

Suicide Prevention and Youth: Saving Lives

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Testimony

Fran Gatlin is in her twenty-ninth year as a practicing school psychologist and in her twenty-seventh year in the Fairfax County, Virginia Public schools. She is the School Psychologist of the Year currently in a school system with more than 168,000 students. Ms. Gatlin earned an undergraduate degree in teaching and is certified in both elementary education and special education for the mentally retarded. She earned a Master of Arts in Education in Educational Psychology and an Educational Specialist (EdS) in School Psychology at Arizona State University. She completed both school and clinical internships and worked at the Tri-City Mental Health Clinic in Mesa, Arizona while pursuing her graduate degrees. She coauthored articles in the Journal of Psychology in the Schools and in the Journal of Educational and Psychological Measurement. Ms. Gatlin is a Nationally Certified School Psychologist and is a member of the National Association of School Psychologists and the American Association of Suicidology. She was chosen by the American Hospice Foundation to participate in the development of their self-study course, Grief at School: Addressing the Needs of Grieving Students. In her current position, as the school psychologist at the largest school in the state of Virginia, Ms. Gatlin is striving to develop a best practices model of school-based suicide prevention. She lectures in a variety of settings on topics which include adolescent depression and suicide, intentional self-injury, and support for grieving students. Ms. Gatlin is working on a task force with the Fairfax Partnership for Youth to increase youth suicide prevention efforts across Fairfax County. NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS 4340 East West Highway, Suite 402, Bethesda, MD 20814 Phone: (301) 657-0270 • Fax: (301) 657-0275

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TESTIMONY PRESENTED TO THE U.S. SENATE COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS SUBCOMMITTEE ON SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES Hearing on "Suicide Prevention and Youth: Saving Lives" Presented by: Fran M. Gatlin School Psychologist Robinson High School Fairfax, Virginia March 2, 2004 Good morning. Thank you, Chairman DeWine, Ranking Member Kennedy, and all the members of the subcommittee for hosting this hearing and giving me the opportunity to testify on this important issue. My name is Fran Gatlin. I have been a practicing school psychologist for more than 28 years. I am currently working at Robinson High School, in Fairfax County, Virginia, which serves more than 3,000 students. Professionally, I am a Nationally Certified School Psychologist and a member of the National Association of School Psychologists and the American Association of Suicidology. It is encouraging that I have been asked to share with you my role as a school-based mental health professional in the effort to help prevent suicide among our children and adolescents. I am fairly confident that my experience reflects that

of many of my colleagues across the country. The role of schools in the identification of student mental health needs, including the prevention of suicide, cannot be underestimated. Indeed, schools have been identified by almost every stakeholder as a critical component in an effective system of mental health care that also includes families, community services, and the medical profession. Why? Because virtually every community has a school, and most children and youth spend on average of six hours a day there under the care of familiar, trained professionals. We have the opportunity to observe students at risk, connect with them and their families, and get them the help they need. Equally important, we can create an environment in which students feel safe and able to seek help. We can use the learning environment to educate students and their parents about the signs and treatment of suicide risk and other mental health problems. And, as we are learning is so important, we can help students understand the vital role they play in preventing the suicide of a friend or classmate by telling an adult when they believe a peer is at risk. But we need the resources to do this important work.

Professionally, I became deeply concerned about suicide prevention over ten years ago. I noticed that students who made suicide attempts or had a psychiatric hospitalization had no diagnosis or treatment before that crisis. So I organized, advertised and offered panel discussions for parents on adolescent depression and suicide. No matter how I advertised these events there were never as many parents in attendance as panel members there to speak to them. I interpreted that outcome as reflecting parental denial that these were issues that could affect their families. This lack of awareness is a serious problem given the scope of the epidemic. Suicide is the third leading cause of death of students aged 10-18. It ranks second among college students. In my state of Virginia, the rate of suicide among high school age youth is approximately one per week. In the United States 30,000 people die of suicide each year. In the world, the suicide rate is approaching a million. As former Surgeon General, Dr. David Satcher said, suicide is the most preventable form of death, but it requires an investment to save lives. The public needs to be educated about suicide. People need to understand that most suicide results from untreated depression and that depression is a treatable illness. Surveys tell us that as many as one in five teenagers seriously considers suicide. 520,000 teenagers require medical services as a result of suicide attempts each year. The psychological pain implied in these numbers is sobering. The reasons for this pain are numerous and ultimately individual to each person. But current thinking is that among teenagers 85% to 90% have a mental health disorder at the time of the suicide while 10 to 15% die of an impulsive reaction to a painful event. The break-up of a relationship, a sense of deep humiliation or retribution when the teen feels wronged by another all can lead to an impulsive suicide death.

Talking with teens about the ambivalence of suicidal individuals may save lives. When they understand there are alternatives to ending psychological pain without ending their life, an unnecessary death may be prevented. Talking to students is a central part of any suicide prevention effort. I learned early on that, of adolescents who kill themselves, 80% tell someone before they die. But they are most likely to tell another adolescent, usually a friend, not their parents, and not someone who is likely to take action on their behalf. I began going into tenth grade health classes and teaching part of the unit that covers mental health, specifically adolescent depression and suicide. In addition to recognizing the signs of depression, my message to these teens is that they may be the only one who knows their friend is depressed and potentially suicidal. They may be the only person

who can seek help for their despairing friend and potentially save a life. I only later learned that this strategy is known as “peer gatekeeper training.” I also began offering a mental health support group within my school. This group is specifically for students who have had a psychiatric hospitalization or a suicide attempt. We know that the people at highest risk for a suicide attempt are those who have already made an attempt. Additionally, those with a psychiatric diagnosis, particularly a mood disorder, are at high risk. Such school-based support groups function both to provide services to students in need, but also to keep a watchful eye on the well-being of this vulnerable population. Three years ago I had so many students with this need that I formed two weekly sessions of the group to meet the demand. It is a group that is on-going and not time-limited. This means that I have students who enter as freshman and remain in the group until graduation if the need continues. I should also interject that this group has included a valedictorian, a recruit to a Big-Ten football program, and many bright, talented and ultimately successful individuals. You see, depression and suicidal feelings can affect anyone, and often disproportionately impact highly intelligent and creative people. The single largest cause of suicide is untreated or under-treated depression. I had been a volunteer screener in the community on national depression screening day for several years. When the Signs of Suicide (SOS) program became available at the high school level, I sought permission to begin depression screening at my school. We offer the screening on a voluntary basis, but require parental permission. We enlist students to make posters advertising the screening and a videotaped “commercial” that is played on the televised morning announcements in advance of the screening day. In this manner the message is from student to student, encouraging their peers to take advantage of the opportunity. In the four years we have been offering depression screening, well over a hundred students have been screened. One was immediately hospitalized and many have entered therapy. A particularly poignant situation was when a mother phoned after her daughter brought home the literature and permission form. She was skeptical and indicated she and her daughter had an exceptionally close relationship and good communication. She indicated she would know if her daughter were depressed. The mother agreed when I asked what she had to lose by signing the permission. The result was an indication of some very serious issues and her mother followed through immediately by seeking treatment. Six months later she emailed me with a lovely thank you message. She reported that the family had entered treatment together and in that time had resolved issues they had not previously recognized. She praised the depression screening as the event that brought her family the opportunity to grow closer and become stronger. As in this case, many times there is not a serious depression, but instead there are stresses and life events which are creating pain for the student. In these cases the depression screening is providing an outlet for expression of that pain so that help can be gotten. While the use of screenings and assessments are critical to this effort, they are only a first step. There must be an established system to address the needs of the students who screen positively for mental health service needs. Further, there must be prevention programs in place to catch many of the students who do not get screened. The support and infrastructure must be part of the school environment to ensure access to services and necessary follow-up. We also need to understand and eliminate the contributing factors to suicide. A significant factor in suicide attempts and deaths is the use of drugs and alcohol. Fifty percent of teens who die by suicide have significantly high blood alcohol

levels or blood chemistry levels at the time of their deaths. Simply stated, 50% of teens are drunk or high at the time of their deaths. The dis-inhibiting effects of the alcohol or drugs may be the dynamic which tips the scale toward death rather than life. Many times when I'm interviewing students at my school because of concerns about depression or suicide I ask if they have been thinking about suicide. The most common response I hear under those circumstances is: "Sure. Everybody does. But I wouldn't really do it." I believe those people are wrong on two counts: Not everyone considers suicide. Some people who are very depressed never consider suicide. Brain research will, no doubt, provide an answer some day why some people tend toward suicide and others never do, even under grim circumstances. But I believe that access to alcohol or drugs when an individual is feeling hopelessness and despair can lead to a fatal outcome. While they might not take action to commit suicide while sober, the substance abuse can mobilize them to take unfortunate action. The other factor that greatly impacts the outcome in these pivotal times is access to a lethal means. Specifically access to a firearm all too often results in the permanent solution to a temporary problem. Nearly two-thirds of adolescent suicide deaths happen by firearm, just as in the adult population. Study after study in the United States and elsewhere indicate that restriction of access to lethal means saves lives. When blocked from following through on a plan, frequently the chain of events is interrupted. The person lives. On a side-note, I would like to thank you, Chairman DeWine, Senator Kennedy, Senator Reed and other members of the Subcommittee for supporting S.1807 to close the gun show loophole and, hopefully, prevent juveniles from buying firearms at gun shows. Suicide also leaves a legacy of suicide. The immediate family and closest friends of a suicide victim are at eight times greater risk for suicide themselves. Schools can help minimize this risk. Five years ago, the year began at my school with the suicide deaths of two students in a three-week period. These events prompted my school to ask the executive director of the American Association of Suicidology to educate us further to ensure we were doing everything possible to prevent another student death. My commitment to suicide prevention was increased further in hearing Dr. Lanny Berman speak. I offered a support group to the students who were friends of deceased. This was a powerful and productive experience—several of these students had found phone messages or email messages from their friend that left them devastated that they had not received them in time to reach out and help. For all of them the loss was excruciating and powerful. But helping these teens deal with the death and understand it as an unfortunate choice will hopefully keep them from ever making that choice. It was reassuring and rewarding to see them reach a point of being able to return to fond memories from the life of their friend instead of remaining stuck in the horror of an unnecessary death. Teens looking forward to graduation and meeting the next phase in their lives have reflected, "I can't believe that two years ago my brain was telling me to kill myself." In the middle of a serious depression the individual is overwhelmed with a sense of hopelessness and the belief that it won't ever get better. But rational thinking helps us to see that usually things do get better. The depression lifts, a new friend comes along, a new opportunity emerges and hope and happiness are restored. During a serious depression, the thinking is not rational. People whose thinking is flawed by the overwhelming gloom of depression are often reliant on family and friends to get them the help they need to survive to see a better day. Schools can play a critical role, as well. Teens do not generally have independent access to mental health services.

Increasing access to school-based mental health services is vital to our efforts to improve suicide prevention. Students need to have someone who is visible and in a familiar setting to feel comfortable in seeking help. Still, even if there are mental health professionals working in their school, many teens are unaware. One of the benefits of my peer gatekeeper training is that all of the students learn I am available to them. I see a great number of students who ask for my support and have also had good success in getting them into treatment. However, as the National Institute of Mental Health (NIMH) indicates, of some 7.5 million children under the age of 18 requiring mental health services, only one in five children receive needed services. This statistic not only has alarming implications for suicide rates but also for other dangerous risk behaviors. We are seeing an increasing number of students engaging in intentional self-injury and substance abuse. The use of alcohol and other drugs to self-medicate mood disorders is common. I believe there is a general lack of awareness that substance abuse may not be the result of simply partying, but instead reflect self-medication of depression. It would be far simpler to treat a mood disorder than to break the cycle of substance abuse and relapse when an individual is struggling with an underlying depression. I believe that any efforts to ensure that our schools are safe and drug-free, must also include school-based mental health services to address the great need of these students. Although the No Child Left Behind Act includes mental health services as an allowable use of funds under the Safe and Drug Free Schools Program, there is tough competition for these limited funds and such services are frequently not offered. Support for mental health programs needs to come from the top levels of federal, state and local education policy leaders. I am hopeful that my school can help me collect data on the effectiveness of these efforts with our students. Since it is not possible to measure suicides that don't happen, my hope is that research would show that the peer gatekeeper training and exposure to advertising for depression screening affect the student's attitudes toward help-seeking. My hope is that research would indicate what I observe anecdotally: students who have been exposed to these programs are more likely to tell an adult if they are depressed or suicidal or if they are concerned about a friend. I have seen an increase in students who tell the adults at school. For example, a boy went to his guidance counselor and said he should go to John Doe's web page and see what was posted. The result is that John Doe is now in a partial hospitalization program. His parents are very grateful to know that he was planning a suicide before it occurred. In the most dramatic episode, a student called 911 and revealed a suicide plan in progress by his friend. The police department utilized heat-sensing technology in a helicopter to locate a warm spot in the woods. Police officers went in and found the boy unconscious on a winter night after he had consumed alcohol and injected himself with morphine. Our teens are finding more serious and frightening ways to act out their psychological pain. As professionals, we are better positioned and trained to help as well. Six years ago I transported a senior in high school to an emergency mental health service after her legal guardian refused. She had let me know she was having suicidal thoughts. The psychiatrist diagnosed depression and prescribed an antidepressant medication. The community mental health clinic provided therapy based on her individual capacity to pay. This past December she graduated with a master's degree in clinical psychology—also with no financial support from her family. The President's New Freedom Commission on Mental Health report, *Achieving the Promise: Transforming Mental Health Care in America*, indicates the need for schools to

play a crucial role in identifying students in need of mental health treatment as well as linking them to services. The Commission specifically recommends that:

- Schools work with parents and local agencies to support screening, assessment, and early intervention;
- Mental health services become part of all school health centers;
- School-based mental health services be federally funded;
- Empirically supported approaches be used for prevention and early intervention; and
- State-level structures for school-based mental health services be created to provide consistent leadership and collaboration between education, general health, and mental health systems.

I am in whole-hearted agreement. Our linkages between school and community-based services need to be enhanced. The health and well-being of our next generations depend on our capacity provide effective suicide prevention education and services. Thank you for the opportunity to address this panel. I look forward to hearing more from the Subcommittee on the issue of suicide prevention and hope you can include support for more school-based mental health and prevention programs in future legislation.

Appendix Extracted from the general literature by Fran Gatlin Principles for talking with teens about suicide

- Talk about suicide should focus on the data that the vast majority of suicide deaths are completed by individuals with a diagnosable mental illness.
- The majority of individuals who die by suicide are depressed or have bipolar illness (formerly known as manic depression).
- Depression is a treatable illness.
- A suicide attempt frequently is accompanied by significant feelings of ambivalence. The person doesn't necessarily want to die; but doesn't see an alternative for ending the psychological pain he is feeling.
- A teen may be the only person who knows a friend is depressed or potentially suicidal. The majority of teens who tell someone they are contemplating suicide, tell a peer.
- Telling an adult is not "ratting" on a friend, it is help-seeking.
- Use of alcohol or illegal drugs is a dangerous dynamic, particularly when a teen is depressed. It could be the factor that mobilizes a teen to commit suicide.
- Access to lethal means, such as firearms, increases the chance of a fatal outcome. Restriction of means saves lives.
- Suicide, which is the third-leading cause of death among teens, is a preventable form of death.
- Suicide leaves a legacy of suicide. It puts the family and closest friends at eight times greater risk for suicide themselves.
- Pair any discussion about suicide with information about who to see to seek help.

Things to avoid in talking with teens about suicide

- Talking about specific means of suicide should be avoided when possible. It sometimes plants an idea.
- Avoid romanticizing the topic in any way possible. Framing it as resulting from mental illness or making an unfortunate choice is safer.
- Avoid videos, particularly those which use attractive teens who talk about surviving a previous attempt. This may plant the idea they too will survive and be a "hero" or a "legend" with their peers.