233-2233
Business Phone:(214)233-0866
Hrs Avail:24

EDINBURGH
EDINBURGH HELP LINE
P.O. Box 1108
EDINBURGH TX 78539
Crisis Phone 1:(512)383-0121
Business Phone:(512)383-5341
Hrs Avail:24

FT. WORTH
*#TARRANT COUNTY CRISIS INTERVENTION
C/O FAMILY SERVICE, INC.
716 MAGNOLIA
FT. WORTH TX 76104
Crisis Phone 1:(817)336-3355
Business Phone:(817)336-0108
Hrs Avail:24

HOUSTON
*#CRISIS INTERVENTION OF HOUSTON, INC.
P.O. Box 13066
HOUSTON TX 77219
CENTRAL
(713)228-1505
BAY AREA
(713)333-5111
Business Phone:(713)527-9426
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION
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LUBBOCK
CONTACT LUBBOCK
P.O. Box 6477
LUBBOCK TX 79493-6477
Crisis Phone 1:(806)765-8393
TEEN LINE
(806)765-7272
Business Phone:(806)765-7272
Hrs Avail:SUN-TH 6AM-10PM FS6PM-MID

PLANO,
PLANO CRISIS CENTER
P.O. Box 1808
PLANO, TX 75074
Crisis Phone 1:(214)881-0088
Business Phone:(214)881-0081
Hrs Avail:9AM-MIDNIGHT

SAN ANGELO
* CONCHO VALLEY CTR. FOR HUMAN ADVANCE
244 N. MAGDALEN
SAN ANGELO TX 76903
Crisis Phone 1:(915)653-5933
Business Phone:(915)655-8965
Hrs Avail:24

SAN ANTONIO
* UNITED WAY HELP LINE
P.O. Box 898
SAN ANTONIO TX 78293-0898
Crisis Phone 1:(512)227-4357
Business Phone:(512)224-5000
Hrs Avail:24

ORANGE
SUICIDE RESCUE
P.O. Box 891
ORANGE TX 77630
Crisis Phone 1:(713)883-5521
Business Phone:(713)883-5521
Hrs Avail:24

RICHARDSON
RICHARDSON CRISIS CENTER
P.O. Box 877
RICHARDSON TX 75080
Crisis Phone 1:(214)783-0008
Business Phone:(214)783-0008
Hrs Avail:24

SAN ANTONIO
CONTACT SAN ANTONIO
P.O. Box 5217
SAN ANTONIO TX 78201
Crisis Phone 1:(512)736-1876
Business Phone:(512)732-2216
Hrs Avail:24

WICHITA FALLS
CONCERN, INC.
P.O. Box 1945
WICHITA FALLS TX 76307
Crisis Phone 1:(817)723-0821
Business Phone:(817)723-8231
Hrs Avail:24

UTAH

LOGAN
LOGAN HELPLINE
121 A UMC UTAH STATE UNIV.
LOGAN UT 84322
Crisis Phone 1:(801)752-3964
Business Phone:(801)752-1702
Hrs Avail:24

MIDVALE
SALT LAKE CO. DIV. OF MH
6856 SOUTH 700 EAST
MIDVALE UT 84047
Crisis Phone 1:(801)566-2455
Business Phone:(801)566-2455
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION
AGENCIES IN THE UNITED STATES

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OGDEN
OGDEN EMERGENCY SERVICES
WEBER CO. MHC
2510 WASHINGTON BLVD 5TH FL.
OGDEN UT 84401
Crisis Phone 1:(801)626-9270
Business Phone:(801)626-9100
Hrs Avail:24

PROVO
* UTAH COUNTY CRISIS LINE
P.O. Box 1375
PROVO UT 84603
Crisis Phone 1:(801)226-8989
Business Phone:(801)226-8989

SALT LAKE CITY
SALT LAKE CITY CRISIS INTERVENTION
#50 N. MEDICAL DR.
SALT LAKE CITY UT 84132
Crisis Phone 1:(801)581-2296
Business Phone:(801)581-2296
Hrs Avail:24

SALT LAKE CITY
SALT LAKE CO. DIV. OF MENTAL HEALTH
54 S. 700 EAST
SALT LAKE CITY UT 84102
Crisis Phone 1:(801)531-8909
Business Phone:(801)531-8909
Hrs Avail:24

VIRGINIA

ALEXANDRIA
ALEXANDRIA COMM MH CENTER
206 N. WASHINGTON ST. 5TH FL.
ALEXANDRIA VA 22314
Crisis Phone 1:(703)836-5751
Business Phone:(703)836-5751
Hrs Avail:24

ALEXANDRIA
ALEXANDRIA C.A.I.R. HOTLINE
418 S. WASHINGTON ST. SUITE101
ALEXANDRIA VA 22314
Crisis Phone 1:(703)548-3810
Business Phone:(703)548-0010
Hrs Avail:NOON TO MIDNIGH

ARLINGTON
*#NORTHERN VIRGINIA HOTLINE
P.O. Box 187
ARLINGTON VA 22210
Crisis Phone 1:(703)527-4077
Business Phone:(703)522-4460
Hrs Avail:24

BLACKSBURG
RAFT
201 MAIN ST.
BLACKSBURG VA 24060
Crisis Phone 1:(703)951-3434
Business Phone:(703)951-4283
Hrs Avail:24

BRISTOL
BRISTOL CRISIS CENTER
P.O. Box 642
BRISTOL VA 24203-0642
Crisis Phone 1:(703)466-2312
Crisis Phone 2:(703)628-7731
Business Phone:(703)466-2312
Hrs Avail:24

DANVILLE
DANVILLE HELPLINE
382 TAYLOR DR.
DANVILLE VA 24541
DANVILLE
(804)799-1414
CHATHAM
(804)432-0639
GRETNA
(804)656-1231
Business Phone:(804)799-1414
Hrs Avail:24

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FREDERICKSBURG
FREDERICKSBURG HOTLINE
P.O. Box 7132
FREDERICKSBURG VA 22404
Crisis Phone 1:(703)321-1212
Business Phone:(703)373-6608
Hrs Avail:24

LYNCHBURG
CRISIS LINE OF CENTRAL VIRGINIA
P.O. Box 2376
LYNCHBURG VA 24501
Crisis Phone 1:(804)528-help
Business Phone:(804)384-0231
Hrs Avail: 6:00PM-12:00AM

NEWPORT NEWS
CONTACT PENINSULA
211 32ND ST.
NEWPORT NEWS VA 23607
Crisis Phone 1:(804)245-0041
Business Phone:(804)861-0330
Hrs Avail:24

PORTSMOUTH
* SUICIDE-CRISIS CENTER, INC.
P.O. Box 1493
PORTSMOUTH VA 23705
Crisis Phone 1:(804)399-6393
Business Phone:(804)393-0502
Hrs Avail:24

ROANOKE
TRUST: ROANOKE VALLEY TROUBLE CENTER
360 WASHINGTON AVE.
ROANOKE VA 24016
Crisis Phone 1:(703)563-0311
Business Phone:(703)345-8859
Hrs Avail:24

WINCHESTER
CONCERN HOTLINE, INC.
P.O. Box 2032
WINCHESTER VA 22601
WINCHESTER
(703)667-0145
FRONT ROYAL
(703)635-4357
WOODSTOCK
(703)459-4742
Business Phone:(703)667-8208
Hrs Avail:24

HARRISONBURG
LISTENING EAR SERVICES
HARRISONBURG VA 22801
Crisis Phone 1:(703)434-2538
Business Phone:(703)434-2539
Hrs Avail:24

MARTINSVILLE
CONTACT MARTINSVILLE-HENRY CO.
P.O. Box 1287
MARTINSVILLE VA 24112
Crisis Phone 1:(703)632-7295
Business Phone:(703)638-8980
Hrs Avail:24

PETERSBURG
CONTACT TRI- CITY AREA
P.O. Box 942
PETERSBURG VA 23803
Crisis Phone 1:(804)733-1100
Business Phone:(804)861-0330
Hrs Avail:24

RICHMOND
EMERGENCY SERVICE/RICHMOND CO. MHC
501 N. 9TH ST., RM. #205
RICHMOND VA 23218
Crisis Phone 1:(804)780-8003
Business Phone:(804)643-5301
Hrs Avail:24

VIRGINIA BEACH
CONTACT TIDEWATER
P.O. Box 23
VIRGINIA BEACH VA 23458
Crisis Phone 1:(804)428-2211
Business Phone:(804)425-1647
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION AGENCIES IN THE UNITED STATES

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VERMONT

BRATTLEBORO
HOTLINE FOR HELP, INC.
17 ELLIOT ST.
BRATTLEBORO VT 05301
Crisis Phone 1:(802)257-7989
Business Phone:(802)257-7980
Hrs Avail:24

ST. ALBANS
ST. ALBANS EMER. & CRISIS SERVICE
FRANKLIN GRAND ISLE MH SERVICE, INC.
8 FERRIS STREET
ST. ALBANS VT 05478
Crisis Phone 1:(802)524-6554
Business Phone:(802)524-6554
Hrs Avail:24

RANDOLPH
ORANGE CO. MH SERVICE EMER SERVICE
P.O. Box G
RANDOLPH VT 05060
Crisis Phone 1:(802)728-9641
Business Phone:(802)728-3230
Hrs Avail:24

WASHINGTON

B'BRIDGE ISLAND
HELPLINE HOUSE
282 KNECHTEL WAY NE
B'BRIDGE ISLAND WA 98110
Crisis Phone 1:(206)842-HELP
Business Phone:(206)842-7621
Hrs Avail:24

BELLINGHAM
THE CRISIS LINE
WHATCOM CO. CRISIS SERVICES
124 E. HOLLY ST#201
BELLINGHAM WA 98225
Crisis Phone 1:(206)734-7271
WHATCOM CO.
(206)384-1485
Business Phone:(206)671-5754
Hrs Avail:24

BREMERTON
BREMERTON CRISIS CLINIC
500 UNION
BREMERTON WA 98312
Crisis Phone 1:(206)479-3033
Business Phone:(206)373-5031
Hrs Avail:24

CHEHALIS
LEWIS CO. INFO. & REFERRAL/HOTLINE
P.O. Box 337
CHEHALIS WA 98532
Crisis Phone 1:(206)748-6601
IN WASHINGTON
(800)562-6160
Business Phone:(206)748-6601
Hrs Avail:24

ELLENSBURG
ELLENSBURG CRISIS LINE
507 NANUM
ELLENSBURG WA 98926
Crisis Phone 1:(509)925-4168
Business Phone:(509)925-2166
Hrs Avail:24

EVERETT,
CARE - CRISIS LINE
2801 LOMBARD AVE.
EVERETT, WA 98201
Crisis Phone 1:(206)258-4357
Business Phone:(206)258-4357
Hrs Avail:24

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MOSES LAKE
GRANT COUNTY CRISIS LINE
MENTAL HEALTH & FAMILY SERVICE
P.O. Box 1057
MOSES LAKE WA 98837
Crisis Phone 1:(509)765-1717
Business Phone:(509)765-9239
Hrs Avail:24

PULLMAN,
WHITMAN COUNTY CRISIS LINE/LATAH COUNTY NIGHTLINE
P.O. Box 2615 CS
PULLMAN, WA 99163
Crisis Phone 1:(509)332-1505
Business Phone:(509)332-1505
Hrs Avail:24

RICHLAND
CONTACT TRI-CITIES AREA
P.O. Box 684
RICHLAND WA 99352
Crisis Phone 1:(509)943-6606
Business Phone:(509)943-9017
Hrs Avail:24

SPOKANE
SPOKANE CRISIS SERVICES
SPOKANE CITY COMM MH
S. 107 DIVISION
SPOKANE WA 99202
Crisis Phone 1:(509)838-4428
Business Phone:(509)838-4651
Hrs Avail:24

YAKIMA
OPEN LINE/YAKIMA
CENTRAL WASHINGTON COMPREHENSIVE MH
P.O. Box 959
YAKIMA WA 98907
Crisis Phone 1:(509)575-4200
STATEWIDE TOLL FREE
(800)572-8122
Business Phone:(509)575-4084
Hrs Avail:24

OLYMPIA
CRISIS CLINIC/THURSTON & MACON CO.
P.O. Box 2463
OLYMPIA WA 98507
Crisis Phone 1:(206)352-2211
Business Phone:(206)754-3888
Hrs Avail:24

RICHLAND
* MID COLUMBIA PSYCH. HOSP. & MHC
DIAL HELP
1175 GRIBBLE
RICHLAND WA 99352
Crisis Phone 1:(509)943-9104
Business Phone:(509)943-9104
Hrs Avail:24

SEATTLE
*#CRISIS CLINIC
1530 EASTLAKE EAST
SEATTLE WA 98102
Crisis Phone 1:(206)447-3222
Business Phone:(206)447-3210

TACOMA
TACOMA CRISIS CLINIC
P.O. Box 5007
TACOMA WA 98405
Crisis Phone 1:(206)759-6700
Business Phone:(206)756-5250
Hrs Avail:24

SUICIDE PREVENTION & CRISIS INTERVENTION
AGENCIES IN THE UNITED STATES

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WISCONSIN

APPLETON
APPLETON CRISIS INTERVENTION CENTER
3365 WEST BREWSTER
APPLETON WI 54914
Crisis Phone 1:(414)731-3211
Business Phone:(414)735-5354
Hrs Avail:24

BELOIT
BELOIT HOTLINE
P.O. Box 1293
BELOIT WI 53511
Crisis Phone 1:(608)365-4436
Business Phone:(608)365-4436
Hrs Avail:24

BOSCOBEL
SUICIDE PREVENTION GROUP
401 E. BLUFF ST.
BOSCOBEL WI 53805
Crisis Phone 1:(608)365-4436
Business Phone:(608)365-4436
Hrs Avail:24

EAU CLAIRE
* SUICIDE PREVENTION CENTER
1221 WHIPPLE ST.
EAU CLAIRE WI 54701
Crisis Phone 1:(715)834-6040
Business Phone:(715)839-3274
Hours Avail: 24

ELKHORN
LAKELAND COMMUNITY CENTER
P.O. Box 1005
ELKHORN WI 53121
Crisis Phone 1:(414)723-5400
Business Phone:(414)723-5400
Hrs Avail:24

ELKHORN,
* LAKELAND COUNSELING CENTER
HWY NN
P.O. Box 1005
ELKHORN, WI 53121
Crisis Phone 1:(414)741-3200
Business Phone:(414)741-3200
Hrs Avail:24

FOND DU LAC,
CIC/FOND DU LAC
459 E. 1ST ST.
FOND DU LAC, WI 54935
Crisis Phone 1:(414)929-3535
Business Phone:(414)929-3500
Hrs Avail:24

GREEN BAY,
C.I.C./MANITOWOC AREA
131 SO. MADISON ST.
GREEN BAY, WI 54301
Crisis Phone 1:(414)682-9172
Business Phone:(414)432-7855
Hrs Avail:24

LA CROSSE
HARBOR HOUSE
1608 MARKET ST.
LA CROSSE WI 54601
Crisis Phone 1:(608)785-0530
Business Phone:(608)785-0530x3516
Hrs Avail:24

LA CROSSE
FIRST CALL FOR HELP
P.O. Box 2373
LA CROSSE WI 54602-2373
FIRST CALL FOR HELP
(608)782-8010
FIRST CALL WI
(800)362-8255
FIRST CALL MN & IA
(800)356-9588
Business Phone:(608)782-8010
Hrs Avail:24

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MADISON
* DANE CO. MHC EMERGENCY SERVICES
31 S. HENRY
MADISON WI 53703
Crisis Phone 1:(608)251-2345
Business Phone:(608)251-2341
Hrs Avail:24

MILWAUKEE
* MILWAUKEE COUNTY CI SERVICE
MENTAL HEALTH EMERG. SERV.
8700 W. WISCONSIN AVE.K RD.
MILWAUKEE WI 53226
Crisis Phone 1:(414)257-7222
Business Phone:(414)257-7222
Hrs Avail:24

OSHKOSH,
CRISIS INTERV. CENTER/OSHKOSH
P.O. Box 1411
OSHKOSH, WI 54902
Crisis Phone 1:(414)722-7707
Crisis Phone 2:(414)233-7707
Business Phone:(414)233-7709
Hrs Avail:24

THIENSVILLE
COPE
OZAUKEE COUNTY HOTLINE
P.O. Box 493
THIENSVILLE WI 53092
Crisis Phone 1:(414)242-6578
Business Phone:(414)242-6578
Hrs Avail:24

MILWAUKEE
* SURVIVORS HELP. SURVIV./LIFE REACH
SEWAS
ST. LUKES HOSPITAL-EMERG. DEPT.
2900 WEST OKLAHOMA AVE.
MILWAUKEE WI 53215
Crisis Phone 1:(414)649-6359
Crisis Phone 2:(414)649-6000
Business Phone:(414)649-6333

MILWAUKEE
UNDERGROUND SWITCHBOARD
P.O. Box 92455
MILWAUKEE WI 53202
Crisis Phone 1:(414)271-3123
Business Phone:(414)271-2810
Hrs Avail:24

STURGEON BAY,
DOOR COUNTY HELPLINE
P.O. Box F
STURGEON BAY, WI 54235
Crisis Phone 1:(414)743-8818
Business Phone:(414)743-8818
Hrs Avail:24

WISC. RAPIDS
WOO CO. UNIFIED SERVICES
CRISIS INTERV. & REFERRAL
310 DEWEY ST.
WISC. RAPIDS WI 54494
WISCONSIN RAPIDS
(715)421-2345
MARSHFIELD
(715)384-5555
Business Phone:(715)421-2345
Hrs Avail:24

W. VIRGINIA

CHARLESTON
CONTACT KANAWHA VALLEY
CHRIST CHURCH UNITED METHODIST
QUARRIER & MORRIS STS.
CHARLESTON WV 25301
Crisis Phone 1:(304)346-0826
Business Phone:(304)346-0828
Hrs Avail:24

HUNTINGTON
CONTACT HUNTINGTON
520 11TH ST.
HUNTINGTON WV 25701
Crisis Phone 1:(304)523-3448
Business Phone:(304)523-3447
Hrs Avail:24

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HUNTINGTON
PRESTERA CENTER FOR MH SERVICES
3375 U.S. RT. 60, EAST
P.O. Box 8069
HUNTINGTON WV 25705
Crisis Phone 1:(304)525-7851
Business Phone:(304)525-7851
Hrs Avail:24

OAK HILL
CONTACT--CARE OF SOUTHERN WV
P.O. Box 581
OAK HILL WV 25901
Crisis Phone 1:(304)877-3535
Business Phone:(304)877-3535
Hrs Avail:24

WHEELING
UPPER OHIO VALLEY CRISIS HOTLINE
P.O. Box 653
WHEELING WV 26003
Crisis Phone 1:(304)234-8161
Business Phone:(304)234-1848
Hrs Avail:24

LEWISBURG
GREENBRIAR VALLEY MH CLINIC
100 CHURCH ST.
LEWISBURG WV 24901
Crisis Phone 1:(304)647-5587
Business Phone:(304)645-3319
Hrs Avail:24

PRINCETON
SOUTHERN HIGHLANDS COMM MHC
12TH ST. EXTENSION
PRINCETON WV 24740
Crisis Phone 1:(304)425-9541
Business Phone:(304)425-9541
Hrs Avail:24

WYOMING

CASPER
* CASPER SUICIDE PREVENTION
FAMILY SUPPORT GROUP ASSOC., INC.
611 THELM DR.
CASPER WY 82609
Crisis Phone 1:(307)234-5061
Business Phone:(307)234-5061
Hrs Avail:24

ROCK SPRINGS
* CRISIS INTERVENTION PROGRAM
731 C.
ROCK SPRINGS WY 82901
Crisis Phone 1:(307)382-6060
Business Phone:(307)382-6060

CHEYENNE
CHEYENNE HELPLINE
P.O. Box 404
CHEYENNE WY 82001
Crisis Phone 1:(307)634-4469
Business Phone:(307)632-4132
Hrs Avail:6 PM TO 7 AM

WORLAND
COMMUNITY CRISIS SERVICE, INC.
P.O. Box 872
WORLAND WY 82401
Crisis Phone 1:(307)347-4991
Business Phone:(307)347-4992
Hrs Avail:24

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