

# MENTAL HEALTH NEWS™

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FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE

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## Understanding and Coping With Suicide

### Teen Suicide in Nassau County New York: Lifesaving Resources

By Julie Weiser, MD, MPH  
Patricia Fulton, RN, CASAC  
and Paula Pontrelli, BS ED, CPP

The Nassau County Child Fatality Review Team (NCCFRT) is a multidisciplinary team that has functioned as a NYS approved child fatality review team as provided in Social Services Law (SSL) §422-b working under the supervision of the Office of Children and Family Services (OCFS) since December 2008. The team was created to review fatalities of Nassau County residents age 0-17 years who die in Nassau County and whose death is otherwise unexpected or unexplained to better understand the causes of these deaths and to make recommendations based on the team's findings in order to reduce future child fatalities. The NCCFRT meetings are confidential and closed to the public.

The NCCFRT would like to share information obtained from the case reviews on teen suicide. NCCFRT reviewed eight



suicide cases that occurred to Nassau County residents between 2008 and 2011. The victims were between the ages of 12

and 17 years of age, and: 4 victims were male; 4 were female; 5 of the victims had a history of mental illness; 4 victims had a

history of mental health treatment; 4 victims had a recent relationship loss or conflict; 2 had academic problems; 3 had a history of drug use; 4 had a positive toxicology for alcohol or drugs at death; 1 had a criminal or juvenile record; and 4 had prior suicide attempts.

The National Institute of Mental Health (NIMH) estimates that about 15% of adolescents in grades 9 to 12 seriously consider suicide in a given year. Nationally suicide is the third leading cause of death in both the 15 to 24 and the 10 to 14 year age groups. According to NIMH, there is reliable scientific evidence that the strongest risk factors for attempted suicide in youth are depression, substance abuse and aggressive or disruptive behaviors. In addition, the Centers for Disease Control (CDC) reports that males are four times more likely to die from suicide than females. Females, however, are more likely to attempt suicide than are males.

*see Teen Suicide on page 29*

### Understanding Suicide in New York City: The Scope of the Problem and Opportunities for Prevention

By Jennifer Marcum, DrPH  
Dilruba Khanam, BA  
Catherine Stayton, DrPH, MPH  
and Kate McDonald, DrPH

In the past two decades, New York City has seen a decline in overall suicide rates.<sup>1</sup> The Department of Health and Mental Hygiene (DOHMH) recently announced that the suicide rate in NYC is approximately half that of the national suicide rate.<sup>1</sup> Yet, the actual number of suicides is high: approximately 475 New Yorkers commit suicide annually—about nine a week.<sup>1</sup>

In order to better understand suicide risks and design prevention strategies, DOHMH conducts public health surveillance of suicide. Public health surveillance is the ongoing collection and analysis of data for the purposes of monitoring the health of a community and identifying high risk groups. Surveillance activities at DOHMH are diverse,

and include everything from tracking disease outbreaks to conducting annual community health surveys. Surveillance activities around suicide are a priority at DOHMH. Specific surveillance efforts include monitoring rates of suicide based on death records and reviewing records from the NYC Office of the Chief Medical Examiner. These activities provide the information DOHMH needs to understand the circumstances and risk factors related to suicide deaths, identify those populations at greatest risk, and plan prevention efforts.

As is the case nationally, in New York City suicide rates are lowest among young adults, black and Hispanic New Yorkers, and highest among white New Yorkers and men. Approximately three quarters of New York City's suicides in 2007 and 2008 were committed by men.<sup>1</sup> The most common method of suicide in NYC is by hanging, accounting for 28% of all suicides, followed by jumping from high buildings (18%).

Suicide can be prevented. Preventing the tragedy of suicide should involve a multi-pronged approach, including clinical, environmental, and community approaches. Clinical approaches aimed at identifying and treating depression and substance abuse are an important part of a comprehensive suicide prevention strategy. According to a recent review of the NYC medical examiner files, 64% of New Yorkers who had committed suicide had a documented history of depression.<sup>1</sup> Alcohol use is also frequent at the time of suicide.<sup>1</sup>

As part of the clinical approach to preventing suicide, DOHMH is working to increase depression screening, diagnosis and treatment. Through publications and health bulletins, the Health Department provides information and resources to help physicians and mental health professionals recognize and effectively treat mental illness. Physicians should routinely screen patients for depression using a simple 2-item tool called the Patient Health Questionnaire-2 (PHQ-2).

Environmental approaches are also effective at reducing the likelihood that certain methods of harming oneself are within reach. New York City has one of the strictest gun control policies in the nation, making it difficult for people to obtain and carry a gun. Although nationally, firearms account for more than half (53%) of all suicides, in NYC firearms are responsible for only 16% of suicides. The low suicide by firearm rate may be partially attributed to the City's enforcement of gun control laws.<sup>2</sup>

Although important suicide prevention strategies are already being implemented in NYC, there is still more work to do. Suicide prevention does not rest only with clinical and environmental strategies. We can all play a part in making sure our friends, family members, neighbors and co-workers are connected to the services and supports they need to live full, healthy lives.

*see New York City on page 28*

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## — From the Publisher —

# Surviving Suicide: All Things Must Pass\*

**By Ira H. Minot, LMSW**  
**Executive Director**  
**Mental Health News Education, Inc.**

**W**e all walk a very thin line in our lives—a line of normal feelings and behavior. At any moment we might fall off that line and descend into the darkness of mental illness. For people with mental illness, their families and loved ones, this concept is well known. Brain chemistry, genetics, or crises in our lives can throw us off that line and we can become seriously ill with depression, schizophrenia, bipolar disorder, or any number of other disorders.

This issue of *Mental Health News* looks at suicide. Suicide was seriously thought about by an estimated 8.3 million adults in the U.S. last year, according to the Centers for Disease Control and Prevention (CDC). For youth between the ages of 10 and 24, the CDC reports that suicide is the third leading cause of death—resulting in approximately 4,400 lives lost each year. There is no age, gender, or ethnic group that isn't affected by suicide in a profound way.



**Ira H. Minot, LMSW**

Years ago following college, I worked as mental health worker at an inpatient psychiatric hospital in New York. When a person was admitted into the hospital and was “suicidal,” they were automatically placed on “one-on-one” status. This meant that a member of the hospital staff

had to be “within arms reach” of the patient at all times. Even at night when the patients were all asleep, a staff member sat in a chair in the open doorway of the suicidal patient’s room ensuring their safety throughout the night. What might seem like going to extreme measures were actually life-saving in nature. Until the patient could be evaluated by the medical and support staff, and placed on a therapeutic regime of medication and daily activities, the safety-net that was placed around the suicidal patient allowed them to stay alive until enough time and the crisis they were in were able to pass.

Many years later, it turned out that I was the one in crisis. Through no fault of my own, I sank into the depths of a serious depression and even tried taking my own life on several occasions. I remember being so depressed and hopeless that my life lost all meaning and I believed that I was a horrible person who didn’t deserve to live. Thankfully for me I survived and eventually got the help I needed to recover. In the process I learned a great deal about mental health, recovery, and what is really important in life.

Probably the most troubling thing I learned was that anyone who is in the

midst of a crisis of any nature can suddenly choose to harm themselves in some form or another—even fatally. Often there are early warning signs which must be acted upon immediately.

Knowing how dangerous an emotional crisis like depression can be for someone, I must tell you this: If you are feeling hopeless right now and are having thoughts of suicide, understand that these thoughts are your illness talking and are not your fault. They will eventually pass if you can get professional help. You need to pick up the phone and call your doctor, the National Suicide Hotline 1-800-273-TALK (8255), a close friend or relation, or 911. Tell them you are in serious trouble and for them to bring you to your doctor’s office or a hospital where you can receive the help you need. No one should be left alone while having thoughts of suicide. If you feel suicidal, be honest about it, because your life depends on it.

All things will pass in time and with the right treatment. You must never give up fighting to get better. There is a caring mental health community nearby which can help you recover. It may take many tries to find the right treatment for you, as it did for me. (\*George Harrison, 1970)



Center for Rehabilitation and Recovery

### Fact Sheet

## What consumers need to know about Health Homes

March 2012

A Health Home is not a residence or a place. It is a group of organizations working closely together to provide physical health, mental health and addiction services. The Health Home will assign a Care Manager who brings together all of those services for you. Your Care Manager will speak with health plans, hospitals, and community-based programs to make sure you get the services you need to stay healthy, out of the emergency room (ER), and out of the hospital.

### FREQUENTLY ASKED QUESTIONS

#### Do I have to be in a Health Home?

No. You do not have to be in a Health Home. But we believe it will be very good for you to be part of a Health Home. The purpose of Health Homes is to bring all your services together. This should make it easier for you to get the care and services you need.

#### How can a Health Home help me?

Health Homes may lead you to many services that can help you improve your health and well-being:

- **Person-centered Planning:** Your Care Manager will work with you to create one plan of care that meets all YOUR physical, mental health, chemical dependency and social service needs.
- **Setting up & Reviewing Services:** Your Care Manager may help you get same day or next day doctor appointments. He or she will make sure you get the services you need to stay healthy.
- **Health Tips:** Your Care Manager may give you information to help you manage medical problems like diabetes, asthma, and high blood pressure. You may also receive support for weight loss, healthy eating, exercise, and smoking cessation.
- **Follow-up Care:** If you need to be hospitalized, your Care Manager will help develop a plan in the hospital so that you can return to the community. After you return, your Care Manager will make sure you get follow-up care; for example, getting you medication and services.
- **Family Support Services:** If you want, your Care Manager can ask your trusted family members to help with planning or delivering your care. All communication with your family and other caregivers will be shared in a way that they can understand.

#### Do I have to use all these services?

No. You will only use the services that you need. Some people may need many services. Other people may only need a few services or may not need any services at all.

#### If I join a Health Home, can I still go to the same program that I use now?

In most cases you can still go to the same programs that you use now.

#### Can I still see my doctor or counselor even if they are not part of my Health Home?

In most cases you will be able to see the same doctors and counselors that you do now. Your doctors and counselors are most likely part of your Health Home.

#### Will a Health Home limit the number of visits I can have to see a doctor or counselor?

No. In fact, Health Homes may increase the number of visits you can have with a doctor or counselor. The reason is that extra visits may help you stay healthy and out of the hospital.

#### How do I join a Health Home?

You will be assigned to a Health Home based on your health needs and the doctors that you use. After you have been assigned to a Health Home, you must fill out and sign a Consent Form. Once you complete that form, you will be a member of the Health Home. There are no fees to join.

#### When will I be assigned to a Health Home?

You will get a letter that lets you know you have been assigned to a Health Home.

#### Why do I have to sign a Consent Form?

The Consent Form allows doctors, counselors and support staff in your Health Home to share information about your health. They will use the information to make sure that you get the right care at the right time. It is illegal for them to share your information with any person or organization outside of your Health Home.

#### When will a Care Manager contact me?

Once you sign the Consent Form and become a member of the Health Home, your Care Manager will contact you.

#### Can I switch Health Homes? If so, who can help me switch?

Yes, you can choose to switch Health Homes. Your Care Manager can help you.

#### I don't want to be in a Health Home. How can I get out of this program?

If you decide not to be in a Health Home, you must call your assigned Health Home. You should call them at the number on the letter.

### NEED HELP?

If you are a consumer and have questions or concerns about Health Homes, you may call:

**Helpline: 212-742-1600 ext. 204** at The Coalition of Behavioral Health Agencies  
 Open every Tuesdays & Thursdays from 1 to 4pm until August 30<sup>th</sup>, 2012

#### About the Center for Rehabilitation and Recovery

The Coalition's Center for Rehabilitation and Recovery is a division of The Coalition of Behavioral Health Agencies. The Center's mission is to increase service access and quality so more people can achieve the promise of recovery. The Center promotes system change by working to integrate best practices in person-centered care throughout the community behavioral health sector of New York City and surrounding areas. We foster change through expert training, organizational development consulting, information dissemination, and cross-systems collaboration. The Center is primarily funded by the New York State Office of Mental Health.

*This material is made possible by a generous grant from the van Ameringen Foundation.*

# Mental Health News Education, Inc. Welcomes New Board Members

Staff Writer  
Mental Health News

**M**ental Health News Education, Inc. (MHNE), publisher of *Mental Health News* and *Autism Spectrum News*, is pleased to announce the appointment of two new members of its Board of Directors. They are Mrs. Judith Omidvaran, representing the autism community, and Jonathan P. Edwards, LMSW, representing the consumer advocacy community.

According to Dr. Peter D. Beitchman, Chairman of the MHNE Board, "We are so pleased to have Judith and Jonathan join our Board of Directors. They both exemplify the outstanding qualities of leadership, commitment, and service to their respective communities that MHNE is devoted to through the educational missions of *Autism Spectrum News* and *Mental Health News*."

Judith Omidvaran

Judith Omidvaran is a parent advocate and leader of the autism community in New York State and across the United States. As a parent of a child with Autism, Mrs. Omidvaran was the inspiration behind *Mental Health News* devoting its entire summer 2006 issue to the theme, "Understanding and Treating Autism Spectrum Disorders." That summer issue was so well received by the autism community that it led to the creation of *Autism Spectrum News* which premiered in the fall of 2008. Judy was also instrumental in introducing MHNE to many other outstanding leaders of the autism community, who now serve on the Editorial Board of *Autism Spectrum News*.

Judith Omidvaran attended the City University of New York and majored in accounting and business administration. Judy worked for 12 years as an Administrative Assistant for a non-profit organization. Her son, Sina Omidvaran was born in 1978, and in 1979 her second son, Shain Omidvaran was born. In 1981 Sina was diagnosed with a severe language delay and possibly autism.

"This is where my journey began into the world of autism. Sina was later diagnosed in Middle School with Asperger's Syndrome (later with High Functioning Autism). From the time Sina, was diagnosed with autism, I immersed myself into finding any type of information I could to best serve Sina's needs so that I



Judith Omidvaran

could "normalize" him as much as possible to help him to survive in the world. I set out to educate my son in order to increase his language and social skills, towards making Sina as independent as possible in order for him to survive, in the future, without parents."

"During my travels into the world of autism, I realized I needed to acquire knowledge about coping with Sina's emotional and behavioral challenges and acquire support services and plan for his financial security. Therefore, my challenge was to locate any information I could find about the psychological/psychiatric treatment of autism and the social services delivery system in New York State; at that time not easily obtainable because there was no internet. I spent many hours in medical libraries and general libraries."

"In order to advocate for my son's needs and connect with other families faced with the same dilemmas as myself and my husband Fred, I joined a variety of parent support and advocacy groups. Also, I discovered various organizations/foundations that were beginning to either raise money for autism research or perform research. There were also many professional journals and conferences/symposiums that provided me with a clearer understanding of how very complicated the wide array of Autism Spectrum Disorders can be and an understanding of the various domains of symptoms that comprise the cluster of symptoms an autistic individual can experience. These symptoms are many and can include: physical disorders such as Epilepsy, gastrointestinal disorders,



Jonathan P. Edwards, LMSW

sensory disorders, movement disorders, fine/gross motor delays, co-morbid with psychiatric disorders including social disconnection, Obsessive Compulsive Disorder, Anxiety, Impulse control disorders, depression, PTSD, and intellectual impairments such as language impairments, lower capacity to acquire educational subjects, processing deficiencies, etc."

"In 2006, my good friend Bonnie Kaplan, also a parent with a son with Asperger's Syndrome, and myself established a support group to address the needs of Families of Adult Children with Asperger's Syndrome/High Functioning Autism. The support group still exists today with a membership of well over 200 people."

"On June 9, 2007, our son, Sina Omidvaran passed away from SUDEP – Sudden Unexplained Death by Epilepsy – a condition where the individual has a seizure and prevents the person from breathing and the heart from beating. On June 16, 2007 Sina was buried on the day that would have commemorated his 29th birthday."

"Since Sina passed away, I'm still very involved with the autism/epilepsy/mental health community, the support group and am attending many conferences/symposiums and fundraisers each year pertaining to my interests. The support group is still very active and I also co-facilitate the Westchester County Autism Advisory Committee and various subcommittees. I'm also grateful for being invited to serve on the Editorial Board for the *Autism Spectrum News* since its inception in 2008."

"I have received several awards from the Westchester County Department of Mental Health and the Arc of Westchester for the services I have performed for the Westchester County autism community."

Jonathan P. Edwards, LMSW

Jonathan P. Edwards, LMSW, is a leading figure in the consumer advocacy movement in New York State and across the nation. Mr. Edwards earned his Bachelor of Arts, Degree, graduating *Magna Cum Laude*, from City College of the City University of New York. He went on to earn his Master of Social Work Degree, graduating as *Valedictorian*, from Hunter College School of Social Work where he has recently been accepted into their Doctoral program. The focus of Jonathan's academic endeavors and work in the field has centered upon his deep interest in consumer advocacy, as well as research around recovery oriented care.

"For the past ten years, I have worked as a leader and change agent within behavioral health. In doing so, I developed and employed a range of skills to facilitate individual and system-wide change through project oversight, policy development, supervision, clinical practice, training, and personal experience."

"I have contributed to and played an integral role in educating consumers and training staff about recovery-oriented practice, and presented at conferences at the organizational, state, and national levels, on cultural competence, peer workforce development, and supervision."

"I am currently the Director of Peer Counseling and Assistant Director for Wellness and Recovery Services at Kings County Hospital, assuming administrative and clinical oversight for twenty one staff members. I am also a Continuing Education Instructor at Howie T. Harp Peer Advocacy Center in NYC, which provides peer advocacy training and coaching for individuals re-entering the workforce. I was recently invited to present on peer leadership in the traditional provider workforce, at the Consumer Leadership Forum sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), and co-presented on supervising peer counselors in behavioral health programs at the Seventh Annual International Interdisciplinary Conference on Clinical Supervision."

*Judith Omidvaran photo courtesy of and © Matt Greenslade - photo-nyc.com.*

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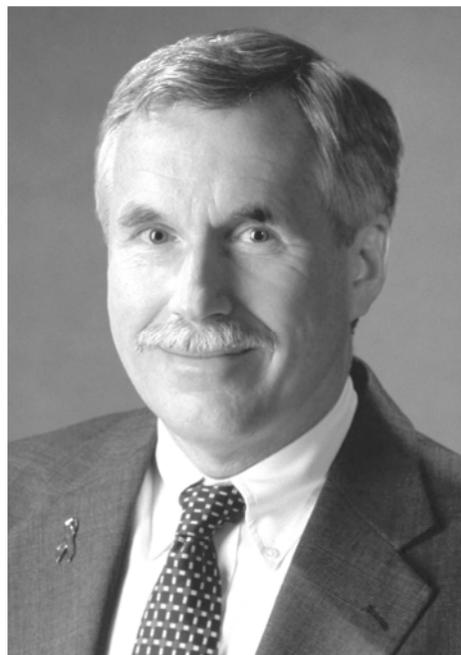
Use Samaritans hotline as a referral for those experiencing chronic mental or physical health problems or as a bridge providing ongoing support between appointments or while seeking care or treatment.

## National Action Alliance on Suicide Prevention Receives Suicide Care Report from Clinical Care and Intervention Task Force

Staff Writer  
Mental Health News

**M**ichael F. Hogan, PhD, Commissioner of the New York State Office of Mental Health co-chairs the Clinical Care and Intervention Task Force of the National Action Alliance on Suicide Prevention. In August of 2011 the Task Force completed a sweeping report entitled "Suicide Care in Systems Framework." Together with twenty eight leaders from across the nation, Dr. Hogan and the Task Force provide important new recommendations on suicide care.

According to Commissioner Hogan, "The National Action Alliance on Suicide Prevention was launched on World Suicide Prevention Day in September 2010 by Cabinet Secretaries Sibelius and Gates. It is an impressive array of public and private sector leaders committed to save lives; the co-chairs are (former) Sen. Gordon Smith and New York's own John McHugh, Secretary of the Army. I am honored to co-lead (with David Covington of Magellan) a high-energy Task Force on suicide prevention in clinical settings (health and behavioral health care). On studying the problem and what we have learned in the decade since publication of the first National Strategy on Suicide Pre-



Michael F. Hogan, PhD

vention, our Task Force came to a simple but profound conclusion: dramatically reducing suicides by an accretion of small steps (e.g. better training, screening or awareness) is almost impossible. Suicide takes place in desperate isolation, and reaching people through better small steps just won't do it. On the other hand, we now have breakthrough examples of how

organizations committed to save lives across entire populations they are responsible for, have done just that."

"The best known example is of course the well-studied commitment of the U.S Air Force Suicide Prevention Program. There clearly are examples in colleges and universities, like Cornell's thoughtful program. But we focused on examples in health care, including the Central Arizona Programmatic Suicide Deterrent System Project and the Henry Ford Health System (HFHS) "Perfect Depression Care" effort. We found that these systems adopted a systematic "do whatever it takes" approach. Top leadership made a commitment. Measurement and performance improvement were "baked into" the effort. And lives were unquestionably saved."

"We were especially inspired by what we learned about HFHS. Motivated to strive for "Six Sigma" or even perfect care for depression, the HFHS team came to decide that losing ONE LIFE to suicide is unacceptable. What more profound measure of good behavioral health care could there be? The HFHS leadership are aware that achieving ZERO SUICIDE might not yet be possible, but that's their goal. And they are committed to robust performance improvement, and a culture of safety that does not seek blame if problems occur. HFHS has now gone for over two years without a known suicide death

in their population under care."

"Our message in the Clinical Care Task Force Report is that piecemeal approaches are no longer enough. These might make the participants feel better, and we might even save a few people. But we now have the technology (from screening for risk, to evidence based treatments, to suicide awareness training, to performance improvement, to follow-up pioneered by the national Lifelines program run by the Mental Health Association of NYC) to begin to work toward ZERO SUICIDE. We are looking for health and behavioral health systems to join in this movement. We ask...how many deaths are acceptable, anyway?"

"We hope this summary of our work encourages you to work toward a commitment in your community or health care organization."

In each of the initiatives we studied, dramatic successes were achieved in reducing suicide attempts, deaths, and in reducing costs associated with unnecessary hospital and emergency department care. Most importantly, these initiatives have demonstrated the capacity to save lives. In reviewing these initiatives, the Task Force found three critical factors common to all that led to their remarkable successes.

*see Task Force on page 12*

## Suicide: More Common Than You Think More Preventable Than You Know!

By Brian Hart, LCSW-R,  
Director of Community Services  
Chemung County Department  
of Mental Hygiene

**J**ust how common is suicide you may ask? According to the latest available data from the Centers for Disease Control and Prevention:

- In 2007, there were 34,598 reported suicide deaths in the U.S.
- Suicide is the third leading cause of death for 15-24 year olds, and this age group accounts for 15% of all suicides nationally

Chemung County, New York in 2004-2005 was traumatized by an unthinkable reality – a cluster of teenage suicides that combined with several other incidents to rock the foundation of the rural community of approximately 85,000. The "suicide contagion" as officials referred to it, included suicides of four local middle and high school students, one teacher, and a physician, and was compounded by numerous other attempts and several other tragic student deaths by unknown causes.

In response to these devastating events, a Suicide Prevention Task Force was assembled with membership consisting of



law enforcement, mental health, school districts, and several human service organizations and youth. With the support of the County Executive's Office, protocols were developed and a Suicide Prevention Coordinator position was created to establish prevention and postvention services that included:

- Utilizing the Signs of Suicide (SOS) evidence-based prevention curriculum to help youth identify and act on

the symptoms of suicide culminating in SAMHSA's 2009 Science to Service award;

- Training key first-contact adults in the school and community to increase the chance that a crisis will be recognized and referred for timely intervention;
- Engaging local high school students in the use of Sources of Strength as a

peer led model that teaches students the importance of identifying natural supports;

- Using the SafeTALK and ASIST curricula, published by Livingworks Education, Inc., as mechanisms to move towards a suicide alert community;
- Partnering with law enforcement, school districts and national speakers to establish a coordinated mechanism for future community responses to attempts and completions;
- Putting assessment tools such as the PHQ-9 in the hands of primary care physicians;
- Collaborating with local school districts to put copies of a L. T. Kodzo's Locker 572 in the hands of staff and students alike to open the dialogue about the importance of being an active advocate for ending bullying and suicide; and
- Creating a community-wide "Walk a Mile in My Shoes" suicide prevention event to raise awareness and rally community support for those affected by suicide.

*see More Preventable on page 29*



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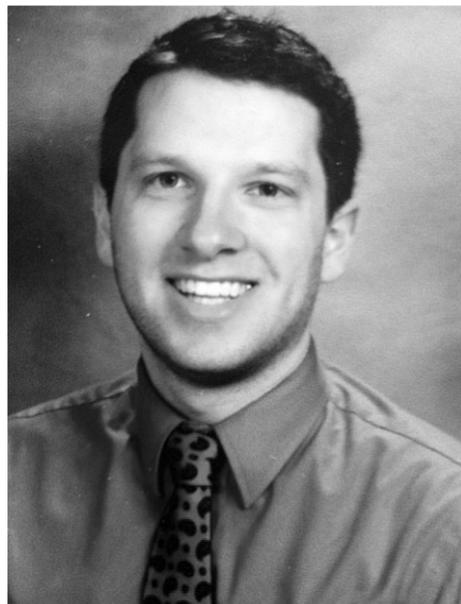
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## Recognizing Suicide Risk for Autism Spectrum Disorder

By Adam Goldberg, EdM  
School Psychologist  
Newmark High School

**A**utism Spectrum Disorder (ASD) encompasses five developmental disorders including Autistic Disorder, Asperger's syndrome, Pervasive Developmental disorder Not Otherwise Specified (PDD-NOS), Rett's Disorder, and Childhood Disintegrative Disorder (CDD). According to the National Institute of Mental Health (2011), symptoms of ASD generally fall into the areas of social impairment, communication difficulties, and repetitive and stereotyped behaviors. A person diagnosed with ASD faces a myriad of potential challenges that may increase his or her likelihood for anxiety and depression and ultimately, suicidal ideation. However, through understanding the early warning signs and employing effective intervention strategies for suicide risk for individuals with ASD, greater success can be achieved in preventing suicide in this population.

These developmental disorders greatly influence people's thinking, how they relate to certain situations, their work, and how they relate to others. Consequently, these factors may increase stress, difficulty with relationships, and difficulty managing emotions (Autism Speaks, 2010). People with ASD may also lack the appropriate skills for dealing with the problems they encounter. It is not uncommon for an individual to feel isolated and helpless as a result of these difficulties. A person with ASD may often express himself or herself in a way that is different than others around them. The school-aged ASD population often faces harsh criticism, intolerance, or abandonment as a result of their idiosyncrasies and unique



Adam Goldberg, EdM

and hyper focused interests. The National Autistic Society (NAS, 2012) explains that some people with Asperger's syndrome have difficulties with personal space when interacting with others. They have been accused of harassment in their attempts to socialize, adding to their depression and anxiety.

A 2001 NAS study in England revealed that 56% of its Autistic participants suffered with depression ([www.icare4autism.org](http://www.icare4autism.org), 2010). The diagnosis of depression depends primarily on people's verbal and communication skills in order for them to convey their depressive symptoms. Those with ASD may have high difficulty expressing themselves to others and being understood. Even in the higher-functioning group, expression of feelings and emotions such as sadness and hopelessness is challenging (Ghaziuddin et al., 2002). As a result, it is extremely important to be

aware of other signs of depression from someone with ASD. An increase in an obsessive or ritualistic behavior may signal the onset of depression. Additionally, a total loss of interest in the usual Autistic preoccupations may be an indication of depressive symptoms, as well (Ghaziuddin et al., 2002).

According to the International Center for Autism Research and Education (2010), suicide rates among those with Autism have skyrocketed. The suicide rate among people on the Autism spectrum is considerably higher than the suicide rates in the general United States population (Gaus, 2007). Children and teenagers with ASD can be susceptible to thoughts of suicide because of the challenges they face fitting in and interacting with their peers on a daily basis. Kim et al (2000) found that depression was more prevalent in children between the ages of 10 and 12 with Autism or Asperger's syndrome than in the general population of children of the same age. Bullying or constant feelings of failure may contribute to helplessness and depression. Suicide might present itself as an option to someone who believes he or she is faced with an unsolvable problem. According to Autism Speaks (2010), "The choice may appear preferable to circumstances such as enduring emotional distress or disorder, which the person may fear more than death."

The absence of the necessary skills to effectively communicate about their problems and emotions makes it difficult for those diagnosed with ASD to express their suicidal thoughts. According to Bonnie Sayers, editor of *Autism Spectrum Disorders* (2008), there are several suicide risk factors to look for with children and adolescents. These include: changes in personal hygiene, different sleeping patterns, a drastic change in clothing styles, eating less or more, verbal out-

bursts, losing or gaining weight, sleeping in class, not taking their prescribed medication, an increase in distractibility, grades plummeting, driving tickets, and the loss of interest in sports or hobbies that were once of major importance. Some may engage in self-harming behavior, make threats about committing suicide, or make statements similar to; "It would have been better if I had died" ([www.autism-help.org](http://www.autism-help.org), 2008). These are also common warning signs for both the neurotypical population and those with other mental illnesses. However, it is more crucial to actively search for these symptoms for those with ASD because of their great difficulty in self-awareness as well as advocating for themselves.

As a family member, friend, teacher, or mental health professional, it is important to remain hyper-vigilant in monitoring possible depressive feelings and thoughts of suicide in someone diagnosed with ASD. In a 2002 study of depression in persons with Autism, Ghaziuddin et al. concluded that it is important to maintain a high index of suspicion, especially when there is a history of a recent change in the level of functioning, particularly around puberty. It is also important to note that this population may utilize unconventional methods of suicide that may not be initially associated with intent. For example, youngsters may wander off into traffic or display head banging in an effort to end their life. If you suspect a high risk of suicide, immediate support includes medical or psychiatric treatment, hospitalization, psychological therapy, mental health case management, or linking into family and community organizations. Telephone counseling or moving the person to a less stressful environment are other options to alleviate the suicidal symptoms ([www.autism-help.org](http://www.autism-help.org), 2008).

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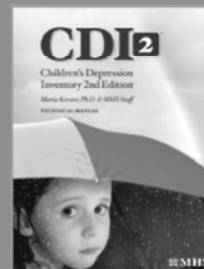
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## Working with Adolescents and Their Families In the Immediate Aftermath of a Suicide Attempt

By Regina Barros, LCSW  
Assistant Executive Director  
North Shore Child and Family  
Guidance Center

**T**error, anger, confusion, anxiety, and desperation are some of the feelings that family members express following a suicide attempt by a young adolescent. The mental health worker who has been working with the teen may be left to wonder - "What did I miss? What didn't I do? What didn't I see? What more could I have done?" The worker may have just seen the client in his or her office a day earlier when everything seemed like it was going well. It probably was going well.

A "normal" adolescent's feelings are often changing; there are shifts in mood and rapid transitions from impulse to action, without pause for reflection or time taken to consider consequences. The decision to act without thinking is similar to the process of relapse to drugs and alcohol. Suicidal attempts often occur when a quick answer or rapid resolution to feelings is not immediately available. The option to "end it all" in the snap of a finger can feel, momentarily, like a viable option; a quick solution to help one to "cope" with immense and intense feelings. The following practice examples illustrate different cases (names and other identifying information are disguised).



Regina Barros, LCSW

### What Happened?

A confused and distraught mother, Mrs. A., telephoned her family's therapist to report that her 14-year-old daughter, Carly, had attempted suicide the night before. Mrs. A.'s, in tears, says, "I was just beginning to trust her again, I thought things were getting better." "What hap-

pened?" asks the therapist who was in shock herself, thinking, "I just saw Carly and there were no signs of distress."

Mrs. A. noted, "She looked fine, I permitted her to go out with her friends to a party with adult supervision just like we discussed in our meetings. She came home after the party and looked a little upset. But, I didn't think much about it and so I went to bed. When I woke up, I discovered her lying on the living room floor. I thought that she had just fallen asleep. When I tried to wake her up, she appeared sluggish. I realized something wasn't right. She admitted to taking some pills she found in the bathroom. They were my pills. I called the police and they came and took her to the hospital." "How is she now?" the therapist asked, fearing the worst. "She is ok. The hospital is going to keep her." The therapist is extremely relieved, but is thinking to herself, "What happened? What did I miss?" Although Carly had a troubled history, including witnessing violence in the home, mother and daughter had been committed to learning how to recognize triggers and scenarios that could escalate to violent outbursts. So what happened?

### Living for the moment

Many teenagers live for the moment. They want to be with their friends to share their thoughts and feelings, the good and bad, the highs and lows. Teens who report

suicidal ideation may be suffering from depression and feelings of hopelessness or worthlessness. They may also be experiencing a wide range of emotions. When there is a history of trauma and violence in their lives, they are likely to have difficulty coping with conflict. When taking action to end one's life, a teenager may think that this is the only option he or she has to change things.

Nevertheless, the desired outcome for the distressed teenager may not be to die, but to find relief in the moment. From a counselor's logical perspective, it seems as if it would be simple enough to teach an adolescent client who fits this profile to understand that feelings change, and that if they can just learn how to "chill out" they can get past their intense bad feelings. But for some teenagers, like Carly, who was distressed and feeling intensely at the moment, it is a black-and-white, all-or-nothing-at-all proposition when it can feel like life and death are in the balance.

Carly originally came for counseling following a big blowup with her mother. The argument was over a relationship that her mother disapproved of and that Carly could only maintain by being deceptive. Carly's suicide attempt came in the aftermath of a fight with her boyfriend that fractured the relationship and left her feeling the pain of unbearable loss.

see *Aftermath* on page 25

## Suicide Attempts and the Family

By Ellen Russakoff, MSW, LSW  
Employee Assistance Professional

**A**s an EAP (Employee Assistance Professional) Counselor, one of the most difficult situations is calls from people whose loved one is suicidal. In this article "family" is construed as people who are involved and concerned.

Dealing with a loved one who is suicidal is one of the greatest challenges a person can face. One could divide the scenarios into four categories: A) those who are significantly depressed and one fears that they may be suicidal; B) people who talk about committing suicide or wanting to be dead; C) those who have just attempted suicide; and D) those who have recently made an attempt and are now in the recovery phase.

For scenario A, in which one fears that a person may be suicidal, there is fair consensus about what one should do: talk to the person. People often think of suicide as an option when they are feeling overwhelmed and helpless. There is no evidence that talking to a person about what they are feeling, including inquiring as to the presence of suicidal thinking, will cause suicidal thinking. The risk of triggering such a thought is much, much less than the risk of not addressing the con-

cern. One can approach the discussion by observing with the person that they seem to be feeling very badly. Regardless of what the person answers, because sometimes people are reluctant to share such feelings, one can follow up with a question such as 'do things seem so bad that you think you'd be better off dead?' The fact that someone reaches out to them may alleviate some of those feelings. Depending upon circumstances, simply acknowledging how difficult a situation is can validate their understanding and ease their distress. Alternatively, people typically feel suicidal when they see no options; discussion with another person may open new ways of thinking about things. One might suggest that the person seek professional help (if the person is not in treatment) or, if they are in treatment, contacting their current therapist for an earlier session. A person who acknowledges and articulates clear, current, suicidal intent should be referred for evaluation by a mental health professional.

In the scenario B in which a person is open about their suicidal thinking, the approach picks up with engaging the person. Because of the scariness for most people about suicide, in some circumstances the talk of suicide is off-putting. It is best to think of talk of suicide as a cry for help, even if the conversations don't feel that way. As noted above, people who

contemplate suicide often feel that there are no meaningful alternatives. Their thinking is constrained; they see few or no options. To the extent that the suicidal thinking is linked to what appears to be an overwhelming problem, then a more structured approach to problem-solving may be helpful. "Overwhelming problems" often can be divided into pieces, many of which may be subject to some solutions. There may be no one singular solution to the problem, thus the sense of being overwhelmed. One could help by analyzing the problem, dividing it into components, prioritizing the component parts and contemplating solutions to the parts may reduce the intensity of the suicidal thinking. While nothing that is said may alleviate his or her distress, often the demonstrated concern is helpful in itself - the person is not alone, "someone else sees possibilities even if I [the patient] don't." Other times, the suicidal thinking may emerge from serious depression, unrelated to life events. In this circumstance, treatment of the depression per se ought to mitigate the suicidal thinking. Here, involvement in professional treatment is critical, as depressions may last for months or more if untreated. None of the treatments for depression work immediately, so a person with serious depression and suicidal ideation needs to have a good alliance with their treatment professional(s).

Scenario C, where a person has just made an attempt, is even more complicated and stressful. Most people don't know what to do to help someone who has attempted suicide. In some cases, the suicide attempt may have been the first you knew that things had gotten so bad. A person who has made a suicide attempt should be evaluated by a mental health professional. The urgency for seeking such an evaluation is typically gauged by the severity of the intention, dangerousness of the attempt, and ability to make another attempt. If the attempt was potentially very dangerous or if there are significant medical consequences, then the person needs to go to an emergency room for immediate attention.

For those in scenario D where you have a loved one in recovery from a suicide attempt, many questions can run through your head. If I leave her alone for just a few minutes - will she try again? Do I need to commit him to keep him safe? Is she giving me signals that I do not understand? Was it my fault he tried to kill himself? A suicide attempt is never the start or the end of an emotional struggle. This goes for the person who makes the attempt, as well as those who love them. It's a frustrating, unpleasant, disheartening and helpless experience to

see *Family* on page 28



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## Saving Real Lives in Virtual Space: Innovative Suicide Prevention Solutions

**By John Draper, PhD, Vice President  
Crisis and Behavioral Health Technology  
and Lifeline Project Director  
Mental Health Association  
of New York City (MHA-NYC)**

The Facebook safety team sees messages like the following every day: “I’m goin to kill myself this is my last post ever ill will miss u all...”<sup>1</sup> Since there are more than 37,000 deaths by suicide every year,<sup>2</sup> and more than 50% of Americans have a Facebook profile,<sup>3</sup> it’s not surprising that people are expressing their feelings of hopeless and suicidal ideation on the world’s most popular social networking site. That’s one reason the National Suicide Prevention Lifeline began offering crisis services to Facebook users in suicidal crisis via chat.

Since 2006, the Lifeline has been working with Facebook to provide help to at-risk users, harnessing the power of social media to reach people where they are. The Mental Health Association of New York City (MHA-NYC) has been administrating the Lifeline project through our subsidiary, Link2Health Solutions, since 2004. The Lifeline is a nationwide network of more than 150 local crisis centers, including New York City’s LifeNet, providing telephone and online help, federally funded by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Although the Lifeline on average handles 70,000 calls per month, we heard from our Facebook fans and others that many people in crisis do not feel comfortable picking up the phone. Now there is a way for at-risk people to get the help they need the way they want it.

Initially, people who reported a friend’s troublesome content on Facebook would generate a message from Facebook encouraging the friend to call the Lifeline at 1-800-273-TALK (8255). The new service, which began in December 2011,



**John Draper, PhD**

enables friends using either the Report Suicidal Content link or the report links found throughout the site, to cause an email from Facebook that now also includes a link to begin a confidential chat session with a trained crisis counselor.

Unlike Facebook’s internal messaging service, users enter the Lifeline Facebook Chat through a link provided in e-mail and are then directed to a chat portal. Security and confidentiality of each chat is assured through the use of high encryption technology. Crisis center workers from two centers in the Lifeline network, the Boys Town National Hotline and Goodwill of the Finger Lakes’ 2-1-1/LIFE LINE, are available 24 hours a day, seven days a week to respond to Facebook users opting to use the chat.

For every person who dies by suicide, dozens of friends and family members are left behind; many often create memorial pages on Facebook to remember their loved one. Along with these pages, the profiles of people who have died by sui-

icide can do as much harm as good. Exposure to suicide, whether through a personal connection or through the media, is an established risk factor for suicide.<sup>4</sup> Researchers believe that messages that glamorize the death, or mention details regarding the method of suicide, can contribute to contagion.<sup>5</sup>

However, not all comments posted on memorial pages or profiles contain unsafe messages. “There is sometimes tension between the needs of bereaved people and the principles upon which we base some of our suicide prevention activities,” says Franklin Cook, a member of the Lifeline’s Consumer-Survivor Subcommittee. He notes that survivors of a person lost to suicide need a space to grieve. “Communication that mentions the circumstances of a person’s death, which might contain dangerous messages, is only one element of grief people share. They also make comments about their loneliness, memories, and financial problems,” he said. Just as you “wouldn’t host a support group on the sidewalk,” Franklin believes it is important to keep private conversations about grief protected from general public access. He is hopeful that private spaces on Facebook and elsewhere on the Internet can be maintained and monitored in a way that meets the needs of the bereaved, while at the same time protecting those who might be at risk of suicide.

When someone has died by suicide, the Lifeline suggests that a friend post a comment that states, “The best way to honor (person’s name) is to seek help if you or someone you know is struggling. If you’re feeling lost, desperate, or alone, please call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255). The call is free and confidential, and crisis workers are available 24/7 to assist you.”

In addition to Facebook, Lifeline advises the safety teams at Twitter, Tumblr, YouTube, and MySpace on best practices for getting crisis support to users thinking about suicide.

The Mental Health Association of New York City (MHA-NYC) has long used technology to expand the reach of our life-saving programs and services. From establishing partnerships with social media entities, to the adoption of web chat and SMS texting applications, MHA-NYC is pioneering ways to utilize new communication tools to further our message and help those with emotional challenges get the support they need.

Locally, LifeNet, New York City’s only accredited, multi-lingual, 24/7 crisis intervention hotline, has lead the way, integrating live chat and texting services to its roster of ways crisis counselors can speak with people about their emotional challenges and offer support.

MHA-NYC and Link2Health Solutions continually envision innovative ways to bring our expertise to people wherever they are. Across New York City, New York State, the country and virtual spaces everywhere, we work to ensure that people can get us when they need help.

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#### Task Force from page 6

- Core Values – the belief and commitment that suicide can be eliminated in a population under care (boundaried population), by improving service access and quality and through continuous improvement (rendering suicide a “never event” for these populations);
- Systems Management – taking systematic steps across systems of care to create a culture that no longer finds suicide acceptable, set aggressive but achievable goals to eliminate suicide attempts and deaths among members, and organize service delivery and support accordingly; and
- Evidence-Based Clinical Care Practice – delivered through the system of care with a focus on productive patient/staff interactions. These methods (e.g., standardized risk stratification, targeted evidence-based clinical interventions, accessibility, follow-up

and engagement and education of patients, families and health care professionals) achieve results.

Core Values: Beliefs and Attitudes  
The Foundation for Eliminating Suicide  
Deaths and Attempts

The Task Force has identified five critical elements that it believes are instrumental for public and behavioral health organizations to adopt and adapt in order to implement suicide prevention effectively.

1. Leadership leading to cultural transformation – Organizational leadership must articulate and infuse the fundamental tenet that a suicide event (attempt or death) is an unacceptable outcome of its care, and build a culture that strives to make suicide a “never event.”
2. Continuity of Care and Shared Service Responsibility – Caring for suicidal persons requires that the suicidal risk be ad-

ressed directly, not merely as a symptom of an underlying disease. That care will most likely require multiple levels of services in a team environment. Discharge decisions from one level of care (e.g., hospital care) must incorporate linkages to other necessary levels of care (e.g., intensive outpatient, private therapist, pharmacological therapy). Organizations must recognize, accept, and implement shared service responsibilities both among various clinical staff within the organization and among providers in the larger community.

3. Immediate Access to Care for All Persons in Suicidal Crisis – Because many persons seek care only when they are in crisis, behavioral health systems must provide 24-hour, 7-day a week availability to individuals trained in assessment, supportive counseling and intervention. Crisis hotlines, online crisis chat/intervention services, self-help tools, crisis outreach teams and other services can ensure that individuals can obtain help

when they need it – eliminating barriers related to cost, distance, and stigma.

4. Productive Interactions between Persons at Risk and Persons Providing Care – Positive health and behavioral health outcomes are partly dependent on a functional relationship between the person requiring help and the persons delivering help. This assistance should respect the cultural preferences and values of the individuals as much as possible. Trusting therapeutic alliances are fundamental to reducing suicide risk and promoting recovery and wellness. Such alliances are most productive when the care is collaborative, where the client is actively engaged in making choices that will keep him/her safe, and when the clinician feels confident that he/she has the training and skills to support the client’s safety and treat the suicide risk.

5. Evaluate Performance and Use for

*see Task Force on page 30*



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LifeNet is a program of MHA-NYC (Mental Health Association of New York City), a non-profit leader in behavioral health services. LifeNet is funded through contracts with the New York City Department of Health and Mental Hygiene and the New York State Office of Alcohol and Substance Abuse Services.

## — Point of View —

**Elder Suicide: A Public Health Challenge of the Elder Boom**

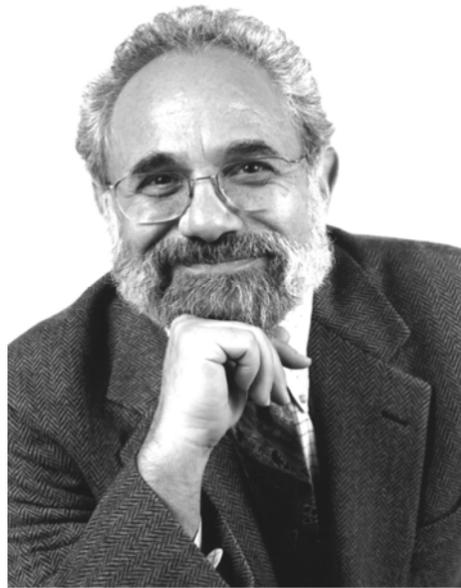
By Michael B. Friedman, LMSW  
Public Policy Advocate

**B**y the age of 88, Mr. W.\* had lost most of his closest friends to death or dementia. His children had moved to other parts of the country. He saw them and his grandchildren rarely. He had retired from his long career as a teacher without finding new interests. But he and his wife were happy. They both read a great deal, and every day they took a walk together, talked about books and the state of the world, stopped for happy hour at a local restaurant where “everyone knew their name.” When his wife developed lung cancer, he took her for treatment and nursed her at home. But her cancer was more virulent than most. She died quickly. The children came for the funeral and stayed a couple of weeks, but then they went back to their homes. He was alone, and he felt lost. He began to have bouts of dizziness and severe heart burn. He went to the doctor, who prescribed medications that helped a bit. One day after a doctor's visit he went home and took his own life.<sup>1</sup>

Nearly 15 older adults take their own lives every day in the U.S. -- about 5400 per year.<sup>2</sup> The frequency of suicide among older adults is not well-known, probably because older adults die from many other causes. Suicide is among the top three causes of death for teenagers and young adults; it is not among the top 20 causes of death for women over 65 and is only the 17th leading cause of death for older men. But the fact of the matter is that older adults complete suicide at a rate nearly 50 percent greater than people 15-24 years old. Older white men are particularly vulnerable, completing suicide at a rate three times that of the general population. White men over 85 are the population at highest risk; they take their own lives at about four times the rate of the general population.<sup>3</sup>

There are a number of striking facts about suicide among older adults.

- Older men are far more likely to take their own lives than older women, despite the fact that women are far more likely to have a major depressive disorder.<sup>4</sup>
- Most older adults who complete suicide have seen their primary care



**Michael B. Friedman, LMSW**

physician within 30 days of taking their own lives but have not been identified as a suicide risk.<sup>5</sup>

- Older adults may not attempt suicide more frequently than younger people, but their attempts are generally more lethal.<sup>6</sup>
- Men usually use guns to take their lives. Women usually take pills.<sup>7</sup>

Reducing suicide among older adults is an important public health imperative that will become even more important over the next two decades as the population of older adults booms.<sup>8</sup> But it will not be easy to achieve.

Frequently the onus is placed on primary care physicians because a majority of older adults who take their own lives have made a doctor's visit shortly before they choose to end their lives. And it is likely that if doctors screened for depression as a matter of course, asked more questions and explored what was going on in their patients' lives, they would identify more of their patients who are depressed and might be able to provide treatment that would avert suicide.<sup>9</sup>

But suicide risk is not easy to identify. Most people who are depressed are not going to kill themselves, some people who kill themselves are not depressed, and a great many people who do kill themselves hide their intention very effectively. Let me rush to say that some do not hide their intentions, and people who say they are considering suicide must be taken seriously.

There are other warning signs of suicide in addition to talking about suicide, including depression, substance abuse, history of suicide attempts, and more. For older adults, recent loss, severe physical illness, social disconnection or increased dependency and loss of dignity sometimes contribute to the decision to attempt suicide. For more warning signs visit NSPL at [www.suicidepreventionlifeline.org/GetHelp/SuicideWarningSigns.aspx](http://www.suicidepreventionlifeline.org/GetHelp/SuicideWarningSigns.aspx).

But most people who exhibit warning signs do not attempt suicide, and people like Mr. W., who are stoic by nature, keep their feelings to themselves and who have guns at home, are very hard to identify as suicide risks.

Yeates Conwell, perhaps the nation's leading expert on suicide among older adults, uses the interpersonal theory of suicide<sup>10</sup> to explain the complex factors that contribute to older adults' decisions to take their own lives. According to this theory the decision arises in large part from a mix of “thwarted belongingness” and “perceived burdensomeness.”

The implication of this theory is that prevention of suicide cannot be accomplished solely through improved identification of risk, timely intervention and access to help. These are important; but, in addition, older people need a place of belonging and a sense that becoming dependent does not mean becoming an intolerable burden.

That will be a tremendous challenge in our ageist society, which tends disparage age. Even in families who choose to be caregivers, older adults with disabilities are often not treated with enough dignity and respect.

In other contexts, the kind of societal change that is needed has been called building “age-friendly communities.”<sup>11,12</sup> It may well be that in the long run the public health challenge of elder suicide is more about building such communities than about traditional preventive interventions.

*Michael Friedman teaches at Columbia University. He is the co-founder and Honorary Chair of the Geriatric Mental Health Alliance of New York. He can be reached at [mf395@columbia.edu](mailto:mf395@columbia.edu). Mr. Friedman's article was originally published on The Huffington Post.*

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## — The NYSPA Report —

# The Need for an ‘Essential Health Benefits’ Federal Floor

By Julie A. Clements, JD, MPP  
Deputy Director of Regulatory Affairs  
American Psychiatric Association

Since the passage of the Affordable Care Act (ACA) in March 2010, health policy experts and health lawyers have been working around the clock to comprehend and respond to an unprecedented number of proposed and final regulations. Noticeably absent from a myriad of federal rules that have been issued are those setting forth a specific list of essential health benefits states must offer as part of the qualified health plans they sell within their health insurance exchanges. For almost two years, health care stakeholders have awaited the issuance of a rule expressing what benefits must comprise the essential health benefits of qualified health plans sold in states’ health insurance exchanges.

On December 16, 2011, the Secretary of HHS, devolved her authority under the ACA to decide what constitutes an “essential health benefit” to the individual states. While the ACA expressly requires each state’s essential health benefits packages to include ten categories of health care services, including treatment of mental health and substance use disorders, the Secretary’s decision to afford the states’ flexibility in deciding which among four type of health plans will serve as the plan to which the states will benchmark their essential health benefits provides the states great control over the design of the qualified health plans they will sell to consumers of their health care exchanges. Thus far, the Secretary’s decision to assign design of essential health benefits to the states, coupled with few federal guidelines, has engendered fear among many health policy experts that essential health benefits will vary greatly from state to state, thus undermining the non-discriminatory provisions of the ACA.

Understanding how the Secretary’s decision could result in the creation of numerous distinct essential health benefits packages requires understanding the interactions between state and federal laws which regulate the benefits included in the four types of insurance plans states may use to determine the “essential health benefits” they will offer as part of their qualified health plans. In a Bulletin issued on December 16, 2011, the Secretary permits states to determine the nature of their essential health benefits packages by selecting any one of the four following insurance plans as a benchmark plan for essential health benefits.

- the largest plan by enrollment in any of the three largest small group insurance products in the State’s small group market;
- any of the largest three State employee health benefit plans by enrollment;
- any of the largest three national FEHBP plan options by enrollment; or
- the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.



**Julie A. Clements, JD, MPP**

The Secretary proposes that the services offered in a state’s essential health benefits package be “substantially equal” to the services provided within one of these four types of health plans. The ACA expressly states that essential health benefits must encompass the ten categories of services identified in the ACA.<sup>1</sup> Additionally, the ACA expands application of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to the essential health benefits packages comprising qualified health plans sold in both the small group and individual health insurance markets.

The type of law governing the permitted essential health benefits benchmark plan types informs the benefits that must be offered should a particular plan be selected as the plan to which to base a state’s essential health benefits. Where a state chooses a benchmark plan regulated by state law, such as a state employee plan, except where exemptions apply, for years 2014 and 2015, the state-mandated benefits included within the “state regulated” benchmark plan can be rolled into the state’s essential health benefits package at no additional cost to the state. This is not the case where a state selects a non-state regulated plan as its essential health benefits benchmark plan and wishes to roll additional state-mandated benefits, not covered by the benchmark plan, into the state’s essential health benefits package. Section 1311(d)(3)(B) of the Affordable Care Act requires States to defray the costs of state-mandated benefits in excess of the states’ essential health benefits for individuals enrolled in any qualified health plan in either the individual market or the small group market.

Currently, there are more than 1,600 specific service and provider coverage requirements across the 50 states and the District of Columbia.<sup>2</sup> Several states have mental health parity mandates or mandates for coverage of autism. In today’s harsh economic environment, what is to encourage a state struggling to balance its budget to enact legislation that expands its

mandated benefits to include mental health parity or autism coverage? Where proposed federal guidance requires a state to assume the costs for any benefits offered in its essential health benefits package that exceed what’s offered in the state’s selected benchmark plan, a state may be enticed to abandon the enactment of additional state benefit mandates or rescind or eliminate current mandates. The most recent guidance on essential health benefits suggests any state-mandated benefits enacted after the December 2011 issuance of the Secretary’s Bulletin cannot be rolled into a state’s essential health benefits benchmark plan, absent the state being liable for additional costs arising from the additional coverage.

States have begun to inventory the health plan products sold within their states, so they can accurately identify the multiple health plans from which they can select a benchmark plan to which to peg their essential health benefits. Each state offers unique state-mandated benefits. To prevent the erosion or elimination of strong state benefit mandates, such as autism coverage mandates and mental health parity mandates, states with strong state-mandated benefits must be careful to select a benchmark plan which does not incentivize the reduction or elimination of coverage for mental health diagnoses.

The Secretary’s decision to assign design of essential health benefits packages to the individual states need not be a race to the bottom. Numerous advocates of mental health and substance use patients have asked federal regulators to consider establishing a national model of mental health/substance use disorder benefits that may serve as a floor for the package of mental health/substance use disorder services required to be offered within states’

essential health benefits. With the creation of a federal floor for mental health and substance use disorder benefits, Americans could benefit from knowing a certain minimum set of mental health diagnoses will be part of their insurance product.

The legislative intent of the ACA, which envisions eliminating discrimination against the insured as a result of their type of illness, is not violated if an individual state, complying with a federal floor on mental health coverage, opts to expand the mental health and substance use coverage offered within its essential health benefits. Each state should have the option to be innovative in its essential health benefits design; each state shall not have the option to be deficient in its essential health benefits design.

The final word is not out on state design of essential health benefits; we must encourage the Secretary to act in accordance with the non-discriminatory legislative intent of the ACA by setting a floor for what must be covered within a state’s mental health and substance use disorder services category of essential health benefits.

#### Footnotes

1. The ACA requires coverage of the following 10 health service areas: 1) ambulatory patient services, 2) emergency services, 3) hospitalization, 4) maternity and newborn care, 5) mental health and substance use disorder services, 6) prescription drugs, 7) rehabilitative and habilitative services and devices, 8) laboratory services, 9) preventive and wellness services and chronic disease management, and 10) pediatric services, including oral and vision care.

2. Of these 1,600 state mandates, about 1,150 are benefit mandates and 450 are provider mandates.



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## Predicting Suicide: Difficulties for Treatment Professionals

By Virginia L. Susman, MD  
Associate Medical Director  
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A widely quoted clinical aphorism is that there are two kinds of therapists: those who have experienced the loss of a patient to suicide, and those who haven't yet. Although the expression sounds a bit nihilistic, this adage conveys a warning to those clinicians who have not experienced a patient's suicide: *do not become overly confident in the ability to predict suicide*. In fact, predicting suicide is the most challenging situation for a mental health practitioner— not only because it is literally a matter of life and death, but also because even the most skilled and empathic of clinicians can never really know what lies in the heart and mind of a patient. Even when there is full and open communication between caregivers and patients, life events and irresistible impulses can occur that destabilize patients' emotional equilibrium and lead them to desperate acts.

Assessing someone's risk for suicide involves understanding the biological factors that contribute to risk such as the presence of medical or psychiatric conditions associated with higher rates of suicide; psychological risk factors including an individual's attitude about the future, religious beliefs and immediate emotional state; and social factors such as whether or not the person has available and supportive networks of friends and family. Familiarity with all the clinical and personal factors that need to be considered when attempting to predict suicide is an essential first step, and a great deal of research has been done which sheds light on the contributions of these factors.

In the United States, someone dies by suicide every 15 minutes and suicide is the tenth leading cause of death. Despite widespread efforts at public and professional education and at reducing the stigma of mental illness, the U.S. suicide rate has been increasing over the last 15 years. Approximately 90% of persons who die by suicide have diagnosable mental disorders; 60% of elderly suicide victims have consulted with a primary care practitioner in the months preceding their death. Given this knowledge, how does this serious public mental health crisis continue to grow?

Unfortunately, predicting suicide is an extraordinarily difficult challenge. We know a great deal about actuarial risk - persons who are at risk due to demographic, historical and clinical factors. We also know a fair amount about times of



Virginia L. Susman, MD

high risk for suicide, specifically times of loss and times of transition. However, we have much less knowledge about, and therefore a rather limited ability to predict, short term risk. Compounding this limitation, is the good and bad news that among all those persons at risk, and despite the fact that suicide is the tenth most common cause of death, the actual rate of suicide is "only" 12/100,000 (Centers for Disease Control and Prevention, 2009 data). Consequently, it is very difficult to predict who will actually attempt suicide in the near term from among those experiencing a dangerous combination of risk factors.

What can be done by a clinician trying to help individual patients in emotional pain and at risk for suicide? Clinicians must stay up to date with scientific knowledge and evidence-based practices. Most practitioners know that older white men, especially those with co-morbid substance abuse or medical illness, have the highest rate of suicide. But are we up to date with emerging information about the significant increases in suicide rates among both middle aged men and women? And are we aware that women, who continue to make three times as many attempts as men but whose attempts are less likely to be lethal, are increasingly using dangerous means of suicide, including using more firearms? Staying current with the scientific literature is a daunting task, but in this internet age and thanks to organizations like the American Foundation for Suicide Prevention ([www.afsp.org](http://www.afsp.org), an organization dedicated to supporting research, disseminating information and providing support to the survivors of suicide), lay persons and professionals can easily update their knowledge and access valuable resources. It is also incumbent on practitioners to be aware that the internet provides detailed information on how to

commit suicide, making it all the more important that we ask our patients what they are studying and what means they have considered.

Clinicians must also do everything in their power to truly understand and foster meaningful connections with the individuals in their care. Although this sounds obvious and simplistic, our health care system does not treat it as obvious, and therefore it is not at all simple. Brief evaluations, over-reliance on patients' self reports, short follow-up appointments, and patients seeing many different providers who themselves may not be systematically passing along critical data at each "hand-off", undermine the essential emotional bond between caregiver and patient, which is the cornerstone of a mutual and trusting relationship. Persons considering suicide often have lost hope and any ability to see a positive future for themselves; sometimes knowing that a concerned and involved caregiver believes there might indeed be relief and hope can be lifesaving. Where in our contemporary mental health system, which treats therapy like a commodity to be sought by "consumers", is there recognition of the value of a genuine and enduring human connection between healer and those in need of healing? These comments have a tinge of the polemical about them, but are intended to draw attention to some serious science.

In a perfect world, an established and enduring relationship between caregiver and patient would help prevent suicide because each would know the other well enough for the caregiver to recognize subtle clinical changes in his or her patient, and for the patient to comfortably confide thoughts and impulses deemed unacceptable, even unspeakable, anywhere else. Such relationships are increasingly rare in today's healthcare system. However, clinicians can inform themselves about evidence-based methodologies for effective communication with persons who may be thinking of ending their own lives. Communicating with persons who are contemplating suicide or who may have already decided to do so, requires time, patience, understanding and the sophistication to not take "No, I won't" for an answer. In 1998, Shea outlined the Chronological Assessment of Suicide Events (CASE), an invaluable method of inquiry which systematically elicits a patient's history, critical attitudes, and beliefs. Employing such an approach could help any caregiver save someone's life. This approach can be used during a psychotherapy session in a practitioner's private office or while in an intense emergency room. It proceeds through a sequential exploration of a patient's current suicidal behaviors and ideas, then on to a review of recently occurring ones. Next, it examines more distant past actions and ideas and concludes with a discussion of future or anticipated

ones. Complemented by using techniques such as Pomeroy and colleagues' idea of "gentle assumption," wherein the clinician acts as though he or she just presumes that problematic or dangerous behaviors have occurred, and Shea's own notion that a patient's "denial of the specific" should not dissuade the interviewer from empathically probing for more detail on similar or related behaviors and beliefs, CASE provides a schema for connecting with the individual in distress and collecting thorough and critical data.

The opinions and observations of other caregivers and patients' loved ones are critical sources of information. Clinicians may hesitate to aggressively pursue these sources for fear of breaching confidentiality. Asking a patient's other caregivers for relevant information and asking a patient's friends and family about unusual, erratic or dangerous behaviors can be crucial interventions. There may be times when disclosing professional concerns about a change in a patient's presentation may be warranted. While it is a core principle of our professional work to faithfully maintain a patient's confidentiality, "first, do no harm" is also a core principle. Sometimes safety does trump privacy. Clinicians may want to seek consultation or peer supervision when uncertain how to navigate complex ethical matters and contradictory expectations. Many clinicians outline confidentiality boundaries early on in treatment by anticipating with their patients those clinical circumstances which might require a recalibration of the delicate balance between confidentiality and safety.

Lastly, a word about the utility of conducting formal suicide risk assessments. In his 2011 book, *Preventing Patient Suicide*, Simon repeated his caution that "suicide risk assessment is a process, not an event." Over the last thirty years, a variety of scales have been devised to assess suicide risk. No single one has been widely adopted, and all share the limitation of capturing only a snapshot in time of interacting risk and protective factors. Nonetheless, these scales can serve as organizing templates, checklists, and adjuncts to clinical evaluations. Perhaps the most compelling and multi-dimensional of these instruments is the Columbia-Suicide Severity Rating Scale. The Columbia scale examines four discrete aspects of suicidality: severity of ideation, the intensity of ideation, actual suicidal behaviors, and the lethality of the behaviors.

In summary, predicting suicide is almost as difficult as it is important. Much is known, and even more remains to be learned. The current rate of suicide poses a major public mental health challenge. We have a collective responsibility to our patients and to our professions to do all that we can to advance the study and prevention of suicide.

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## Homeless and At Risk to Receive Critical Medical and Diagnostic Care At ICL's New Healthcare Choices Clinic in Queens

Staff Writer  
Mental Health News

ICL Borden Avenue Veterans Residence is making significant strides in reintegrating homeless veterans into NYC communities. The latest advance -- the opening of a much needed HealthCare Choices clinic adjacent to the shelter -- will assist homeless veterans, as well as immigrants, elders and other underserved populations in the community. A February ribbon-cutting ceremony celebrated the clinic's debut.

"The easier we can make access to health care, the more lives will be saved. Right now, homeless people and underinsured New Yorkers are much less likely to find critical and necessary health care because of disabilities, immigrant status and/or poverty," explains Dr. Peter C. Campanelli, CEO and President, Institute for Community Living (the founding agency of HCC). He continues, "Not only will HealthCare Choices treat patients' medical needs, it will also provide psychiatric and dental services -- a model integration of services that is vital when working with the homeless."

Through a HEAL award from the New York State Department of Health, the Brooklyn-based, award-winning HealthCare Choices is opening a satellite site in Queens. HealthCare Choices at ICL Borden Avenue will provide accessible, integrated outpatient services to approximately 3,200 adult patients annually to underserved populations with a special emphasis on those who are homeless, have behavioral disorders and other special populations, as well as to elderly and immigrant residents liv-



Dr. Peter C. Campanelli

ing in the community. Services offered will include ambulatory primary and specialty medical, dental, psychiatric, physical therapy and podiatry. To meet the need for an urgent care alternative to emergency rooms for issues that can be safely addressed within a clinic setting, HealthCare Choices at ICL Borden Avenue will offer walk in and next day appointments.

In order to identify and engage prospective homeless clients, ICL will rely on referrals from within its own agency as well as the DHS shelters and from agencies such as Common Ground, one of the largest developers and managers of supportive housing in the nation. Common Ground also operates, under contract with

DHS, outreach programs that target people living on the streets in parts of Manhattan and all of Brooklyn and Queens.

HealthCare Choices is a pioneer in providing integrated health and mental health care to New Yorkers who are homeless and have special needs.

A Federally Qualified Health Center, Brooklyn's HealthCare Choices (HCC) is recognized by the National Committee for Quality Assurance as a Level-3 Patient-Centered Medical Home. It uses a state-of-the-art electronic practice management system and is part of the Brooklyn Health Information Exchange that facilitates electronic sharing of medical information among providers and the clients themselves.

The multilingual doctors and staff at HCC specialize in Primary Medical Services, Gynecology, Dental Care, Psychiatry, Psychological Testing, Neurology, Gastroenterology, Physical Therapy, Podiatry, Pulmonology and Cardiology. The Brooklyn clinic also offers wellness programs, which include: a Wellness Center that offers exercise and education; a pioneering diabetes self-management program; hypertension and smoking cessation education; exercise and weight management services and healthy eating workshops and education.

HCC is known for its strong partnership cultivated between the patients, their personal physicians and when appropriate, family members of the patient. As a Medical Home, HCC improves health outcomes through better coordination and integration of patient care for persons enrolled in Medicaid throughout the state. Its electronic practice management system allows for ease of managing patient records, prescribing medications directly to

the pharmacy, track and schedule patients for medical appointments and monitor specific clinical conditions that impact the patients at the clinic. Future initiatives will allow patients to receive services and be monitored across multiple health care providers and institutions. *For more information about HealthCare Choices, please call 718-234-0073.*

ICL Borden Avenue is a transitional residential program located in Long Island City, Queens, for 243 homeless male and female veterans. Residents benefit from an unprecedented collaboration between the New York City Department of Homeless Services, the local and national offices of the US Department of Veterans Affairs (VA) and the Institute for Community Living (ICL) that provides a multi-faceted service system tailored to meet their unique needs. The program:

- restores a sense of pride and purpose to the veterans;
- assists them to develop the skills needed to live independently;
- facilitates their transition to more independent and permanent housing in the community of their choice; and
- encourages them to take active roles in society.

Each veteran is provided with case management and help securing entitlements such as VA benefits that enable them to access supportive housing.

The Institute for Community Living (ICL), begun in 1986, operates ICL Borden Avenue Residences and is the founding

*see ICL Healthcare on page 28*

## Dr. Campanelli to Retire Next June: Search for New CEO Underway

Staff Writer  
Mental Health News

Mrs. Barbara Sass, Chairperson, Institute for Community Living (ICL) Board of Directors, announced today the impending retirement of Dr. Peter C. Campanelli. Dr. Campanelli will be completing a 27-year tenure as the President and Chief Executive Officer from the not-for-profit agency he founded in 1986. ICL is now one of the largest behavioral health agencies in the country and is renowned for its integrated health approaches and programs helping individuals and families with psychiatric, intellectual and/or developmental disabilities. Dr. Campanelli will continue to serve in his current capacity until June 2013 while the Board conducts a nationwide search. Information regarding the actual search process will be shared in a later public statement.

Mrs. Sass acknowledges the enormous value and capacity Dr. Campanelli has

brought to ICL and its development over the last 27 years. "It is without question that Dr. Campanelli's exceptional dedication and visionary leadership have led ICL to become one of the largest, most well-respected, not-for-profit providers of community-based behavioral healthcare in New York City -- and in the country." She continues, "Over the past five years, Dr. Campanelli has been working with the board on succession plans for all levels of the agency to ensure continuity of leadership. The Board joins me in wishing Dr. Campanelli a good and well deserved retirement."

From its operational roots housed in a refurbished garage in Brooklyn to an agency that today provides over \$110,000,000 in service annually to a population that is often relegated to benign indifference, the Institute for Community Living continues to help those who are mentally ill, substance abuse involved and homeless, many of whom suffer from chronic comorbid medical conditions that considerably shorten both the length and quality of their lives. At its core, the mission of ICL has always been

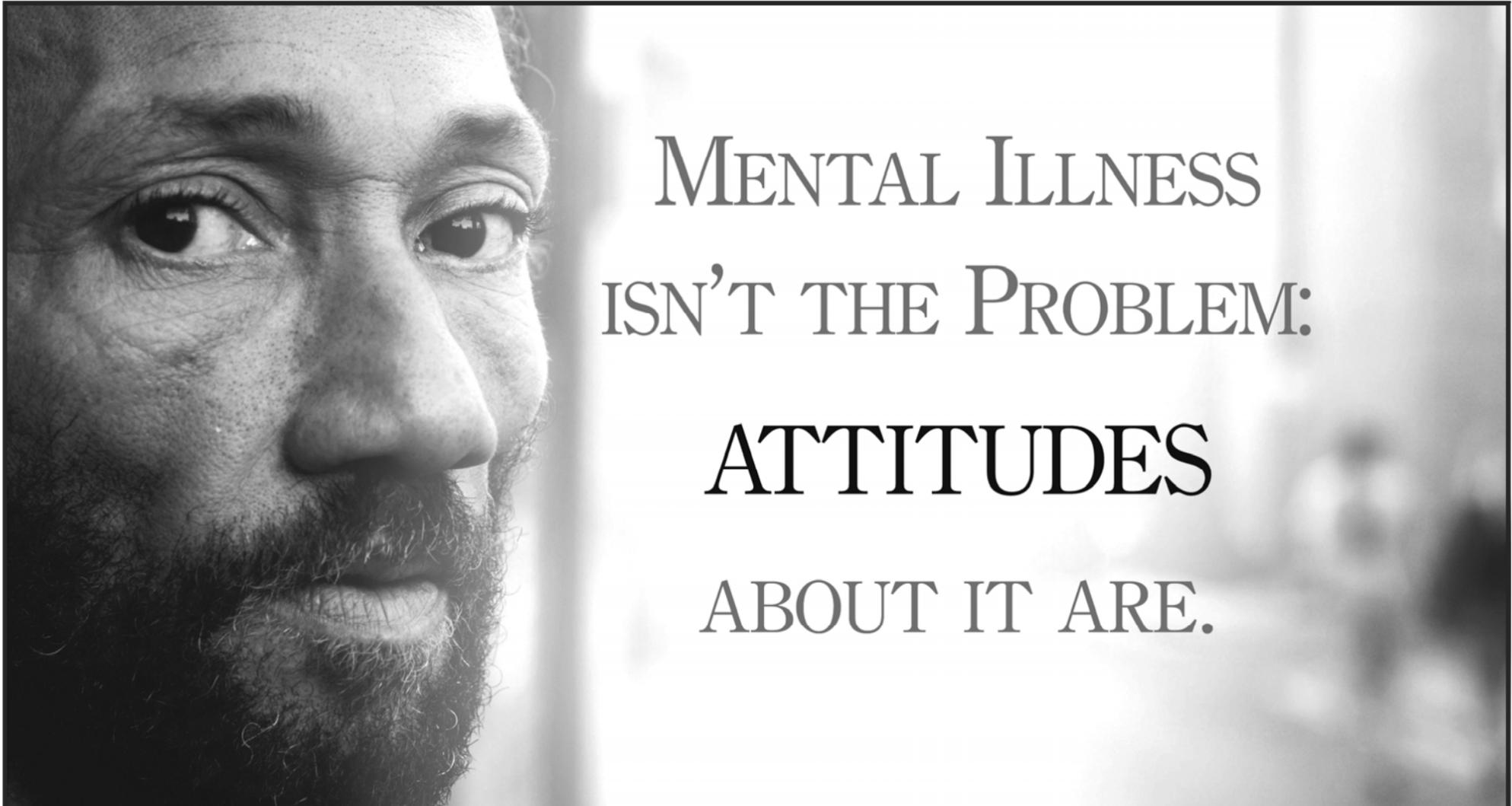
to improve the quality of life of the people served. Initially accomplished through housing, the agency has since expanded to provide evidenced-based treatment and interventions through Assertive Community Teams, clinics, primary care and rehabilitation programs.

Due to Dr. Campanelli's innovative leadership, disparities in access to behavioral health services have been reduced while service outcomes and effectiveness have been improved. Throughout the course of his career, Dr. Campanelli has tirelessly and broadly advocated on local, state and national levels to ensure the availability and accessibility of behavioral health services, for persons residing in underserved and, often, impoverished communities. His goal has been to ensure that they can readily access services as good as those available to more prosperous individuals through leading universities and medical centers.

Dr. Campanelli holds a Doctorate in Clinical Psychology from Rutgers University, Graduate School of Applied and Professional Psychology, and is a licensed

Clinical Psychologist in New York and New Jersey. He is a Board of Directors member for the National Council for Community Behavioral Healthcare. Dr. Campanelli has served as Board Chair and member of the Association of Community Living, Mental Health News and Managed Care Innovations, and as a Board of Directors member for the Human Services Council of New York City. He is the former President, Board of Directors, Coalition of Voluntary Mental Health Agencies. Dr. Campanelli is a past recipient of the Peterson Prize for Community Service from Rutgers University. His work has been recognized twice with the Gold Medal Award from the Hospital and Community Psychiatry Division of the American Psychiatric Association and the Congressional Community Corporate Partnership Award from the Honorable Edolphus Towns.

Dr. Campanelli states: "I am in debt to the many staff and board members who have served and helped build the organization into what it is today. I will always be dedicated to the mission of ICL and will support it in every way possible."



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## River Angel: Therapy and Loss in the Early Days of AIDS

**Julie List, LCSW, Director  
Pelham Counseling Center  
JBFCs**

It's been 17 years since Keith Braverman\* washed down a bottle of valium with a fifth of vodka, left his wallet and keys on his kitchen table, and jumped into the Hudson River. Keith wrote one suicide note, and it was addressed to me. He attached a postcard to the note: the two embracing angels in Caravaggio's *The Seven Acts of Mercy*.

Keith was my patient at the Greenberg/Manhattan West Clinic of JBFCs for nearly two years prior to his disappearance. This act was what he would have called his "rational suicide," although the resulting loss for his family, friends, doctors, and me was as deep as any other. As a gay man with AIDS in 1995, prior to the availability of the protease inhibitors, Keith believed that the deterioration of his body and mind was his inevitable future, and he couldn't bear the thought of wasting away, in pain and alone.

Keith was a 43-year-old, white, non-practicing Jewish gay artist and writer, in recovery for five years from alcohol abuse, who was transferred to me for ongoing weekly psychotherapy after his prior therapist left the agency. Keith had been diagnosed with AIDS less than a year before. His longtime lover, Joey, had died of AIDS six years earlier. Keith's

current on-again/off-again lover, Kevin, (who lived with another man in a long-term relationship) also had AIDS but was not as ill as Keith. Keith reported to me that all of his friends had AIDS.

When Keith came to JBFCs, he had a T cell count of 3. That was our marker in those days; we geared ourselves for the proximity of death by the dwindling number of lingering T cells. We soon learned that our patients' T cell counts could rise and fall over a long period of time and that the "viral load" was a better predictor of their longevity.

Keith was an attractive man with dark eyes and hair, tall and slender, emanating intelligence and vulnerability. He was losing weight rapidly. He always wore boots, claiming it made it easier for him to walk with the KS (Kaposi's sarcoma) lesions on the bottoms of his feet. Rolling up his pant leg, he showed me the other dark purple lesions on his calf. He also had a few on his nose that embarrassed him. He periodically got radiation to burn them off his face.

Our clinic, under the wise tutelage of the late Marilyn Brodsky, LCSW, had formed a connection with GMHC (Gay Men's Health Crisis, the organization founded in 1981 by Larry Kramer and others), and we had a continuous flow of gay men in various stages of the disease sent to us for outpatient weekly therapy and, if necessary, psychotropic medication monitoring.

Keith was immediately matched with our psychiatrist, the late Dr. Eugene Glynn, an expert on issues of gay men in therapy and AIDS. Dr. Glynn was a brilliant, older gay psychiatrist who treated hundreds of sick and dying young men throughout the worst of the AIDS epidemic. He also taught the JBFCs community of social workers and psychologists about the medical and psychic traumas of the disease.

Dr. Glynn and I were partners in working with Keith, who was struggling with acute anxiety since his diagnosis. Dr. Glynn prescribed 5 mg of Valium daily, a common anti-anxiety medication in Dr. Glynn's time. Given the sad predictability of the foreshortened lifespan of these very ill patients, there was less concern about the habit-forming nature of this medication. As the year progressed, Keith became more depressed, prompting Dr. Glynn to add 20 mg of Prozac to the daily medication regimen.

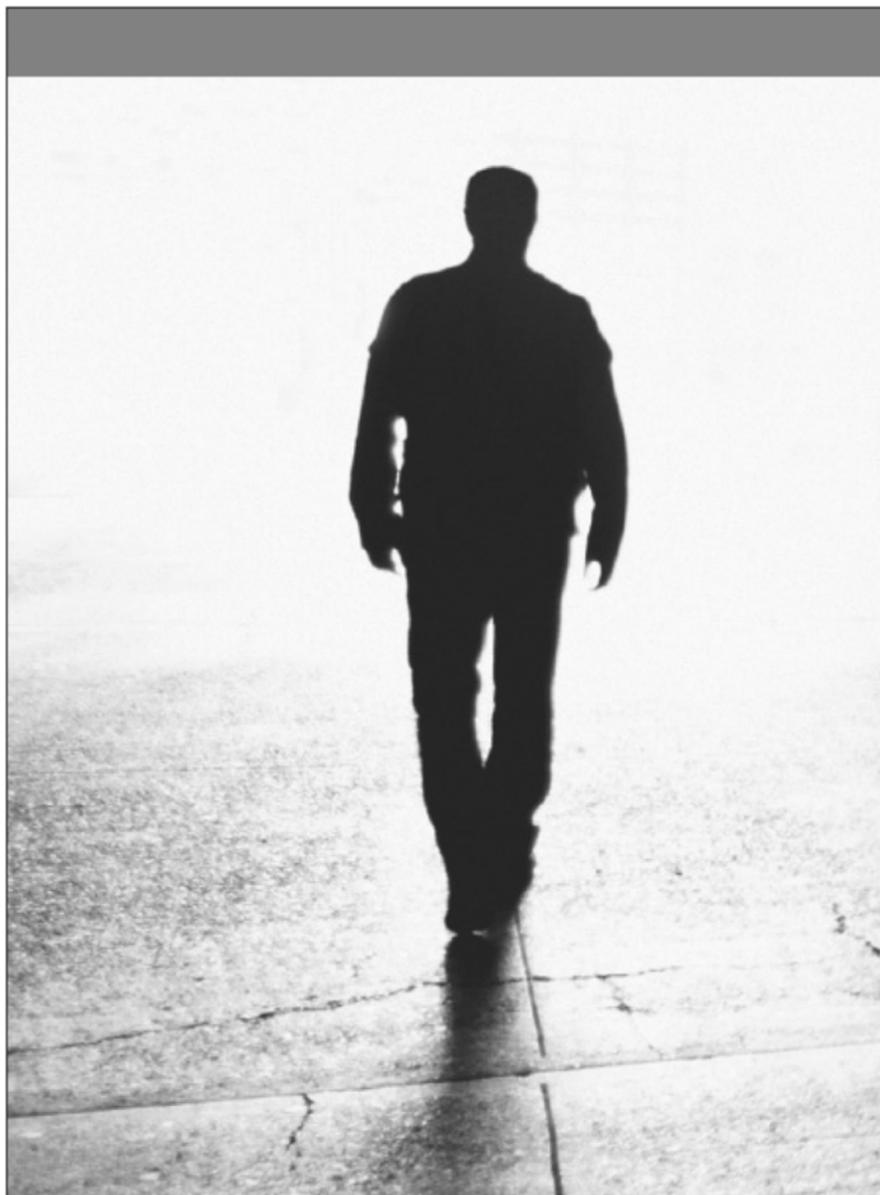
Keith told both Dr. Glynn and me that if he started to get sicker without any hope of improvement, he would consider taking his own life while he still had control over his ultimate destiny. At this time, there were no approved antiretrovirals, no hope for a cure, just the certainty of a painful withering away. According to Dr. Glynn, many of his patients had similar plans but became too sick too quickly. It was a controversial topic for us, given our mission to help people to stay alive at all costs.

*6/29/94: Progress Note.* Keith reports his health is improving (T cells 6) although his KS lesions are increasing. Reports AIDS represents "the cruelty of nature."

In the early stages of the AIDS epidemic, there was little knowledge of the origins or the course of the disease. It was erroneously called the "Gay Plague" because it appeared with alarming frequency in white gay male communities. Gradually our patients included gay men of color, IV drug users, the female partners of IV drug users or bisexual men, and heartbreakingly, the babies and children of women with AIDS. HIV positive mothers unknowingly passed the virus to their babies through the birth canal or in their breast milk. We lost several children in the clinic in the early days of AIDS.

As a social worker in the late 1980s and continuing throughout the mid-1990s, there was no foolproof medication cocktail to prolong the lives of our patients. Thus we had to learn to provide therapy to a generation of mostly gay young men whose friends and lovers were dying in droves. Obituaries of 30- and 40-year-olds appeared daily in *The New York Times*—men of enormous promise, withering away in their prime. Our patients reported going from one memorial service to another, and they were becoming numb. The high number of death notices of young

see *River Angel* on page 26



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## Are Bridges Suicide Magnets? They Don't Have To Be!

By Kenneth Popler, PhD, MBA  
President & CEO  
Staten Island Mental Health Society, Inc.

**B**ridges are suicide magnets. But, they don't have to be. San Francisco's Golden Gate Bridge has the unfortunate distinction of being the most popular suicide destination in the world. It has been the scene of 1,500 deaths by suicide, approximately 30 per year.

Results from a comprehensive study of suicides from the Golden Gate Bridge, conducted by the Marin County Coroner's Office (2009), found that the "typical" jumper is a white (80%), male (74%), never married (56%), with a median age of 40.

The *New York Times* (July 6, 2008) reported on research conducted by Dr. Richard Seiden, a professor emeritus and clinical psychologist at the University of California at Berkeley School of Public Health. The Times reporter, Scott Anderson, reported that, "In the late 1970s, Seiden set out to test the notion of inevitability in jumping suicides. Obtaining a Police Department list of all would-be jumpers who were thwarted from leaping off the Golden Gate between 1937 and 1971 - an astonishing 515 individuals in all - he painstakingly culled death-certificate records to see how many had subsequently "completed." His report, "Where Are



They Now?" remains a landmark in the study of suicide, for what he found was that just 6 percent of those pulled off the bridge went on to kill themselves. Even allowing for suicides that might have been mislabeled as accidents only raised the total to 10 percent."

Dr. Seiden was quoted to conclude, "But to me, the more significant fact is that 90 percent of them ... were having an acute temporary crisis, they passed through it and, coming out the other side, they got on with their lives."

Closer to home, within a 30-day period earlier this year, two adults, on two separate occasions, drove to the center of the

Verrazano-Narrows Bridge that links Brooklyn and Staten Island, and jumped to their deaths. Were these deaths preventable? I believe that they could have been.

Several years ago, in 2008, New York's Metropolitan Transportation Authority (MTA) installed suicide-prevention phones on the Verrazano Bridge. However, they neglected to install adequate signs. Therefore, the phones are essentially invisible.

Since the phones' installation, the only calls received by LIFENET, the suicide prevention hotline that is connected to them, are from MTA employees testing the phones and motorists whose cars have

broken down, according to an editorial published by the *Staten Island Advance*.

But this is not the case on bridges outside of MTA jurisdiction. For example, the New York State Bridge Authority (NYSBA), in partnership with the Hudson River Coalition for the Prevention of Suicide, maintains an award-winning suicide prevention program.

Research has shown that fences and other physical barriers remain the most effective deterrents of suicide attempts from bridges. However, after considerable research that included mental health professionals, international experts, and law enforcement officials, the NYSBA implemented "a comprehensive package that utilizes technology, awareness and informed intervention." (*Comprehensive Plan for Suicide Prevention, 2007*)

The successful NYSBA suicide prevention campaign is a combination of signage, access to LIFELINE, its suicide-prevention hotline, and assistance in informing potential suicide victims that there is help available. This interactive endeavor has produced positive results.

The suicide-prevention phones, appropriate signage, and public awareness campaigns are seen as "human barriers" to suicide (instead of, or in addition to, installing fences and other physical barriers), but *only* if a potential suicide victim knows that they are there and where they

see *Bridges on page 24*

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## The ECT Controversy

By Susan Rogers, Director  
National Mental Health Consumers'  
elf-Help Clearinghouse

Although many believe they have been helped by electroconvulsive therapy (ECT) – in which seizures are electrically induced, usually to treat severe depression – ECT also involves serious risks. In fact, many others believe it has destroyed their lives.

The risks – permanent amnesia and permanent deficits in cognitive abilities – have been confirmed by researchers such as Dr. Harold Sackeim, a well-known proponent of ECT, whose 2007 study in *Neuropsychopharmacology* ([www.nature.com/npp/journal/v32/n1/full/1301180a.html](http://www.nature.com/npp/journal/v32/n1/full/1301180a.html)) concludes: “This study provides the first evidence in a large, prospective sample that adverse cognitive effects can persist for an extended period, and that they characterize routine treatment with ECT in community settings.” And an excellent series in *USA Today* ([www.clrp.org/pdf/PatientsDanger.pdf](http://www.clrp.org/pdf/PatientsDanger.pdf)) also highlighted the dangers of ECT.

The Food and Drug Administration (FDA) continues to classify ECT equipment in its high-risk Class III category — which comprises only 10 percent of medical devices — despite repeated pressure from ECT equipment manufacturers to reclassify it into the lower-risk Class II. In his testimony ([www.power2u.org/downloads/ECTtestimonyDanFisher.pdf](http://www.power2u.org/downloads/ECTtestimonyDanFisher.pdf)) before an FDA panel on January 27, 2011, Daniel B. Fisher, MD, PhD, said that “the short-term gains of ECT do not justify its associated brain damage, memory loss, cognitive deficits and increased risk of death.” Citing research showing that ECT does not decrease suicide, Dr. Fisher recalled a 19-year-old man he had seen in an outpatient clinic who was experiencing major depression and had been slow to respond to medication: “He was admitted to an inpatient facility where the psychiatrist immediately started a series of 8 ECT treatments. Upon discharge, his depression had slightly lifted, but he could no longer recognize his friends. He was so distraught over this side effect of the ECT that he hung himself.”

ECT survivors speak openly about the devastating effects of ECT. In her acclaimed book *Doctors of Deception: What They Don't Want You to Know*



Susan Rogers

*About Shock Treatment*, Linda Andre wrote, “Eventually you realize that years of your life have been erased, never to return. Worse, you find that your daily memory and mental abilities aren't what they were before.”

Last January, when Dr. Oz aired a one-sided segment on ECT, numerous shock recipients posted comments on his website in protest. Sonia Weaver wrote: “I believed the doctors who told me the procedure was safe and effective and am left with major memory loss and permanent cognitive deficits. Those of us who have been damaged by ECT deserve to have our voices heard as well.”

I am not suggesting a ban on ECT. Even Marilyn Rice – a former high-ranking government economist who founded the Committee for Truth in Psychiatry (an organization of shock survivors) after 8 shock treatments wiped her memory clean of years of specialized knowledge and forced her into retirement – did not promote a ban. Linda Andre writes that Rice “always maintained a healthy respect for the kind of emotional suffering that made people desperate for relief, no matter how fleeting.” All Rice sought was the opportunity for truly informed consent. “I'm not against shock,” she would say. “I'm against lying about shock.”

### Bridges From page 23

are located. According to the *Poughkeepsie Journal* (May 24, 2007), “... phones have been effective on the Mid-Hudson Bridge for more than two decades..” “More than 50 people have used them and have been persuaded not to jump.” (Although seven people did jump during that time, only one of them had used the phone, the *Journal* reported.)

According to NYS Police Sgt. Jaime Alvear (as reported by the *Times Herald-Record*), “The phones give us a chance to get there. Most people don't want to do it, so they pick up the phone.” The Ser-

geant's observations and comment actually paraphrase Dr. Seiden's findings at the Golden Gate Bridge (as cited above): “... the more significant fact is that 90 percent of them ... were having an acute temporary crisis, they passed through it and, coming out the other side, they got on with their lives.”

Meanwhile, at the Verrazano Bridge, the MTA, having already installed suicide-prevention phones, should fulfill its entire responsibility by installing prominent signs and initiating a strong public awareness campaign aimed at saving lives.

Could the next suicidal jumper be spared? Let's make the attempt.

**Aftermath from page 10**

In order to work with an adolescent client, who has recurrent feelings of desperation, the therapist must have the confidence to allow them to “have all their feelings” in the privacy of their therapy meeting. They must allow their young clients to talk about their thoughts of death and what that means to them, and help them to openly express the fact that sometimes death feels like a viable choice to them, then help them to see that there are better options to explore. We need to help our young clients to be in the moment with their despair and desperation, then help them to discover and embrace their strengths. This is a delicate dance that requires courage and patience by both parties.

**A Delicate Dance**

One morning sometime after the events described above, when the social worker arrived at her office, Mrs. A. and Carly were sitting in the waiting room. Mom was beside herself, stating that her daughter lied and was defiant, and that she couldn’t live with her for another day. She demanded, “Put her in the hospital!”

The worker was confused. She thought things had improved. Nevertheless, she made an assessment and determined that Carly was not suicidal. Carly said, “I don’t want to kill myself, but I hate that my mom loses control and gets upset so easily. This time instead of swallowing

pills, I decided to leave the house and I stayed out all night. I slept in the playground around the corner from where we live. I do not want to go to the hospital, I am not crazy and I do not want to kill myself. But, I don’t want to be around her (mother) because of how we fight. I am not going to a hospital.”

It took the better part of a day to arrange for an alternative to a hospital referral. The work included another assessment, this time by the team psychiatrist, to validate that Carly was not suicidal. There was much consultation, many phone calls and a good deal of careful planning. It was determined that if Carly could not go home with mom, that a temporary respite placement was a viable and less expensive alternative to psychiatric hospitalization. During the course of evaluation, we discovered that the daughter’s behavior was inducing mom’s own vulnerabilities and feelings of desperation that went back to her own difficult growing-up years.

The work following the week-long respite was entirely focused on strengthening the relationship between mother and daughter. Carly learned alternatives to being impulsive when she felt desperate, anxious and angry. To affirm what she was learning, she would say “I know what not to say to my mother not to set her off” and “I don’t want to argue and fight anymore.”

Advocating for an alternative educational placement to help her with some of her learning deficits was also a major accomplishment. Encouraging Carly to keep active after school was important as

well, so she would not have to be caretaker for her younger siblings. She found a part-time job and joined the girls’ field hockey team.

It has been several months since respite and the family is now ready to end treatment. Will there be new episodes of violent outburst? Will there be other crises to resolve? Maybe. But Carly has learned ways to cope that are alternatives to suicide.

Conclusion: “I am in pain but I am willing to change.”

When working with an adolescent who attempted suicide it is important to keep a few principals in mind. Although this is by no means a complete list, it will provide some direction.

(1) *A suicidal gesture is a crisis that is an opportunity for change and growth.* The crisis offers the therapist and client (family) the chance to explore dynamics that led to the suicidal “dangerous act.” It offers the opportunity to better understand the adolescent’s belief system regarding what he or she thinks would be the impact of their death. The therapist can bring reality testing to the discussion. Teenagers, during this development stage, often think that the world revolves around them and their friends. (see number 3, below, for illustration).

(2) *The therapist must form an alliance with the adolescent and her or his par-*

*ents.* The therapist must gain the trust of both the adolescent and parents. This is a balance that requires persistence in the early phase of treatment. If the adolescent believes that the worker is aligned with her or his parents they will be likely to withdraw. If the parents think that the worker is favoring their child’s perspective, the therapist will lose respect from the parents. The therapist must establish trust and mutual respect with both parents and child. The parents must feel that the therapist understands their frustration, anxiety, fear and anger. The crisis offers an opportunity for the parents to explore how their behavior may have impacted their child. A solid relationship with all family members enables the therapist to give strong directives, if needed, during critical periods. For example:

*Mom:* “Take her; put her in the hospital....” (She is really saying, “I can’t do this anymore, I don’t want to hurt her or for her to hurt herself. Help me do it differently.”)

*Social Worker:* “No not the hospital, but I understand we do have to do something different. Trust me, the hospital and the police are not the answer.”

The therapist must be comfortable entering the family system. Understanding the communication style and patterns between the parent and child takes time and

*see Aftermath on page 28*

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**River Angel from page 22**

men had not been this significant in America since the losses from the 1919 influenza outbreak.

At first I wasn't sure if I was up to the task of doing psychotherapy with a man dying of AIDS. I had no special training for this, other than the courses Dr. Glynn had been giving us. Although there was literature on working with physically ill patients, nothing of this magnitude had ever occurred with such virulent insistence, decimating the young. In addition, once the means of transmission was understood, gay men were accused of "bringing it on themselves" with their "promiscuous" lifestyles. A disease that was transmitted via sex and needles did not initially get much sympathy from the larger community.

7/8/94: *Progress Note.* Keith is relieved, because his CMV test was negative. [CMV causes, among other things, blindness.] Feels he has gotten a reprieve. Gives me herbs he grew in his garden.

Keith had never come out as a gay man to his parents or to his sister. Although he had lived with Joey for many years, he told his family Joey was his close friend and roommate. Even when Joey died, there was no discussion of AIDS or of being gay. A great deal of our treatment focused on how to tell his parents that he was sick and then to reveal to them that he was gay and had known since he was four years old.

11/3/94: *Progress Note.* Keith continues to struggle with whether to tell parents about diagnosis. We examine the pros and cons. He admits there is a part of him that

wishes to punish them by keeping them in the dark.

Instead of telling his family, he decided to confide in the rabbi—who happened to be gay—in the town where his parents lived so that once Keith died, the rabbi could help the family deal with the many facets of the complicated loss. He felt this was a good outcome of our discussions in therapy.

Keith's main source of pleasure and support came from his best friend and sometimes lover, Kevin. Kevin was slowly starting to pull away, however, dedicating himself to his live-in partner, his career, and his own health. Keith continued to have numerous medical tests and tried to fight off the spread of the KS lesions on his face. He was no longer sexually active and this led to a deep sense of alienation.

12/8/94: *Progress Note.* Keith feels depressed, lonely, yearning for physical affection, especially from Kevin. Feels that he is "rotten fruit" and no one would want him. Never imagined he would have AIDS and be alone.

Our relationship seemed unusually close—and different—given that I was his therapist. Yet he knew absolutely nothing about me other than how I looked, the art on my walls, and my responses to our discussions about his fears of dying and loneliness. Sometimes he came in excitedly, reporting about a party he had attended at Friends Indeed, a gay men's organization. He balanced his urge for human, sexual connection with a haunted feeling of tiptoeing through a graveyard, fearing that he would soon be among the dead. We talked about how he had

stopped painting when Joey died, as he didn't want to belong to the meaningless "gallery scene" anymore. His doctor had told him this would be the last year of his life, and his primary search would now be for love. For Christmas he gave me a candle and a postcard of an angel, a beatific creature with no defined gender. On the back he wrote, "Happy whatever, but mostly, thanks. K."

1/20/95: *Progress Note.* Keith is experiencing pain from his KS lesions on the bottom of his foot and leg. Worries that he has begun a gradual decline. Wonders if he could possibly meet anyone to love at this late stage. Feels lonely, wants companionship.

1/26/95: *Progress Note.* Has gotten all of his legal and financial documents in order, in case he dies suddenly.

A few months after this session, Keith drank some vodka and took an unknown quantity of Valium, unbeknownst to Dr. Glynn and to me, as a "dry run" for his eventual suicide. Dr. Glynn evaluated him and assessed that Keith was not an immediate suicide risk and that he did not need to be hospitalized. He increased Keith's dosage of Prozac. We all discussed that for an alcoholic in recovery to take a drink represented a serious loss of faith.

Keith admitted that seeing friends in love, Kevin going away for two months, and the terrible feeling of having nothing to look forward to had led to this event. Although he contracted for safety and expressed he still had the will to live, he acknowledged how acutely painful it was to live with the specter of death beside him. He felt it as a palpable presence.

3/9/95: *Progress Note.* Makes attempts

to meet someone, feels rejected. Thinks the KS lesions make him completely unappealing. Thinks he must give up on hoping for more affection from Kevin, which fills him with grief.

Over the course of our work together, Keith's doctors told him that he could go blind from CMV, that his KS was worsening, and at one point, that he might have lymphoma and that his stomach lining was thickening. His T cells remained low, his viral load increased. In addition, he began drinking socially again after five solid years of sobriety. Our treatment focused on the meaning of giving up on sobriety, since it had given him such strength and self-esteem. He admitted he wanted me and others to notice, he wanted to provoke his friends to worry about him and maybe attract Kevin back to his side. In addition, one of Keith's primary doctors, a woman, suffered a nervous breakdown and took a leave of absence.

In September 1995, after a short reprieve in the Hamptons over the summer, Keith returned depressed and hopeless. His distress intensified as his bouts of diarrhea increased and he felt like he was on his final decline. Dr. Glynn saw him more frequently to assess for suicidal ideation, but Keith insisted that he didn't need to go to a hospital.

9/15/95: *Progress Note.* Keith continues to feel very depressed. Has a KS lesion on his penis and feels no one will ever want him. He's angry about this disease, doesn't know if he can accept it.

At this point, in spite of our attempts to

see *River Angel* on page 30



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**Family from page 10**

watch someone you care about fall into a depression; to see someone hurting that way. Do not allow their suicide to overshadow the rest of their person. Engagement in usual family and other social activities is helpful, although the person may be self-conscious. Acceptance of people as they are includes accepting the suicide attempt. It should not be a taboo topic and it should not be the only topic.

The Effect on Loved Ones  
and Hints to Help Understanding

The frustration and sense of helplessness in helping a loved one dealing with suicidal thoughts or actions is normal; it does not make you a bad parent, spouse, partner, sibling, child, or friend. It would be wonderful if one were able to give concrete answers to all questions about risk, but unfortunately, those answers do not exist. The only thing one can do to help your loved one is encourage them to start/continue counseling so they are getting the kind of professional help they need and listen if they clearly ask for more help. Many suicidal people are capable of recognizing when they are more at risk for hurting themselves and will let you know. Then it is time to get them immediately to professional help, whether they can see their own therapist or go to an emergency room for an evaluation. It may be time for them to be admitted to a hospital. Let your loved one know that it is okay for them to tell you this; you will help them get the assistance they need.

But another aspect of suicidal behavior is a fundamental sense of hopelessness. Hopelessness is an emotion that does not motivate a person to reach out – for there is no hope. There are some more subtle signals that you can look out for that might suggest higher risk of dangerous behaviors: loss of interest in things/activities that used to give them

pleasure, if someone who has regularly been very depressed suddenly becomes happier/calmer, if your loved one starts to give away things that are important to him/her, and talk about things being better “if I weren’t here” or “I don’t want to live anymore.” If your loved one displays any of these warning signs – ask them straight out – “are you thinking about or planning to end your life?” Yes, it’s a very scary question to ask – and it could save their life. If he or she says yes, then it is time to take him or her to the nearest emergency room. If they refuse to go to the emergency room, suggest that they call the National Suicide Prevention line at 1-800-273-TALK (8255). Professional counselors can talk to them and assist them in getting professional assistance.

A related question that often comes up is the issue of confidentiality. Mental health professionals are obliged to follow rules of confidentiality that are incorporated into federal and state regulations. Many people misunderstand these rules. These rules significantly limit what the professionals may tell someone, especially without authorization. These rules do not apply to people who are not professionals and are concerned about someone. These rules do not prohibit a friend or family member from informing a therapist or doctor about their patient’s condition. The kind of information that is most useful to the professionals are factual observations of the behaviors of the individual that may not be known by the professional, such as the person not showering, not eating, lying in bed all day, talking of despair, giving things away. The mental health professional is permitted to listen to whatever one says; the rules only limit what the professional may say! You should be aware, though, that the professional is likely to reveal to the patient what was said and by whom. This disclosure occurs because the professional needs to be forthright with the

patient and may be bringing in information to the conversation with the patient that the professional would otherwise not be privy to. This informing of the patient is not to betray the person who provides the information but only to make the conversation sensible. As a result of this likely revelation, if you are going to call someone’s therapist or doctor, it is best to let the patient know it, so they are not surprised and understand the context in which the information was shared.

Self-Care and Resources

The caring for and worrying about a loved one who has attempted suicide is exhausting. It is certainly stressful. Sometimes that stress can even turn to resentment towards your loved one. Again, these feelings are normal and this may be a sign that you need to also make sure that your own needs are being met. You might find it helpful to get some counseling for yourself to help you cope with the stress and worry you are always feeling. It can be extremely helpful to discuss your thoughts and feelings with an impartial 3rd party who is knowledgeable about suicide, warning signs, and the stress that family members of depressed people deal with. You might find that a few sessions is all you need to refresh yourself; you do not have to feel that you are committing yourself to a weekly appointment indefinitely. The following are some ideas of where to get some emotional relief from the stress.

- Check to see if your employer (or your spouse’s or parent’s) offers an EAP (Employee Assistance Program) benefit. Through many companies you can get a few counseling sessions with a qualified clinician completely free of cost. It might be just the amount of counseling you need to feel emotional refreshed. If you do not have that available, call your in-

surance provider to find out about your mental health benefits and to get referrals to clinicians in your area. If you do not have insurance right now, go to [www.nmha.org/go/find\\_therapy](http://www.nmha.org/go/find_therapy) to see if one of those resources can assist you in finding care in your area.

- If individual counseling does not sound like it would be a good fit for you – maybe you would find a support group more helpful. Support groups can be run by professionals or simply another person who has had the same experience you are having right now. You can find one by: searching for your local Mental Health America affiliate at [www.nmha.org/farcry/go/searchMHA](http://www.nmha.org/farcry/go/searchMHA) and then calling to locate the kind of group you need; or you can also call the National Alliance on Mental Illness at (800) 950-NAMI (6264) and they can refer you to your local chapter who can assist in finding an appropriate group. Active duty military, national guard and reservists as well as their dependents, can also contact Military One Source at (800) 342-9647 or [www.militaryonesource.com](http://www.militaryonesource.com). Alternatively, there are many online support groups you can find by doing a Google search. The National Suicide Prevention Hotline website has a special page ([www.lifeline-gallery.org](http://www.lifeline-gallery.org)) designated for personal stories by those who have attempted suicide as well as those who love them.

It is important not to allow your concern for your loved one consume you; you need to show yourself as much care and concern you give them. Maybe if they see you reaching out to help yourself – they will be more inclined to do it themselves. You both deserve to feel better. Suicidal thinking and acts typically occur within crisis situations, and crises can be resolved. A hopeful attitude is often realistic as well as therapeutic.

**Aftermath from page 25**

patience. The motivation for change must come from the family.

(3) *Adolescents need guidance in seeking alternatives to suicide.* Help the adolescent identify reasons for living that she may not have considered before. Help them to discover and make alternative choices to suicide next time intense feelings surface and start to build. Raise awareness of reasons for living that she may not have thought about before. For example:

Social Worker (SW): “What makes you want to kill yourself?”

Young person (YP): “My mother will suffer. She doesn’t want me, so there, I won’t be around.”

(The social worker has made a deliberate choice not to challenge this since the girl and mom have so much conflict. This is a theme that will require ongoing work, but the social worker is helping her to seek reasons for living.)

SW: “What about other people, will anyone else miss you?”

YP: “I don’t know, and I don’t care”

SW: “What about your little brothers and sisters? They seem to love you so much. I watch how you interact with them in session. You are so good with them.”

YP: (Becomes tearful)

The social worker knows that the young person has been very protective of them since their births. They jump into bed with her in the morning. She cares for them when mom is at work. And when mom is losing control, she offers them safety. This offers the opportunity for the young person to see that her younger siblings, who she adores, will be affected if she dies. She acknowledges that she has never thought about this.

Adolescents must come to see that their therapist “is not judging me, but trying to understand me and know that although I am in pain, I am willing to change.” This brief article offers practice illustrations and principles for helping young adolescents and their families, who are struggling with finding alternatives to suicidal behavior, to cope with painful life circumstances. In order for these approaches to be successful in saving lives, preventing hospitalization and preserving families, a strong system of children’s outpatient community-based mental health centers is essential.

**New York City from page 1**

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**ICL Healthcare from page 20**

agency of HealthCare Choices. ICL is a not-for-profit organization that assists individuals with psychiatric disabilities, intellectual disabilities, developmental disabilities and/or histories of homelessness. At the heart of ICL are the people that are served and the communities in which they live.

The agency provides evidence-based and best practice innovative treatments,

*Kate McDonald, DrPH, is a Senior Researcher in the Office of Research and Evaluation, Bureau of Mental Health, Division of Mental Hygiene, at the NYC Department of Health and Mental Hygiene.*

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2. NYC Media Release: Health Department Announces Suicide Rate in NYC Is Half of the National Rate and Is Lower Than Other Major U.S. Cities. February 2012.

rehabilitation programs and support services to over 10,000 adults, children and families through over 100 programs located in Brooklyn, Manhattan, Queens, the Bronx and Montgomery County, Pennsylvania. ICL also offers over 1,500 housing units, a comprehensive system of clinical treatment options and, in addition to ICL Borden Avenue, operates a Brooklyn shelter for women with mental illness. For more information about ICL, please visit [www.ICLinc.org](http://www.ICLinc.org).

**Teen Suicide from page 1**

Specific risk factors for suicide among adolescents vary with age, gender, cultural and social influences. However, the following are some factors which may be present: a diagnosable mental or substance abuse disorder; impulsive behaviors; recent losses as in parental divorce, relationship difficulties or death; family violence; prior suicide attempt; access to a firearm; family history of suicide, mental or substance disorder.

Some of the national trends noted above were seen locally in Nassau County and some were not. Based on the reviews it seemed that teens themselves did not know what to do when a friend was suicidal. Based on all the above factors, the NCCFRT sent a letter to all 56 school districts. In this outreach, the NCCFRT encouraged districts to seek ways to implement primary and secondary prevention activities. Though the number of proven interventions for suicide prevention is limited, there are some evidence based interventions that schools can take that may reduce the risk. The school setting has been identified as a critical place to recognize warning signs of suicide and to implement primary and secondary prevention activities. Recommendations to the school included the following:

1) Creating district-wide suicide prevention, intervention and postvention guidelines for dealing with suicidal and potentially suicidal youth which should include

educating students on warning signs, increasing awareness on how to get help for self and friends, provide in-service for faculty and increasing parent awareness. Components of the guidelines, adapted from the Oklahoma Suicide Prevention Toolkit, that should be considered include:

- Gatekeeper programs: School and/or community personnel are trained to increase identification of those at risk. Such training could be implemented during staff development days. Examples of such programs include: safeTALK, ASIST, QPR and Kognito At-Risk for High School Educators. Parents can be included as well. Specific materials for parents can be found at: the American Academy of Child and Adolescent Psychiatry web site (fact sheets for families) and the Columbia Teen Screen website.
- Screening Programs: Screening programs are designed to screen young people for suicide risk factors and mental illness indicators. Students at risk are referred for services. Example: Columbia TeenScreen and Signs of Suicide (SOS)
- Crisis Management: Crisis management involves strategies geared towards youth in immediate crisis. Levels of interaction vary. They are designed to find the youth at risk the appropriate services. Examples: Long Island Crisis Center, [www.crisischat.org](http://www.crisischat.org), National Suicide Prevention Lifeline: 1-800-273-TALK

- Postvention Strategies: Postvention strategies are designed to reduce future suicides and suicide attempts. Examples: Suicide Prevention Resource Center's 'After a Suicide: A Toolkit for Schools'; CONNECT Postvention Training and Media guidelines for suicide reporting.

2) Schools were also informed that model protocols from other states are available on the internet. One such example can be found at: [www.state.me.us/suicide/about/reportdocs.htm](http://www.state.me.us/suicide/about/reportdocs.htm) as part of the Maine Youth Suicide Prevention Program website. Resources at this site include an information booklet, a gatekeeper resource book and a prevention, intervention and postvention guide.

3) Other resources suggested included:

- [www.omh.ny.gov](http://www.omh.ny.gov) (and click on suicide prevention bar on left)
- [www.preventsuicideny.org](http://www.preventsuicideny.org)
- [www.preventsuicideli.org](http://www.preventsuicideli.org)
- [www.sprc.org](http://www.sprc.org)
- [www.childinjuryprevention.org/mechanism.aspx?id=2](http://www.childinjuryprevention.org/mechanism.aspx?id=2)
- [www.longislandcrisiscenter.org](http://www.longislandcrisiscenter.org)

Suicide is one of the most preventable causes of death. Early diagnosis and treatment of risk factors increases the

likelihood that an adolescent can lead a productive adult life. But in many instances, these children are not being identified or diagnosed. Oftentimes, this can be attributed to poor help seeking behaviors and attitudes. A major factor contributing to this deficiency in help seeking behavior, on the part of both the referring individual and the distressed child, is a perceived stigma associated with mental illness. "Social marketing campaigns can stimulate cultural changes that de-stigmatize mental health problems, remove barriers to accessing appropriate care and encourage help seeking" (SPRC, 2004). Focusing on increasing awareness of suicide as a serious public health problem and dispelling myths about suicide and suicide prevention results in changes in beliefs and attitudes. There will then come about a decrease in the stigma associated with suicide and life threatening behaviors.

**Credits**

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*If you're feeling lost, desperate, or alone, please call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) The call is free and confidential, and crisis workers are available 24/7 to assist you*



**More Preventable from page 6**

"Walk a Mile in My Shoes" has matured from its humble grass roots into an important initiative in the region highlighting the impact that suicide can have on all of us. Designed to raise awareness around the prevalence and preventability of suicide, the event has grown significantly over the past seven years, with the 2011 event drawing over 1,900 participants. In addition, corporations and the faith based community have joined the walk; participate in various trainings, and out of this collective desire to spread a message of hope, the Glad Tidings created the i-Matter festival as a faith based concert with positive suicide prevention message.

The impact of our community's efforts has been significant. The Signs of Suicide initiative, for example, assesses students for: 1) potential risks; and 2) their abilities to identify and intervene on behalf of others. Of the 1037 evaluations completed in 2009, 643 students (62%) indicated that they "have a better idea how to help" a friend or how to access help for themselves. In addition, over 275 adults, such as teachers, physicians, parents have completed training in the Applied Suicide Intervention Skills Training (ASIST) curriculum. Similarly, over 1,500 community members have completed the Suicide Alertness for Everyone

(SafeTALK) curriculum.

Always taking suicide seriously is extremely important, and can save a life, but how do we know when someone is suicidal vs. looking for attention?

- Developing a suicide alert community is not only a tremendous place to start, but it is consistent with the 1999 Surgeon General's recommendation for addressing suicide prevention. This can be accomplished by attending trainings such as QPR, safeTALK or ASIST as many communities across the nation offer these or similar trainings. ([www.qprinstitute.com/programs.html](http://www.qprinstitute.com/programs.html) or [www.livingworks.net/training/map](http://www.livingworks.net/training/map))
- Recognizing signs/symptoms, or what Living Works refers to as "invitations" can be the first step in trying to identify if someone is suicidal, as many individuals who speak of suicide have often not decided if they in fact want to act on such thoughts.
- To recognize such "invitations," be aware of an individual's level of sadness or despair, helpless and hopelessness, anger, anxiety, difficulty concentrating, or loss of pleasure, as well as such things as isolation, increased substance use, or tardiness... or as the

American Association of Suicidology has indicated in their mnemonic:

- |   |                 |
|---|-----------------|
| I | Ideation        |
| S | Substance Abuse |
| P | Purposelessness |
| A | Anxiety         |
| T | Trapped         |
| H | Hopelessness    |
| W | Withdrawal      |
| A | Anger           |
| R | Recklessness    |
| M | Mood Changes    |

If someone conveys a sense of a suicidal threat we should respond by seeking an emergent professional response:

- Begin by contacting a suicide hotline, the police, or simply calling 911. If on Facebook, type "suicide" in the Help Center section;
- Be an active listener by allowing them the opportunity to talk about anything that is on their mind without reacting or trying to convince them to change their mind;
- Comfort can be provided in the reassurance of your voice and by your presence alone until help arrives.

However, the signs/symptoms leading up to a completed suicide can often go unnoticed. On any given day, most of our lives can certainly seem hectic with day to day demands, pressures of responsibilities in school or work; family needs; finances... All of which can become overwhelming at times. Therefore, noticing that someone may be suicidal can present challenges. This can be further complicated by an inherent avoidance when suicide may be the farthest idea from our minds or worse yet, we may fear what discovering someone who is actually suicidal may mean. These examples and many more make a strong case for community wide participation in gatekeeper trainings, with a goal of establishing a community alert community that results in suicide prevention knowledge being as common as First Aid and CPR are today.

If you have doubts about how to help don't hesitate to contact the National Suicide Prevention Helpline at 1(800)273-TALK (8255) as trained professionals are only a phone call away. For more information and helpful weblinks to other important suicide prevention organizations, visit our local suicide prevention website at [www.walkamile.net](http://www.walkamile.net).

*The Chemung County Department of Mental Hygiene is located at 425 Pennsylvania Avenue, Elmira, New York 14901, (607) 737-5501.*

**River Angel from page 26**

keep him connected, Keith initiated a gradual pulling away from Dr. Glynn and me. At the time, he described it as a financial necessity, even though I offered to lower his fee. I encouraged him to keep going to GMHC and to Friends Indeed, where he had often found solace, but he insisted his diarrhea kept him from going. We had some talks with one of his doctors to assess the progression of the disease.

9/29/95: *Progress Note.* Keith continues to feel depressed since his return from summer vacation. Is finding it harder to discover any meaning in his life now. Is still pining for Kevin. Hates being alone and sick. He says he is "rotting." Wants to come every other week. Feels depressed, detached from his own life, frightened of the future.

His symptoms also included fever and chills, and he had a hard time concentrating or working. I tried again to get him a Buddy from GMHC, but he continued to refuse. His worries about finances intensified, and he feared he might need to leave his apartment or get a roommate, stating, "I never expected to live this long."

In what would end up being our final session, Keith reported a feeling of desolation about his medical condition but denied suicidal thinking. He reported he stayed in bed all day the day before and didn't take his medication. He achingly described that he was in mourning for his lover, Joey, his fear of getting sicker, and his deepening financial problems. He met with Dr. Glynn after the session and denied a suicidal plan or intent, claiming he was just grieving the loss of love in his life.

Two weeks later Keith was gone. Kevin left me many messages on my office voicemail as did a detective from the 6th Precinct. Keith was missing, his wallet and keys were on his kitchen table, and there was a suicide note addressed to me. I don't remember who called to read me the content of the note:

*Julie, Please try not to feel bad about*

*this. You've done nothing but help me. Thank you forever. K.*

I took the blow hard, like a punch in the gut. Later, on the phone, Kevin said Keith had gone into the Hudson River, that his plan, his rational suicide had always been to kill himself before his living body and mind decomposed. And Kevin knew that Keith's plan was to mix Valium with vodka and then drown himself. Nonetheless, Kevin was enraged; he couldn't believe Keith had given up before the disease took him. Kevin was heartbroken.

It was a Saturday. I was home that day. I couldn't feel anything at first. It was a shocking absence, a void. Although I normally shed tears easily, none came. I started fixating on the idea of Keith's body on the bottom of the Hudson River. Then the terror set in. Gentle, talented, intelligent, and frightened Keith was being tossed over sharp rocks, rolling over and over in polluted waters, his body battered and cold. His dreams of a late, last love dashed, knowing he was dying, he made a calm decision to take control of his own demise.

I couldn't stop obsessing about Keith in the freezing waters. I told my supervisor about it. She understood grief and loss, but I needed more than that. After being the container for this man's last two years of life, I needed something more to find some peace.

Dr. Robert Abramovitz called me at home after he heard what had happened. He was the Chief Psychiatrist of the agency and the head of the newly founded Trauma Center. I had known him since I started at JBFCS in 1987, and I felt he might be able to help.

When he asked me how I was holding up, I finally became tearful. I told him about my intrusive thoughts of Keith being enveloped in the freezing grip of the dark water. About the man who had suffered such pain and solitude as the disease wiped out his generation and was about to carry him into the vortex. I kept imagin-

ing him under tons of heavy water and the thoughts would not stop.

"Julie," Dr. Abramovitz said, in the gentlest voice possible, "That is not Keith in the water. That is just the shell that housed his spirit. Keith is free, Keith is not there at all."

Those simple words released me. I could then feel the strong connection I had had to Keith and to the bravery that he had shown me while dealing not only with his own physical deterioration but also with the horrors of an epidemic that had been killing his friends and lovers since 1981. The sadness I felt was not only that we hadn't been able to help him to stay alive, but also the hopelessness about losing all the young men, women, and children who had been dying for more than 15 years.

In the following days, I spoke with Keith's parents, who were truly devastated. They called me in great distress, not having known he had AIDS or that he was gay. They were trying to understand the enormity of this loss, wanted answers that nobody had. Kevin came in to meet with me to give me the note and the postcard. We cried together and embraced when he left.

Sometime later I was told they found Keith's body. It was no longer under the waters of the Hudson River.

My colleagues, including peers and supervisors, were kind and empathetic. Some whispered, "It's her first suicide," and it was. Dr. Glynn and I talked a lot about Keith. Dr. Glynn had lost many patients in his long career, most to natural causes, some to suicide, and he told me that some of the men with AIDS chose to take control of their deaths the way Keith had. At that moment in time, they had no way to fight the vicious speed of the disease.

In time the void became a sharp missing of my visits with Keith and an insight into his utter necessity for love. In some ways I wondered if he died more from loneliness than from AIDS itself.

Given that the only note he left was for me, I wondered what my role in his life had been. I posited that perhaps leaving

me the note had been a gift. He didn't want me to feel like I had failed him, he didn't want me to feel responsible or guilty. Leaving the note also kept me tied to him forever, as one can see by the fact that I kept all of his session notes, the angel postcard, the suicide note, and the postcard of Seven Acts of Mercy. I have kept Keith with me every day for these 17 years, and this article is my way of bearing witness to his brave struggle and the battles his compatriots fought against a merciless enemy.

**Postscript**

There is an even crueler irony to the timing of Keith's premature death. In the middle of 1995, an experimental class of drugs was starting to become available to certain patients with advanced AIDS. By 1996, a class of drugs, known as protease inhibitors, was shown to have extended the lives of some of the very ill. Although the cost was astronomically high, more than \$15,000 a year per person, the benefits were so great that people were actually living with AIDS. By 1997, the domestic AIDS death rate dropped by 47 percent. \*\* Could Keith still be alive today if he had waited for the medication cocktail? We'll never know, nor will we know whether he would have died on his own shortly before he took his own life.

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\* All names have been changed in this article.

\*\* John Henkel, "Attacking AIDS with a 'Cocktail' Therapy," *HealingWell.com* (<http://HealingWell.com>), accessed March 19, 2012. The article originally appeared in the July/August issue of *FDA Consumer Magazine*, 1999.

**Task Force from page 12**

Quality Improvement – Setting a goal of zero suicides and managing a system of care to achieve that goal requires organizations to evaluate performance rigorously and to use untoward events as opportunities to improve their capacity to save lives at risk.

**Systems Management: Implementation and Action for Care Excellence**

To achieve the goal of zero suicides will require countless managerial decisions – both the major policy shifts and the details of patient care management. In this context, the Task Force recommends three major managerial areas to guide the organization of effective service delivery.

1. Policies and Procedures – All health and behavioral health organizations should have specific written policies and procedures focused on the detection and response to persons presenting for care with suicide risk. Staff must be trained on how to employ the policies and procedures, with regular (e.g., annual) scheduled refreshers.

2. Collaboration and Communication – Responding to suicide risk should be premised on collaborative care characterized by direct and open communication with persons at risk of suicide and timely and effective communication patterns with all personnel who are collaborating in the person's care.

3. Trained and Skilled Work Force – Public health and behavioral health organizations should assure that staff working with persons with suicide risk have been appropriately trained and possess requisite skills.

**Evidence-Based Clinical Care Practice: Comprehensive Quality Care To Save Lives**

While research has shown that over 90 percent of persons who die by suicide had a diagnosable mental health disorder and/or substance use disorder, empirical research has shown that it is insufficient to treat only the mental disorder. In contrast, the extant literature does show that targeting and treating suicidal ideation and behaviors, independent of diagnosis, hold the greatest promise for care of suicidal risk. It is vital that direct intervention and treat-

ment be provided for potential suicidality. Care for persons at risk of suicide should be person-centered, where their personal needs, wishes, values, and resources become the foundation of developing a plan for their continuing care and safety. Where appropriate and practical, families and significant others should be engaged and empowered as well. Cultural values and preferences should be respected as much as possible. The Task Force has identified the following four components of care.

1. Screening and Suicide Risk Assessment – Universal screening for suicide risk should be a universal part of Primary Care, Hospital Care (especially emergency department care), Behavioral Health Care, and Crisis Response settings (e.g., help lines, mobile teams, first responders, crisis chat services). Any person who screens positive for possible suicide risk should be formally assessed for suicidal ideation, plans, availability of means, presence of acute risk factors (including history of suicide attempts), and level of risk.

2. Intervening to increase coping to ensure safety – All persons identified as at risk of

suicide by primary care practices and clinics, hospitals (esp. emergency departments), behavioral health organizations and crisis services should have a collaboratively designed safety plan prior to release from care. This should include inquiring about means access and planning to restrict access to lethal means (balanced with respect to other obligations, including legal and ethical requirements under federal and state laws).

3. Treating and caring for persons at-risk of suicide – Treatment and support of persons with suicide risk should be carried out in the least restrictive setting using research-guided practice techniques.

4. Follow Up – Persons with suicidal risk leaving intervention and care settings should receive follow-up contact from the provider or caregiver.

*To read the entire Task Force report, go to <http://actionallianceforsuicideprevention.org/wp-content/themes/twentyten/images/pdfs/taskforces/ClinicalCareInterventionReport.pdf>*

*Visit the National Action Alliance on Suicide Prevention website at <http://actionallianceforsuicideprevention.org/>*

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# Deadline Calendar & Ad Size Specifications

### Deadline Dates

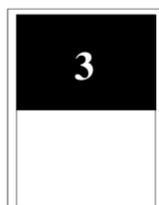
- Fall Issue - July 23, 2012
- Winter Issue - October 24, 2012
- Spring Issue - January 23, 2013
- Summer Issue - April 23, 2013



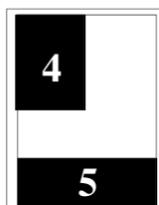
Full Page  
\$1,000



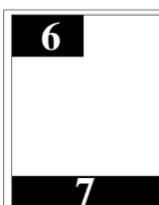
Half Vertical  
\$750



Half Horizontal  
\$750



Quarter V & H  
\$500



Eighth V & H  
\$300

### Ad Sizes - In Inches

	<u>Width</u>	<u>Height</u>
Full Page (1)	10.4	12.8
Half Vertical (2)	5.1	12.8
Half Horizontal (3)	10.4	6.4
Quarter Vertical (4)	5.1	6.4
Quarter Horizontal (5)	10.4	3.1
Eighth Vertical (6)	5.1	3.1
Eighth Horizontal (7)	10.4	1.5
Business Card (not shown)	5.1	1.5



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