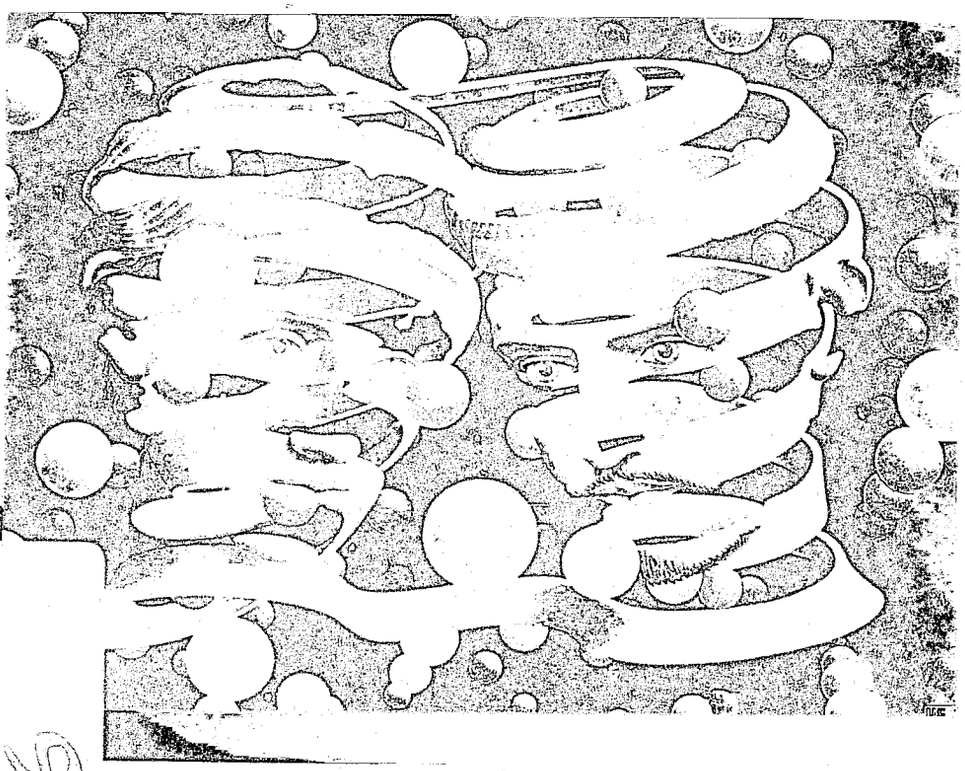

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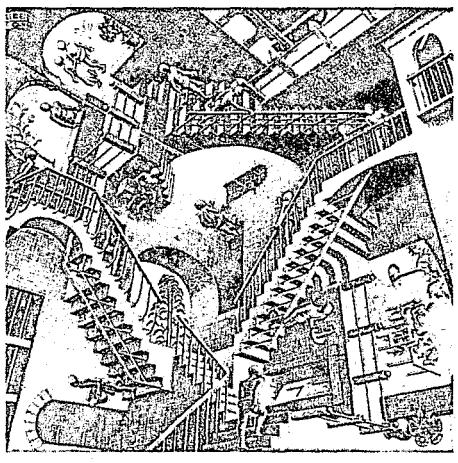
Contents



4 "Just say no." 118410
By First Lady Nancy Reagan

6 Student problems and challenges 118411
By U.S. Senator Lawton Chiles

8 Educated suicide prevention 118412
By Iris M. Bolton

12 Agencies stand united
By Lucy D. Hadi

14 Bad news offenders 118413
By Wolfgang Pindur and Donna Wells

17 Delusions of grandeur
By Blanca Gonzalez 118414

22 Schools respond with drug prevention 118415

24 Pros tackle drugs

26 LAPD's Project DARE 118416
By Chief Daryl F. Gates

28 Drugs: TV's new 'Vice'

Sections

2 NSSC Report

30 National Update

31 Legislative Update

33 Legal Update

34 Resource Update

35 *Principals of Leadership*

Resource Order Forms

29 "What's Wrong With This Picture?" (film/tape)

32 *School Crime & Violence: Victims' Rights* (book)

118412

Educated suicide prevention

By Iris M. Bolton

While there is no certain answer to why our children are killing themselves, there are ways parents and educators can help stop this tragic loss.

Many of our children are giving up on life. Last year an unidentified 15-year-old boy thrust a crumpled paper into the hands of a teacher and disappeared into the crowded halls of his high school. It read:

War child
Peace child,
Falls inside himself . . .
Into a crevice of
ungathered ends.

His words may speak for hundreds of his peers across the country.

Nationally, suicide increased in youthful populations by 136 percent between 1960 and 1980 (5.2 to 12.3 per 100,000). According to the National Center for Health Statistics, suicide is the third leading cause of death for those 15 to 24 years old.

Accident and homicide traditionally have "outranked" the suicide rate, except for white males whose suicide rate exceeds that of their homicide rate.

Between 4,000 and 5,000 adolescent boys and girls from different social and economic backgrounds are killing themselves each year. For every young person who completes suicide, another 100 try and fail, some becoming paralyzed or disabled for life. Estimates of attempts severe enough to require medical attention are estimated to be approximately 500,000 yearly.

Boys complete suicide five times more often than girls; whites approximately twice as often as blacks; and girls attempt suicide ten times more often than boys. It is the young, white male who is primarily at risk. Every 90 minutes a young person completes the act of suicide. These numbers evidence a major health problem in the United States.

Public awareness and concern has grown as the number of children and young adults who are lost to suicide each year increases. Communities are beginning to mobilize. Individuals and groups from various helping professions are tackling the problem. School prevention programs are being developed. Community awareness projects are under way. Research is being funded by local, state and national sources.

A subject which was once feared is now being addressed with the hope young lives will be saved and the alarming statistics will decrease during the next few years. According to Kim Smith of the Menninger Clinic in Albuquerque, there is recent encouraging evidence the suicide crisis is currently at a plateau.

School systems, already charged with enormous responsibility for the well-being of youth, now are being challenged to assist with suicide prevention, intervention, and the aftermath (also known as *postvention).* School systems are targeted as the key resource because of their influence on the attitudes and behavior of today's youth.

School personnel are asking the following questions about suicide:

- What is the extent of the problem?
- What facts are already known?

Iris M. Bolton is executive director of the Link Counseling Center, Atlanta, Georgia, and author of My Son . . . My Son.

- Why does suicide happen?
- What are the warning signs?
- How can we help?
- What can we do after a suicide?
- What are appropriate referral resources?
- Is there hope?

Facts about suicide

Four out of five people who commit suicide have talked about it or threatened it previously. It is a myth that someone who talks about it won't do it. Most often, that is a very clear call for help.

Drugs or alcohol are involved in two out of three suicides. Use of these chemicals intensify the already-existing feelings of helplessness and hopelessness the person is experiencing.

A suicidal person is not necessarily mentally ill. This person simply may be seeing things through a very distorted and constricted lens. To many suicide individuals there seems to be only two choices: continuation of a powerful sense of pain or cessation of that pain.

The act of suicide is not seen as a moving toward something, but as a moving away from unbearable pain. Most suicidal people are undecided about living or dying. Happily, most are suicidal for only a limited time, and if prevented from self-destruction, go on to lead useful lives.

Asking someone about suicidal feelings will not cause the act. The person may feel relieved someone finally took the problem seriously and recognized the pain.

Why does suicide happen?

There are no absolute answers for why adolescents attempt and complete suicide in such comparatively large numbers. Mental health professionals have been searching for years for an answer to that question. There is general agreement that, although there is usually ambiguity about dying, adolescents who take their own lives feel hopeless about their situation and believe it will never change. Suicide seems to be a response to intolerable pain.

A complex set of cumulative factors, different for each individual, seems to interact with the person's biological, emotional, intellectual, and social stages of development. These can be viewed as inseparable components in a young life experience.

The following characteristics have been identified as possible interactive factors:

Biological: Depression due to chemical imbalance; physical illness; somatic illness such as headaches or stomach aches; physical disability; learning disability; chemical changes during puberty; or, possible physical dependency on drugs/alcohol.

Emotional: Sadness; stress; impulsive behavior; a sense of powerlessness; loss, grief; loneliness; low self-esteem; anger or rage; guilt; impatience; helplessness; hopelessness; aggressive feelings; a sense of being overwhelmed; worthlessness; depression; suppressed grief or anger; anxiety; fear; pessimism; dependency; sexual identity confusion; fear of failure or success; or, emotional dependency on chemicals.

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Intellectual: Inability to communicate feelings; perfectionism; pressure to achieve or perform; tunnel vision; mistaken belief others are better off without them; self-criticism; exaggeration of faults; lack of meaningful work or sense of industry; fear of punishment; dislike or criticism of appearance; unrealistic view of death; revenge; indecisiveness; unrealistic expectations of others; or, false beliefs, such as the ability to handle drugs or alcohol.

Social: Isolation; withdrawal; friendlessness; lack of social skills; peer pressure; unpopularity; feelings of not belonging; delinquency; embarrassment before peers; scorn; labeled as "crazy," "stupid" or "different"; in trouble at home, school or with the law; confused by role changes; a runaway.

The common causal theories of adolescent suicide are psychodynamic, developmental, cognitive, sociological and biological. They must be considered interactive with each other, as one theory alone is inadequate to explain the phenomenon of suicide.

The *psychodynamic* theory considers the influence of the past on the present and future. Suicidal ideals develop from rejection or perceived loss of love by significant others.

The *developmental* theory looks at the stress of adolescence and emphasizes change, crisis, pressure and impulsiveness, finally exploding into rage after a precipitating event, such as a romantic breakup or the death of a loved one.

The *cognitive* theory depicts the adolescent as having a sense of immortality, believing that death is reversible, not final. This unrealistic view of death is due to incomplete intellectual development.

The *sociological* theory emphasizes alienation, isolation, withdrawal and loss of social contact. With the reduction of social structure and norms in our changing culture, suicide results from a perception of society's disintegration.

The *biological* theory considers biochemical correlates of suicidal behavior and looks at their relationship to affective disorders. Chemical or biological abnormalities are thought to contribute to suicidal ideation and behavior.

Pioneers in the field of suicidology are exploring theories, collecting data and analyzing statistics. Signs of depression continue to be observed in many suicidal youth through conscious and unconscious behaviors. Professionals recommend learning to identify the warning signs.

What are the warning signs?

Research indicates suicide attempts often follow: marked changes in personality, behavior or appearance; participation in new and self-destructive

behaviors; talk of death or of not being around in the future; signs of depression (although many adolescents may be temporarily depressed and will never commit suicide); and, preparation for dying, such as giving away important and treasured possessions.

Other signs of suicide include a current suicidal plan, previous suicide attempts, poetry or themes on death and dying, changes in relationships, moody behavior, self-criticism, the inability to concentrate, sleeping too much or too little, an increase, decrease or other change in eating habits, expressions of anger at self and the world or, sudden improved behavior following period of depression.

The most vulnerable times for youth suicides are during "rites of passage," including graduation, anniversaries and birthdays. Holidays, anniversaries of unhappy events, season changes and springtime also are critical periods. Suicides also frequently occur following a perceived loss or after changes in family situations, including divorces, relocations or financial setbacks.

How can we help?

Suicide counselors offer practical advice for parents and educators concerned about potentially suicidal youth.

- Do not ignore warning signs. Take threats seriously.
- Find a time privately to let the person know the clues you've observed and say you are concerned the person might be thinking of giving up on life.
- Stay calm and listen actively. If you are right, the person most likely will be relieved someone has noticed and cared.
- Remember, you cannot make someone choose to live. You are not responsible for the person's life, but you can give support and possibly insight to other choices or alternatives.
- Remind the person that suicide *cannot be reversed.* It is a permanent solution to a temporary problem.
- Reassure the person that many people think about suicide but never actually do it.
- Explore the individual's plan for suicide, such as how it might be accomplished, availability of method and other factors. This can be an excellent indicator of how complete the plans are.
- Share some of your experiences with the individual, perhaps describing a time when you felt defeated or hopeless.
- Do not allow yourself to be sworn to secrecy. You may lose a friendship but may save a life.
- Be honest with the person if you plan to call a family member or friend. Make the call in front of the individual so that the potential victim won't panic or mistrust you. Stay with the person until someone comes.
- Know the services available in your area or contact someone who does and make the appropriate referral to professional help.

Where to get help

Parents and educators, as well as troubled youth, can turn to school counselors, a family physician, psychiatrist, psychologist, community mental health agency, local hospital emergency centers or clergy for support and advice. These trained professionals are available to those concerned about potential suicide.

Those working with youth need to remain aware that sometimes depression is masked and there are no obvious warning signs of suicidal behavior. Sometimes a suicide takes people by surprise. Sometimes that can't be avoided.

What schools can do after a suicide

When a loved one dies, strong emotional attachments are broken and mourners are left to grieve. When someone dies by suicide, the grief of family and friends can be particularly devastating. Suicide survivors may experience tremendous conflict about why victims ended their lives.

Guilt and anger often are associated with one's perceived failure to prevent the suicide. These feelings can be experienced even by a student who didn't know the person well. The sudden impact of violence, the shock and disbelief, the sense of rejection and the stigma which sometimes surrounds suicide compound the natural grieving experience.

Newly bereaved survivors may experience depression, illness, accidents, alcoholism or thoughts of suicide in order to end the unbearable pain of their shattered lives.

Survivors need to know that their reactions to the suicide are common and, at the same time, that each person's healing process is different. There is no correct timetable. They need to know they can survive the pain even though they may doubt that themselves.

The unique characteristics of the grief process related to suicide require sensitive, caring and understanding assistance, especially for the siblings in the family. Suicide response actions become prevention efforts as the mourner is helped through the grief process to recovery and a sense of hope for the future.

When a student suicide occurs, rumors are rampant and it is usually

Books on teen suicide and its prevention:

Bolton, I. *My Son . . . My Son.* 1325 Belmore Way, NE, Atlanta, Georgia 30338; 1983.

Elkind, David. *The Hurried Child: Growing Up Too Fast Too Soon.* Reading, Massachusetts: Addison-Wesley, 1981.

Giovacchini, Peter. *The Urge to Die: Why Young People Commit Suicide.* New York, New York: Penguin, 1983.

Grollman, Earl A., ed. *Suicide: Prevention, Intervention, Postvention.* Boston, Massachusetts: Beacon Press, 1971.

Hewett, John H. *After Suicide.* Philadelphia, Pennsylvania: Westminister, 1980.

Kiev, Ari. *The Courage to Live.* New York: Bantam, 1981.

Klagsbrun, Francine. *Too Young To Die: Youth and Suicide.* New York, New York: Pocket Books, 1986.

McCoy, Kathleen. *Coping With Teenage Depression: A Parent's Guide.* New York, New York: NAL, 1982.

Polly, Joan. *Preventing Teenage Suicide.* New York, New York: Herman Services Press, 1986.

Rosenfeld, Linda & Prupas, Marilynne. *Left Alive: After A Suicide Death in the Family.* Springfield, Illinois: Charles C. Thomas, 1984.

best to calmly tell the student body the truth. Sometimes families prefer to keep that information private, and when their requests are followed, the school administration gets caught up in the participation of that "secret." The truth usually is known and the "secret" can become lethal and destructive if it leaks out. Credibility and trust can be irrevocably lost. Those working as suicide counselors usually believe students can deal with the truth no matter how painful. A lie or a secret can have enormous destructive power in everyone's lives.

Administrators must make decisions based on available information. "Trust your instincts and do the best you can" is the best motto. Telling the student body what happened dispels rumors and has a calming influence once the shock is absorbed.

Students can be assured they will be released to go to the funeral, with parental permission, when arrangements are known. Homeroom teachers can be given time to discuss such feelings as shock, disbelief and anger. Small group discussions are helpful and relieve tension.

Students can be encouraged to plan a memorial service, start a memorial fund or do something in memory of the deceased student. Letter writing to the family is an appropriate project, as is thinking of things to do for the parents and siblings. Writing poetry, essays or journals also may be helpful.

An assembly can be held, led by a mental health professional in the community who specializes in grief counseling. A large meeting like this takes a special ability on the part of the counselor, but it is important to help students understand their feelings of shock and disbelief, anger and guilt. They need to ask "why?" They may be feeling discouraged about life themselves and considering suicide as an option, so it is especially important for students to have support and the freedom to express themselves.

A teacher in-service can help the faculty deal with their own feelings of loss and can instruct them how to help students and each other. A meeting for concerned parents can be held for the same purpose. Both of these sessions can be conducted by a grief counselor.

Following a suicide teachers can let students talk about what happened and share memories through cards and letters. Teachers can encourage expression of feelings, both positive and negative. Faculty may choose to start a "support group" after school, led by a counselor, for anyone who wants to attend.

Other teacher support can come from just being available to help individual students. In appropriate class sessions teachers can mention the deceased person's name, showing the student is remembered.

Students should be told that physical reactions such as upset stomach or headaches are common and natural responses to grief. Discussions about the grief process help classmates realize they should expect to experience shock, denial, guilt, anger, depression, resignation and, eventually, acceptance of the reality. Students should be told the healing occurs slowly and takes time.

Children should be helped to know it is all right to grieve alone, to grieve with their families and to grieve with the school community. Parents and educators should instill hope and know that suicide aftercare becomes prevention as the mourners are helped throughout the grief process to recovery and to a sense of hope for the future.

Schools can help with both suicide prevention and aftercare by providing an atmosphere which enhances and teaches self-esteem, communication skills, relationship building, learning from mistakes and stress management.

A comprehensive system-wide approach to suicide education can be developed which includes teacher awareness training, parent awareness training, student awareness, community referral resources and linkage, crisis intervention strategy and aftercare for faculty and students.

A number of programs have been developed around the country and are available for replication. It is important for every community to study these programs and to adapt them to suit their own particular needs. By sharing material, we can learn from each other, creativity can be expanded, and the personal and public needs of our own communities will be met.

For more information on suicide prevention:

The National Committee on Youth Suicide Prevention
666 Fifth Avenue, 13th Floor
New York, New York 10103
212/247-6910

Youth Suicide National Center
1825 Eye Street, NW, Suite 400
Washington, D.C. 20006
202/429-2016

Suicide Information & Education Center
723 14th Street, NW, #103
Calgary, Alberta
T2N 2A4
403/283-3031

American Association of Suicidology
2459 South Ash Street
Denver, Colorado 80222
303/692-0985

Cherry Creek Program
3665 Cherry Creek North
Suite 370
Denver, Colorado 80209
303/651-2829

Peer Facilitator Quarterly
Educational Media Corporation
Box 21311
Minneapolis, Minnesota 55421

Suicide Prevention Center, Inc.
184 Salem Avenue
Dayton, Ohio 45406

A word of caution

Many of us are on the cutting edge of suicide prevention. Individuals working in this field must be careful to educate and inform without sensationalizing and without promoting thoughts of death and dying.

Few suicide prevention programs have been evaluated so it is not yet possible to measure results. Those working with this issue must continue to move slowly and responsibly, not out of panic but out of genuine concern for young people. By constant monitoring, professional consultation, development of evaluation components and exchange of ideas, we can only hope that together we can make a difference.

As Chantal said many decades ago: *The greatest gift one can give to another is a deeper understanding of life, and the ability to love and believe in self.* □