

Calendar

may

- May 1-6:** American Psychiatric Association Annual Meeting, New York, NY. www.psych.org.
- May 3-6:** Alliance of Information and Referral Systems (AIRS) 28th Annual Training and Education Conference: Catch the Wave of I&R, Norfolk, VA. Sara Hamilton at (202) 464-5086 or www.airs.org.
- May 4:** Gatekeeper Training, Augusta, ME. Sponsored by Maine Youth Suicide Prevention Program. (207) 622-7566, ext. 202.
- May 4-7:** Innovative Practices for Suicide Prevention, Montreal, Canada. Sponsored by Centre for Research and Intervention on Suicide and Euthanasia. www.crise.ca/congres.
- May 5:** National Anxiety Disorders Screening Day, sponsored by Freedom from Fear: (718) 351-1717 or www.freedomfromfear.org.
- May 6-7:** California Strategy for Suicide Prevention State Planning Meeting, SPAN-California, Sacramento. mchaffee@wini.com, (760) 753-4565 or www.span-caifornia.org.
- May 12-14:** From Science to Services: Emerging Best Practices for People in contact with the Justice System, sponsored by National GAINS Center. Las Vegas. www.gainsctr.com/conference/default.asp.
- May 13:** Maine Youth Suicide Prevention Program Action Committee Meeting, Augusta, ME. Cheryl.M.DiCara@state.me.us.
- May 16-20:** 2004 U.S. Public Health Professional Conference, Anchorage, AK. (866) 544-9677 or www.coausphsconference.org.
- May 18:** Mass. Department of Public Health 3rd Annual Statewide Suicide Prevention Conference, Worcester, MA. Cindy Rodgers at 617-624-5413 or cindy.rodgers@state.ma.us.
- May 25:** First Annual Symposium on Crisis Intervention, Baltimore, MD. Justin Stapleton at jstapleton@santegroup.org or www.thesantegroup.org.
- May 25:** Bipolar Affective Puerperal Psychosis: NIMH Mood & Anxiety Disorders Program Distinguished Lecture Series, Bethesda, MD; sponsored by NIH. For more information, contact Holly Giesen: (301) 435-8982 or by email: giesenh@intra.nimh.nih.gov.
- May 27-28:** Suicide & Youth: Protecting Our Greatest Asset! Winnipeg, Manitoba. Mood Disorders Association of Manitoba at (204) 786-0987 or SPEAK at (204) 831-3610.
- May 27-29:** Mental Health Europe 2004 Conference, "Education for Change", Nova Gorica, Slovenia. International conference on education and prevention in the field of mental health. +386 1 23 078 32, mateja.trpin@sent-si.org or www.mhe.sme.org/files/EFC%20Slovenia%202004.doc.
- May 27-30:** 16th Annual American Psychological Society Convention, Chicago, IL. (202) 783-2077 or www.psychologicalscience.org.

june

- Jun 2-4:** 13th Intl. Conference on Safe Communities, Prague, Czech Republic. www.safecommunities.ca/events.htm, +420-224-942-575 or safe@cbtravel.cz.
- Jun 6-9:** World Health Organization 7th Conference on Injury Prevention and Safety Promotion, Vienna, Austria. www.safety2004.info.
- Jun 9-11:** Cultural Diversity in Crisis Work: Opportunities and Challenges. Mississauga, Ontario, Canada. www.saintelizabeth.com/documents/CWSB brochure2004final_001.pdf

Jun 9-12: National Mental Health Association Annual Meeting, "Justice for All – Fighting for America's Mental Health," Washington, DC. (703) 684-7722 or www.nmha.org.

Jun 24: Maine Youth Suicide Prevention Program Steering Committee Meeting, Augusta, ME. Contact Cheryl.M.DiCara@state.me.us.

Jun 24-27: National Association for Rural Mental Health 2004 Annual Conference, "The Changing Faces of Rural Mental Health," Boulder, CO. www.namh.org. namh@facts.ksu.edu or (320) 202-1820.

july

Jul 12-13: SAMHSA training event, "Women Across the Life Span: A National Conference on Women, Addiction and Recovery," Baltimore, MD. www.ncsacw.samhsa.gov.

Jul 14-15: SAMHSA training event, "Putting the Pieces Together: 1st National Conference on Substance Abuse, Child Welfare and the Dependency Court," Washington, DC. www.ncsacw.samhsa.gov.

Jul 28-Aug 1: American Psychological Association 112th Annual Meeting, Honolulu, HI. For more information, call 800-374-2721 or visit www.apa.org.

august

Aug 8-13: XXVIII International Congress of Psychology, Beijing, China. www.icp2004.psych.ac.cn or Xianolan FU with Chinese Psychological Society at +86-10-6202-2071.

Aug 15-17: Third Global Conference on the Promotion of Mental Health and Prevention of Mental and Behavioral Disorders, Auckland, New Zealand. For more information, visit www.mentalhealth.org.nz.

Aug 26: Maine Youth Suicide Prevention Program Steering Committee Meeting, Augusta, ME. For more information, contact Cheryl.M.DiCara@state.me.us.

Aug 25-28: 10th European Symposium on Suicide and Suicidal Behavior, "Research, Prevention, Treatment and Hope," Copenhagen. www.suicideprevention.dk or suicideprevention@ics.dk.

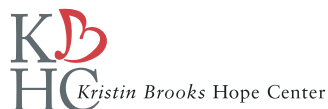
september

Sep 8-12: NAMI (National Alliance for the Mentally Ill) 2004 Annual Convention, Washington, DC. www.nami.org/template.cfm?section=convention.

Sep 10: 2nd Annual World Suicide Prevention Day. Sponsored by the International Association of Suicide Prevention and the World Health Organization. Details to follow.

Sep 12-16: "Scaling the Summit: Suicidal Behavior in Diverse Cultures," Durban, South Africa. www.med.uio.no/iasp.

Sep 22-24: "Suicide Prevention in the New Millennium: Advancing the Illinois Strategic Suicide Prevention Plan," Springfield. Sherry Bryant at sher44@msn.com or www.ilsp.net.



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Non-Profit Organization

Coming Next Month:
Military veterans and risk for suicide

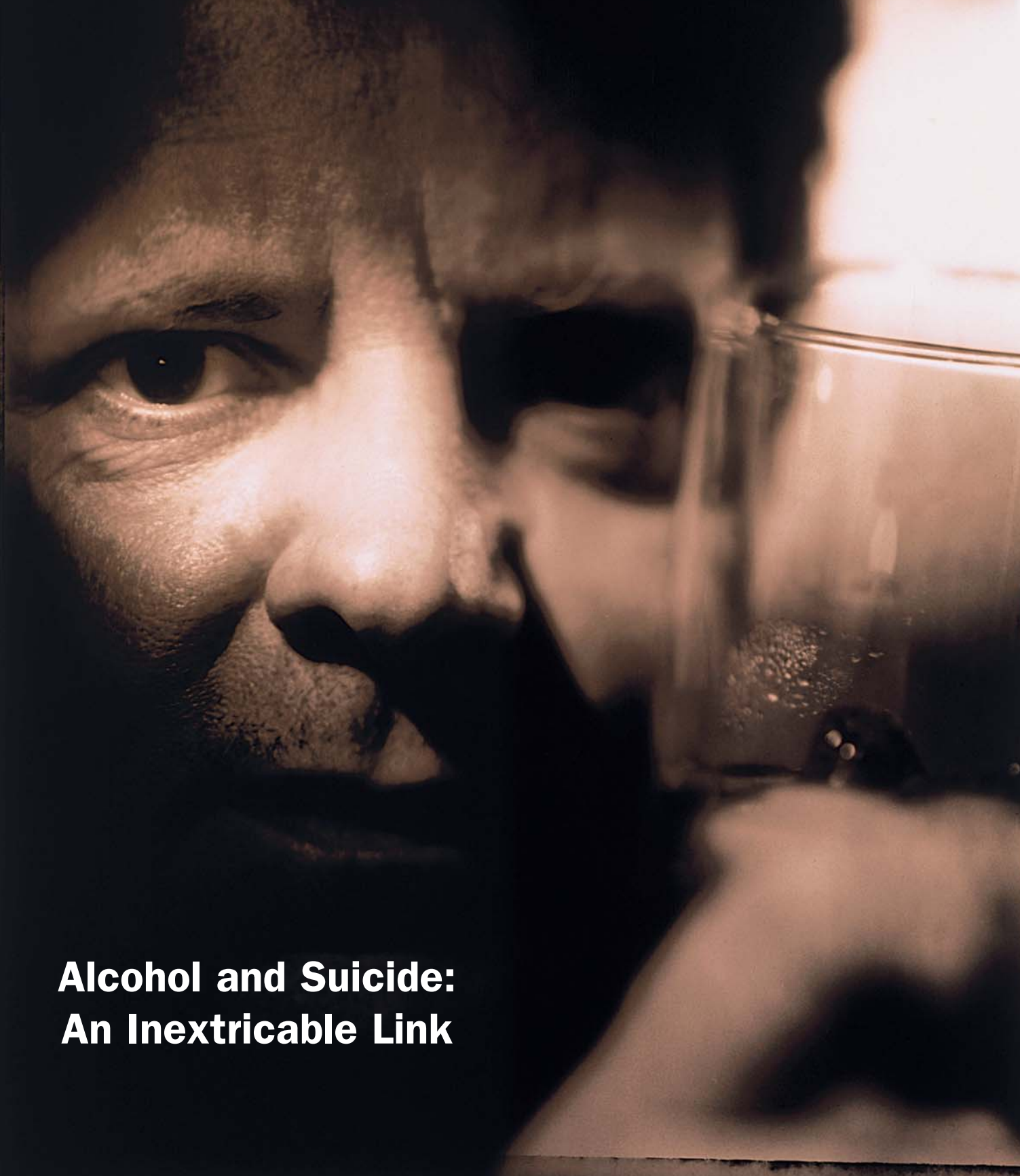
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The National Journal

volume three • number four



**Alcohol and Suicide:
An Inextricable Link**



H. Reese Butler II, *Publisher*, with devoted companion Budweiser Rio.

The announcements have alerted alcoholism researchers to suicide as an all-too-common outcome of prolonged addiction to alcohol ...

From the Desk of the Publisher

April is National Alcohol Awareness Month, sponsored by the National Council on Alcoholism and Drug Dependence. And April 8 is the 2004 National Alcohol Screening Day®. To mark these events “Preventing Suicide/The National Journal” presents an overview of alcohol and suicide.

Our focus this month is also sparked by two major program announcements calling for further research to understand better the link between suicide and alcohol. These were initiated last August by the NIMH (National Institute of Mental Health) in conjunction with NIAAA (National Institute on Alcohol Abuse and Alcoholism) and NIDA (National Institute of Drug Abuse).

These program announcements (page 2) are the first of their kind for the alcoholism research community – a call to action by the federal government to researchers who study alcoholism. The announcements have alerted alcoholism researchers to suicide as an all-too-common outcome of prolonged addiction to alcohol, and have spurred researchers to action so the link between suicide and alcohol can be better understood – and lives can be saved.

The NIMH/NIAAA/NIDA program announcements call for: first, developing centers on interventions for the prevention of suicide; and second, research on the reduction and prevention of suicidality.

Last summer’s program announcements are groundbreaking as they are the first initiatives from the federal government that involve NIAAA and directly address suicide. Moreover, they demonstrate the impact of recent federal attention to suicide as demonstrated in the 2001 National Strategy for Suicide Prevention (NSSP), the 2002 Institute of Medicine’s “Reducing Suicide: A National Imperative,” and the 2003 President’s New Freedom Commission on Mental Health, which calls for the implementation of the NSSP as the first of its six major goals.

Finally, the recent attention given to suicide by NIAAA and its partners at NIH shows that to prevent suicide we must build bridges not only among existing federal entities such as NIAAA, NIDA and NIMH but among all facets of the prevention community. To save lives by reducing suicide, all those in prevention must look beyond the borders of their own areas and form working partnerships with other entities. The federal government has set the stage in this regard, most recently with the NIMH/NIAAA/NIDA consideration of suicide. It is up to each of us to follow in those footsteps.

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Third Aeschi Working Group Conference Explores New and Better Therapies for the Suicidal Person

By Melinda Moore
KBHC Interim Executive Director

Editor's Note: Melinda Moore attended the Aeschi Conference, "Attempted Suicide: Towards New and Better Therapies," held March 3-6 in Aeschi, Switzerland. This report is a preview of future coverage of the Aeschi Working Group planned for coming issues of "Preventing Suicide/The National Journal."

Nestled in the Swiss Alps, high above Lake Thun and the resort town of Spiez, rests the village of Aeschi (pronounced "Eshi"), the most unlikely spot for a biennial meeting of an international group of clinicians and researchers, representing an array of therapeutic models, and their mainly clinical audience, all seeking consensus among their disparate approaches, but more important, a better way to treat their suicidal patients.

Emanating from a 1999 meeting to discuss the findings of a Swiss suicide study, the current Aeschi Working Group members* came together and discovered their mutual dissatisfaction with the current state of suicide treatment and research discourse. The group has been convening a conference in March, inviting a limited number of participants, meeting every two years since.

"We agreed that new models of understanding suicide are badly needed. We agreed that patient-oriented models are needed, as opposed to physician-oriented approach based on a traditional illness model," says Konrad Michel, M.D.

"Aeschi is very much about developing better concepts of suicidal behavior and applying them in clinical practice . . . Aeschi is not about advocating one specific form of treatment but about finding the essential ingredients for an effective treatment of suicidality."

This year's conference agenda included an impressive range of speakers, including radical behaviorist Marsha Linehan on the therapeutic relationship in Dialectical Behavioral Therapy (DBT), and Jeremy Holmes on Attachment Theory.

Psychoanalyst John (Terry) Maltzberger's gloss and response to Edwin Shneidman's theory of "psychache" provided a thought-provoking foil to the neuro-biological discussions of suicidal

"Aeschi is very much about developing better concepts of suicidal behavior and applying them in clinical practice . . . Aeschi is not about advocating one specific form of treatment but about finding the essential ingredients for an effective treatment of suicidality."

states by psychiatrists Michael Bostwick and Konrad Michel, Lisa Firestone's Voice Theory presentation, and Richard Young's Narrative and Action Theory lecture.

David Jobs provided a realpolitik perspective to the treatment of suicidal patients, presenting impressive research on the Collaborative Assessment and Management of Suicidality (CAMS) Protocol, an approach aimed at squaring the realities of managed care and outpatient treatment with the assessment and enjoining of the suicidal patient in their own treatment plan. In word and deed, Jobs attests to the "Aeschi spirit, . . . which speaks to the interest and desire to think outside the box. . . . How we reconcile these perspectives is sort of the dialectic or the tension that we'll try to evolve."

*Aeschi Working Group:

Konrad Michel, M.D., Antoon A. Leenaars, Ph.D., David A. Jobs, Ph.D., John T. Maltzberger, M.D., Israel Orbach, Ph.D., Ladislav Valach, Ph.D., Richard A. Young, Ph.D., Pascal Dey, M.A., and Michael Bostwick, M.D.

For more information: www.aeschiconference.unibe.ch

"Preventing Suicide/The National Journal" devotes space to letters from its readers. Address letters "To the PSNJ Editor" and include a daytime address, phone number and email. Send to letterstotheeditor@hopeline.com or to Kristin Brooks Hope Center, 201 N. 23rd St., Suite 100, Purcellville, VA 20132-3006. The journal reserves the right to edit letters to meet its style and length requirements.

Table of Contents

Features

Aeschi Explores New and Better Therapies	1
Alcohol and Suicide: An Inextricable Link	2
What We Know About Alcohol and Suicide	4
What We Don't Know About Alcohol and Suicide	6
How Do We Prevent Alcohol-Related Suicides?	7
Alcohol in the News – StateWatch	8
Alcohol in the News – NationWatch	9
Alcohol and Suicide: Learning More	10

Regular Features

Books	
Andrew E. Slaby, M.D., on <i>The Noonday Demon: An Atlas of Depression</i>	11
Frontline	
Bullying and Suicide	12
Happenings	13
Calendar	Back Cover

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Alcohol and Suicide: An Inextricable Link

For centuries society has recognized an inextricable link among alcohol, self-destructive behaviors and suicide. This link is apparent in some of the most talented creative geniuses among us, including acclaimed writer Ernest Hemingway, legendary for excessive drinking and severe depression. Hemingway used a shotgun to end his life on July 2, 1961, following in the footsteps of his father, brother and sister who also killed themselves. His eldest granddaughter Margaux, a model and film actress, too ended her life by overdosing on barbiturates in July 1996.

What have we learned about the relationship between alcohol and suicide, among not only creative minds but society-at-large?

Decades of research strongly suggest that alcohol is a contributing factor in scores of suicides for both men and women.(1) One study showed that between 18 and 66 percent of suicide victims have alcohol in their blood at time of death.(2)

Yet the role that alcohol plays in suicide remains unclear.

- Do those on the verge of taking their life drink alcohol to lower inhibition and calm themselves as they face death?
- Does alcohol impair psychological and cognitive processes that would normally block non-drinkers from contemplating or completing suicide?
- Is excessive alcohol consumption merely one indicator of a broader social disintegration that often accompanies suicide?
- Are those who kill themselves abusing alcohol in the months or years prior to their death? Are they alcoholics?
- Are alcoholics more prone to consider suicide by the very nature of their disease?
- Does chronic alcoholism change brain chemistry to make the addict more prone to bouts of depression or other mental illness that can bring about thoughts of suicide?
- Are those with depression or other mental illness more likely to abuse alcohol and form addictions to “self-medicate” a brain disorder, to alleviate their “psychache?” Will that brain disorder itself eventually lead to suicide?

“While alcoholism is an established risk factor for suicide, data on conditions that distinguish alcoholics at particularly high risk for suicide are meager,” notes Kenneth Conner, Psy.D., M.P.H., an assistant professor of psychiatry and psychology at the University of Rochester School of Medicine and a researcher whose focus is alcoholism and suicide.

For decades the study and treatment of alcoholism have evolved without giving adequate consideration to potential for suicide among alcoholics. That began to change in 2002 when the National Institute on Alcohol Abuse and Alcoholism (or NIAAA, one of the National Institutes of Health) co-sponsored a workshop to advance a national research agenda for alcoholism and its link to suicide.

“We met in Bethesda in March of 2002,” recalls Conner, who co-chaired the workshop. “The group focused on a discussion of available research on alcoholism and suicide, gaps in the knowledge, and how to fill those gaps and improve prevention and treatment for both alcoholism and suicide.”

This workshop reflected a general groundswell of interest in research and prevention of suicide, notes Conner. That interest also led to two federal program announcements in August 2003 calling for research on suicidal behavior, and reducing and preventing suicidality tied to alcoholism. NIAAA was one of the agencies releasing these program announcements, joined by NIMH (National Institute of Mental Health) and NIDA (National Institute on Drug Abuse). Their goal?

“To stimulate research on suicidal behavior and alcoholism,” notes Conner. “For the first time NIAAA was specifically soliciting suicide-related research.” Conner adds that while research on suicide and alcohol has occurred over the years, this area is not as well developed as other alcoholism research.

An outcome of the March 2002 research workshop is a focus on suicide and alcoholism in a special issue of “Alcoholism: Clinical and Experimental Research” (ACER). Slated for publication later this year, this special issue is a first for the alcoholism research community. It will include among other content a summary of proceedings from the 2002 Bethesda workshop.

“This is a huge step forward,” says Conner of the pending publication of the suicide-focused issue of ACER. “This is a very prominent alcoholism journal – and it’s dedicating a specific issue to suicide.” Page Chiapella, Ph.D., with the Division of Treatment and Recovery Research at NIAAA serves as co-editor of this pending special issue along with Conner.

“NIAAA is emphasizing suicide and suicide-related issues more than ever before,” notes Conner. “This includes recognizing research accumulated over years time showing that suicide is a grave problem in alcoholics – and that the two are inextricably linked.”

Take Note!

In August 2003 the National Institute on Alcohol Abuse and Alcoholism (NIAAA), together with NIDA and NIMH, issued its first-ever research announcements for further investigation on the link between alcohol and suicide:

Developing Centers on Interventions for the Prevention of Suicide (DCIPS)

This is a Request for Applications (RFA-MH-04-003) that was issued Aug. 6, 2003, with a receipt date of Nov. 18, 2003. It has funding set aside for an initial five-year infrastructure for the study of preventive and treatment interventions for suicidality related to mental health, substance use disorders and alcohol use disorders. <http://grants2.nih.gov/grants/guide/rfa-files/RFA-MH-04-003.html>

Research on the Reduction and Prevention of Suicidality

This is a Program Announcement (PA-03-161) issued Aug. 7, 2003; it is open until 2006. This PA calls attention to particular areas that researchers might focus on to better understand the link between suicide and alcohol.

<http://grants1.nih.gov/grants/guide/pa-files/PA-03-161.html>



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Even Hollywood has dealt with alcoholism in profound ways, including the groundbreaking Paramount film, “Lost Weekend.” For his performance as an alcoholic, who as a result of a drinking spree cannot remember a lost weekend, actor Ray Milland won an Academy Award. Since its release in 1945 “Lost Weekend” has become a landmark film classic on the tragedy of alcoholism. Not surprisingly the film ends on a happier note than the novel on which it is based. Written by Charles R. Jackson, the novel resembles an autobiography of its author, who took his own life in New York in September 1968.

“There’s generally an increased interest in suicide prevention given the surgeon general’s report, the Senate and House resolutions, activities of SPAN (Suicide Prevention Action Network),” Conner continues. “It’s kind of a groundswell of interest. And alcoholism institutions recognize this.”

Some of the latest research findings about alcoholism and suicide are aiding treatment and prevention efforts.

“It’s a bit speculative, but there’s some promising research on the treatment of depression in alcoholics using fluoxetine, an antidepressant,” notes Conner. “Such treatment might reduce suicide risk in alcoholics.”

Marital- or couples-based treatment is another promising area, according to Conner.

“Alcoholics seem to commit suicide in the throes of severe marital or relationship difficulties,” he points out. “Given the connection between partner-relationship difficulties and suicide among alcoholics, couples’ treatments demonstrated to be effective in the treatment of this population may also be a promising strategy to reduce risk for suicidal behavior.”

For now these research findings should be applied only conditionally to current treatment regimens to reduce suicide

risk among alcoholics, according to Conner.

He recommends that promising findings be evaluated in a sub-population of alcoholics – those at high risk for suicide. High-risk alcoholics could be defined as those who have a co-occurring depression diagnosis, are in treatment because of a suicide attempt or have attempted suicide in the past. Once evaluated, this research could be widely disseminated and applied to current treatment procedures.

In the meantime, Conner stresses the importance of alcoholism clinicians and counselors having training and knowledge of depression and other mental disorders that can lead to suicide.

“I don’t think alcoholism clinicians in general have a lot of training in this area,” he notes. “We’re (the research community) not ready to hand them a package and say, ‘Do this.’ But a better dissemination of basic research information about the inextricable link between alcoholism and suicide would certainly be useful. If they can better recognize depression, that will improve their ability to effectively treat the alcoholic.” ■

About the author of this series: Denise M. Pazur is an award-winning communications practitioner and contributor to this publication.

What We Know About Alcohol and Suicide

Decades of research on the link between alcohol and suicide have shown the following:

ALCOHOLISM A FACTOR

People with severe alcohol dependence or alcoholism have increased risk for suicide. One study found that alcoholism was the strongest single predictor of subsequently completed suicide in a sample of attempted suicides.(3)

AGE AND SEX A FACTOR

As alcoholics age, they face increased risk for suicide. In other words, middle-aged and older alcoholics have a greater suicide risk than do young alcoholic adults, as do those who are male.(4)

FIREARMS A FACTOR

A connection exists among alcohol and suicide and firearms. One study showed that suicide victims who had been drinking but not necessarily intoxicated, were 4.9 times more likely to have used firearms than those who had not been drinking.(5)

BINGING A FACTOR

Suicide attempts among adults with alcohol dependence often occur in the context of an alcohol binge.(6) Another study found that high-school students who drink habitually and binge drink were more likely to have thoughts of suicide, made suicide plans and attempted suicide.(7)

TROUBLE AT WORK A FACTOR

People whose drinking results in trouble at work are six times as likely as others to commit suicide in the home.(8) The same study showed that people who were hospitalized with drinking problems had ten times the risk of death by suicide.

COCAINE A FACTOR

Cocaine use is associated with increased suicidal behavior and suicidal ideation in depressed alcoholics.(9) This was not observed for other drug use such as cannabis (marijuana). In other words if a person with alcohol dependence and major depression uses cocaine, the risk for suicide is heightened even further than if that person did not use cocaine.

ALCOHOL AVAILABILITY A FACTOR

A recent study found that states in which more spirits are sold per capita have higher suicide rates, and concluded that a 10% increase in spirits sales would result in a 1.5% or 1.4% (two samples were used) increase in a state's suicide rate.(10)

MOOD DISORDERS A FACTOR

Medically serious suicide attempters with alcoholism are more likely to have a mood disorder than control subjects – that is, alcoholics that have not made suicide attempts.(4)

UNEMPLOYMENT A FACTOR

Medically serious suicide attempters with alcoholism are more likely to have financial difficulties than control subjects – that is, alcoholics that have not made suicide attempts. (4) Also, when unemployment rates rise, so does per capita alcohol consumption and suicide for the population as a whole, according to a 1998 study of alcohol use and suicide in the United States between 1934 and 1987.(11)

RELATIONSHIP DIFFICULTIES A FACTOR

Alcoholics who complete suicide are more likely to have partner-relationship difficulties and other interpersonal life stressors than control subjects.(4) The upshot? Suicide prevention efforts in alcoholics must include a focus on depression as well as interpersonal factors including partner-relationship difficulties.

YOUTH AND SUICIDE AND ALCOHOL

- A study of coroners' reports and death certificates from 1978-1983 in Allegheny, Penn., found that 46% of adolescent suicide victims had alcohol in their blood – compared with just 12.9 percent in 1968-1972.(5)
- A recent study of three states found that suicide rates among 18-20-year-olds decreased when the minimum legal drinking age was raised to 21, representing 424 lives per year.(12)
- Teen suicide victims who were intoxicated (a blood alcohol concentration of 0.10% or more) were seven times more likely to have used a firearm than suicide victims with no alcohol in their blood.(5)

Other things the research suggests

Programs should be tailored to different groups of people according to their risks. For example:

- Suicide prevention programs for younger female drinkers should stress detecting interpersonal conflict, conflict resolution, counseling and legal protection from abusive intimate partners in order to counter potential for suicide in these women.(13)
- Suicide prevention programs for middle-aged female drinkers might focus on identifying and treating alcohol and other drug use as well as depression.(13) ■



Four or More

Alcoholics who commit suicide are likely to have four or more of the following risk factors:

- Continued drinking
- A major depressive episode
- Prior thoughts of suicide
- Poor social support
- Serious medical illness
- Unemployment
- Living alone

This, according to a 1992 study (9) of a sample of alcoholics, mostly white males, in St. Louis. The study found that over 80 percent of alcoholics who took their lives had four or more of the characteristics above when compared with control groups comprised of living alcoholics and also non-alcoholics who suicided. The upshot? Physicians and treatment counselors need to identify individuals who are 1) alcoholic, 2) show signs of being at risk for suicide, and 3) intervene on their behalf.(14)

Love, Michael

To my family:

I don't understand how a loving God would allow my head to be filled with such terrible thoughts all the time. Ever since coming out of the hospital the world has seemed like cardboard, as if all the faces and everything I see aren't "right," that death is around me much of the time. What is God trying to prove? It's horrible and I didn't want to fully admit how bad it is. I didn't want to end up in the hospital as a psychotic. I've had a couple of good days here and there. The medication seemed to help for a little while, but nothing is taking away this feeling that the world is a freaky place where I don't belong. The job interviews and phone calls and everyday conversations I have feel forced, unnatural, creepy. I'm not blaming the medical community. They did the best they could, but the doctors really don't understand what it's like to live this way 24 hours a day. This brain disease is hideous for those of us seriously affected. The genetic factor is huge. We understand so little about it. Please forgive me. I can't go on like this. It's too horrible. I'm sorry I plan to use alcohol at the very end. I don't want to go to the hospital again. I'm sure I would feel the same if I had a great job and a great marriage. This is a chemical disorder that has been worsening over the years. I believe God has a reason for this, mysterious as it is, and that He has a place for me that is peaceful. I love you all very much.

4:15 p.m. 3/21/97

Love, Michael



Editor's Note: The above is the verbatim message left by Michael Kluesner, who took his life at age 38, just eight days and 12 years after his sister Amy ended her life in March 1985. Michael bought a used rifle and two bullets – one to test the gun and the other to take his life. He then drove his van to a park by a lake and shot himself at about 3 p.m. on March 22, 1997.

Michael had struggled with alcohol and drugs since high school, recalls his father Al Kluesner, who, together with wife Mary and two other couples, co-founded Suicide Awareness Voices of Education, or SAVE, the Minneapolis-based prevention organization.

“Michael's depression was 'early onset' but he was not medically treated until he was 30 years old. Depression robbed Michael of personal relationships, good jobs, good humor, grace and social ease. When his depression eased up he was charming, caring, social and lovable...Michael had been treated for depression for over 10 years and was later diagnosed as bipolar,” notes Al in a wrenching survivor story posted at the AFSP website.

“In January 1997 Mary (Michael's mom) knew that Michael's depression was deepening despite the treatment. She knew that we were losing Michael. Five weeks before his death she said to me that she didn't think Michael would make it. I didn't agree because he had the best team of doctors, psychiatrists, psychologists and mental health counselors in Minneapolis...Mary was with Michael at the last session with his doctors,” adds Al. “He cried openly at that time pointing out that 'the pain is too great.' When asked why he didn't suicide, he said, 'I can't do it because of my family.'...And we still lost him.”

To read the entire text of Al Kluesner's survivor story about the loss of two of his children to suicide, log on to www.afsp.org, visit the survivor section and click on “stories.” For more about SAVE visit www.save.org.

What We Don't Know About Alcohol and Suicide

A connection between alcohol and suicide does exist. This has been substantiated by research. But the nature of that connection is unknown. Why? What is impeding researchers from better understanding the connection between alcohol and suicide?

First, blood alcohol concentration (BAC) screening is not routinely conducted in medical treatment settings – unless the presence of alcohol would alter the course of treatment for an individual.

Second, researchers must backtrack to examine the autopsy report in suicides to see if alcohol was in the bloodstream. Currently this information is not documented on a death certificate. (Note that once the NVDRS, or National Violent Death Reporting System, is put in place in all 50 states, this information and much else related to circumstances surrounding all violent deaths, including suicides, will be readily accessible.)

In its 2001-2005 Strategic Plan, the NIAAA is facilitating development of research to clarify the relationship between alcohol and violence – including suicide. In doing so NIAAA looks to assist in development of interventions to reduce or prevent alcohol-related violence.

Also, while much has been documented about suicide risk factors, particularly with mental illness and alcohol and substance abuse disorders, there has been little rigorous evaluation of the effect of evidence-based or empirically validated interventions on suicidality or suicide risk, according to NIH.

“There is a small but growing area of intervention research that tests targeted treatments of suicidal behavior per se, but much more research is needed to determine efficacy of those approaches along with treatments for the common conditions that accompany suicidality,” notes the NIH. Among these common accompanying conditions is alcoholism.

“It has been documented that alcohol consumption is a correlate and possible cause of a significant proportion of violent and aggressive events, including homicides, suicides, physical and sexual assaults, and child abuse, including incest,” states the 2001-2005 NIAAA Strategic Plan. “...In the U.S., alcohol is associated with violence to a far greater extent than all other drugs combined. ... Alcohol consumption has also been found to combine with suicidal conduct, especially among young males, perhaps through its effects on judgment, mood, and impulsive behavior. The extent to which alcohol causes violence versus simply being associated with violence remains unresolved. Studies in both animals and humans link alcohol more than any other drug with a high incidence of violent and aggressive behavior. Alcohol-related violence is the result of interaction between individual and environmental factors that either promote or inhibit violence. Findings from numerous studies implicate personality, expectancy, situational, and sociocultural factors that may interact with alcohol's pharmacological effects. What is not clear is whether and under what circumstances these interactions may combine to lead to violent episodes.” ■



Did you know?

- The lifetime risk for suicide death among alcohol-dependent individuals has been estimated to be 7 to 10 percent.
- Suicide attempts are associated with increased risk of later suicide death by 40-fold.
- Males die by suicide more frequently than females by a ratio of 4 to 1.
- Older white males have the highest suicide rate, followed by young American Indian and Native Alaska males.
- Married persons have lower rates of suicide than unmarried persons.
- Rural suicide rates exceed those in urban areas, and state rates vary by region, with Western mountain states having the highest suicide rates in the nation.
- For the year 2000, estimates of the number of persons treated annually for self-inflicted injuries, most of which are suicide attempts, range from 264,000 to 864,000.
- An estimated half the number of persons who attempt suicide do not seek treatment.
- Individuals diagnosed with HIV/AIDS, multiple sclerosis and brain cancers have increased risk for suicide.
- Patients with cancers who also have depression, unrelieved pain, and deteriorating functional ability have been reported to have higher rates of suicide ideation.
- Persons with an alcohol use disorder (AUD) and a history of a suicide attempt have a greater than 20-fold increased risk for subsequent suicide death.

Source: NIAAA RFA-MH-04-003 and PA-03-161

How Do We Prevent Alcohol-Related Suicides?

Given what we know about the link between alcohol and suicide, how do we move toward preventing alcohol-related suicides?

1st

FIRST, BY CONSIDERING WHO IS AT RISK:

Alcoholics: Studies show that alcoholics or alcohol-dependent individuals – especially those with comorbid major depression – are at greater risk for suicide than non-alcoholics .(15)

Youths: Alcohol use among adolescents has been associated with considering, planning, attempting and completing suicide.(16-18) In one study, 37 percent of eighth-grade females who drank heavily reported attempting suicide, compared with 11 percent who did not drink.(19) Research does not indicate whether drinking causes suicidal behavior, only that the two behaviors are correlated.

Studies show that alcohol is involved in a high number of youth suicides. One study of coroners' reports and death certificates found that 46 percent of adolescent suicide victims had alcohol in their blood.(5) And a statewide survey of South Carolina high-school students found that teens who reported binge drinking and habitual drinking were more than twice as likely to have made a suicide attempt requiring medical care than those who did not binge drink. In addition, teen suicide victims who were intoxicated at time of death (a blood concentration level of 0.10 percent or more) were *seven times more likely to have used a firearm* than suicide victims with no alcohol in their blood.

General population: Alcohol may be a factor in “impulsive” or “spontaneous” versus “planned” suicides – especially among people with clinical depression, whether that condition has been diagnosed or not. A 1988 study found that alcohol was involved more frequently in suicides where the victim left no suicide note, had made no prior suicide attempt, and had no long-standing diagnosis of physical or mental condition that could be linked to propensity for suicide. These victims also tended to use a firearm to take their lives. These people might not have committed suicide if they had not been drinking, concludes the study's authors.(20)

2nd

SECOND, BY IDENTIFYING WAYS TO LIMIT RISK IN EACH OF THESE POPULATIONS:

Alcoholics: Better diagnosis and treatment of alcoholism in our society could reduce alcohol-related suicides. So could education and training programs aimed at treatment specialists and the general medical community to better recognize signs of alcoholism, depression and accompanying risk factors or “red flags” for suicide potential.

“Because these patients (alcoholics) may receive treatment in mental health or substance abuse treatment facilities, it is important to implement and expand integrated services that

address both addictive and psychiatric disorders,” write researchers in the study “Comorbidity of Alcoholism and Psychiatric Disorders: An Overview.” “In addition, most research on treating alcohol use disorders has systematically excluded people with comorbid psychiatric disorders. The result is a wide gap between research and clinical realities.”

To further demonstrate the need for professional training to better assess presence of alcoholism and risk for suicide, consider that there are about 108 million visits to nearly 4,000 emergency rooms/departments each year in the United States, according to the NIH. As many as 30 percent of these ER patients present with alcohol-related problems. So nationwide alcohol accounts for a huge portion of ER visits each year. The efficacy of brief interventions in emergency care settings is a relatively new area of research, reports the NIH. A summary of pertinent research findings in this area can be found in the “Tenth Special Report to the U.S. Congress on Alcohol and Health,” published in 2000 by NIAAA.

Youths: Limiting access to firearms could aid in reducing youth suicide rates. So could controlling access to alcohol, including raising minimum legal drinking age to 21. As with alcoholics, the medical and substance abuse treatment communities need further education to recognize signs of suicide risk. Additionally, state laws such as those in Wisconsin that bar parents from mandating drug or alcohol treatment for their children age 14 and over should perhaps be reconsidered. These laws can impede parents' ability to place their child in a treatment program that can help arrest a drinking or drug problem, sometimes one that is masking an underlying depressive disorder. If left unchecked, this substance abuse can diminish a youth's ability to cope and erode the social support network they may sorely need to avoid suicide as the “solution” to problems that have been exacerbated by alcohol or drug abuse.

General population: Changing environmental factors that lead to drinking patterns and levels that increase risk for suicide among the general population may help. These could include restriction of alcohol through increasing alcohol taxes. Also improved diagnosis and treatment of depression by medical personnel could help reduce alcohol-related suicides. ■



Alcohol and Mental Health in the News

StateWatch

ALASKA

Alcohol treatment program cuts costs

An experimental program in Fairbanks has proven successful in steering individuals with alcohol addiction into treatment and reducing ER costs. A group of clergy, politicians, police, business and medical officials collaborated and developed a program to address the growing problem of chronic alcoholism. They focused on 50 people identified as "frequent flyers," individuals that continuously ended up in hospital ERs, or jail, following an alcohol-related incident. The group enrolled them in treatment programs, sometimes going to court to force individuals to get help. After one year, they report ER costs are down 42% and related health costs declined 30% for these individuals. (Join Together Online, 1/15/04)

COLORADO

Increase in inmates with drug and alcohol problems

The Detention Bureau Chief in El Paso County says at least 20% of the county's jail population have mental health problems, and 90-95% of the inmates also have a history of drug and alcohol abuse. Within the past year, the county added two mental health counselors and boosted hours of psychological and psychiatric coverage at the jails. Inmates now attend daily group meetings in mental health wards, and deputies receive more mental health and suicide training. Although pilot jail diversion programs operate in other parts of the state, correction officials say El Paso does not have such programs because community mental health resources are scarce in their county. (Denver Post, 8/24/03)

IDAHO

Tax increases to help pay for alcohol treatment

The Idaho Association of Counties approved a resolution calling on state legislators to increase beer and wine taxes to help offset medical costs related to alcohol abuse. Last session, lawmakers rejected such tax increases. Of the \$4.1 million raised in beer tax during the last fiscal year, approximately \$800,000 went to alcohol treatment, with the remaining portion allocated to the state's general fund and its permanent building fund. The majority of the \$2.4 million raised by wine taxes was allocated to the general fund. (Alcoholism and Drug Abuse Weekly, 9/29/03)

KENTUCKY

Inmate screening for mental health

A Senate panel approved a bill to provide screening of jail inmates for mental illnesses or suicide risks while they are being booked. SB 64 would build on the legislature's past efforts to improve mental health care for county jail inmates. Under the program, Telephonic Behavioral Health Triage, mental health workers would screen inmates over the phone to identify people with problems including drug or alcohol addictions, mental health problems and mental retardation. State officials said it would help jails across the state that cannot afford visits from mental health workers. Five counties across the state have experimented with the program. For one year, it should cost \$3.25 million. (Lexington Herald-Leader, 1/23/04)

NEW JERSEY

\$10 million earmarked to treat parents with substance use disorders

The commissioner of the Department of Human Services announced \$10 million will be earmarked to treat parents who abuse drugs and alcohol and who are involved with the state child welfare system. The funds will be used to create 850 new treatment slots for parents with substance use disorders who are at risk of losing their children. It is estimated that the treatment dollars will serve about 2,500 families in the coming year. The funding increase includes \$3 million previously allocated under the settlement of a class-action lawsuit brought by Children's Rights, Inc., plus \$7 million in state and federal welfare funds being redirected to provide treatment for parents who are both on public assistance and involved with DYFS. The state estimates that one-third of all child abuse or neglect cases each year in New Jersey involve at least one parent with a substance use disorder. (Press Releases, NJ, Dept. of Human Services, DYFS, 2/10/03; Northern NJ, Record, 2/6/04)

NEW YORK

Counties receive funding for drug treatment diversion program

A program aimed at getting nonviolent repeat offenders into drug treatment rather than jail is receiving a \$2.8 million expansion. The program, Road to Recovery, is a collaborative effort by the State Department of Criminal Justice and the Office of Alcoholism and Substance Abuse services. The funding will be shared by 17 counties in the state. Albany County chose not to participate, primarily because it was believed that the program could, in the long run, cost more than it receives. Some observers said funding provides for the prosecutorial arm, but not for social services. (Times Union, 10/28/03)

OHIO

Children's treatment center closes due to funding cuts

St. Joseph Children's Treatment Center closed its doors because of state funding cuts, leaving the Dayton area without a comprehensive mental health facility for children. Services for 130 children a year in residential treatment, 100 a year in day treatment and about 140 in outpatient care will be eliminated. Hospital officials said the state will spend more money in the long term on these children because children who are not being treated are committing violence to others. About 30% of Ohio's juvenile inmates have serious mental illnesses, and 77% abuse drugs or alcohol. Juvenile incarceration, at about \$4,800 a month, costs more than outpatient treatment and intensive day treatment provided by the hospital. The director of the Ohio Association of County Behavioral Health Authorities said treatment works; she cited an Ohio pilot program that reduced six-month recidivism in youths with mental illness from 49% to 15% by diverting delinquent youths into treatment. (Dayton Daily News, 2/5/04)

OREGON

Ballot measure fails; cuts to begin in May

Oregon voters failed to pass Measure 30 — a referendum that would have increased the state's income tax to pay for social services, jails and schools. As a result, county officials warned that state-funded services used by persons with mental illness and thousands of other needy patients could be cut significantly. In Multnomah County, for example, officials say the total state cuts to the county's budget for the 2003-04 fiscal year total \$5.3 million; next year, state cuts could reach \$27 million. Multnomah County voters approved an income-tax measure in May for schools and social services, which helps to soften some of the state cuts, but officials say it is not enough to offset the expected state cuts. County officials said among the cuts likely are: \$16 million for mental health and alcohol and drug treatment that could cause as many as 25,000 people to lose services, including housing and financial help for medications; and \$2.5 million cut over the current and next fiscal year to eliminate 11 positions overseeing treatment and supervision of 600 high and medium risk jail inmates. (Oregonian, 2/5/04)

PENNSYLVANIA

Philadelphia unifies mental health and substance abuse agencies

Culminating a multi-year effort to create a unified city system for delivering mental-health and substance abuse treatment, the mayor of Philadelphia signed an order establishing the Office of Behavioral Health and Mental Retardation Services. With a budget of more than \$1 billion, the new office is larger than any other city department. The four offices forming the new department are the Office of Mental Retardation Services, the Office of Mental Health, the Coordinating Office for Drug and Alcohol Abuse Programs, and Community Behavioral Health, a city-operated managed-care organization. The system has been operating for the last several years on a trial basis, and has already won awards for government innovation. (Philadelphia Inquirer, 10/24/03)

SOUTH CAROLINA

Proposal for health super agency defeated

A Senate subcommittee decided against merging the Department of Mental Health and the Department of Disability and Special Needs with the health divisions of the Department of Health and Environmental Control. Lawmakers also voted against merging the Departments of Health and Human Services and Alcohol and Other Drug Abuse Services into one new super agency. (See Headlines, Vol.

4 #2) The subcommittee instead approved an amendment that requires the Department of Health and Environmental Control's health division to coordinate with the Department of Health and Human Services and to report annually to the legislature on that effort. The amendment is part of a massive government restructuring bill. (Augusta Chronicle/AP, 2/18/04)

SOUTH DAKOTA Alcohol tax fails

A proposal to increase the state alcohol tax by five cents failed in the House Taxation Committee. HB 1169, which sought to increase the wholesale liquor tax, would have generated an additional \$28 million in tax revenue. Counties would have received an estimated \$17 million a year, with the state and cities splitting the rest. Supporters of the bill said counties need help with the rising cost of law enforcement, courts and other services. Law enforcement makes up about 35% of the budget for all counties, and the majority of crimes are alcohol-related, according to the County Commissioners Association. (AberdeenNews.com/AP, 2/6/04)

VIRGINIA County jail praised for addiction treatment

A program in Henrico County is gaining national attention for its unique approach to addiction treatment in the county jail. It is based on a social-recovery model, combining military-style discipline with the doctrine of Alcoholics Anonymous. Inmates participating in the program are kept in a stand-alone cellblock. They learn about the mistakes they made that led them to misuse alcohol and other drugs by listening to each other's experiences. The county program has a waiting list of prisoners who want to join. Officials say the program's \$80,000 a year cost has saved the jail money. (Join Together Online, 2/5/04)

Illinois, New Mexico, Pennsylvania and Washington receive millions from HHS for alcohol, drug interventions

Last October four states received a total of \$68 million from the U.S. Department of Health and Human Services (HHS) for brief interventions to deal with people at risk of dependence on alcohol or drugs. Grant funding breaks out as follows:

Illinois: \$17.5 million
New Mexico: \$17.5 million
Pennsylvania: \$16.9 million
Washington: \$16.1 million

The monies are to fund early intervention services in hospitals and other general medical and community settings to reach people at risk of dependence on alcohol or drugs.

For more see www.samhsa.gov/news.

NationWatch

Physicians call on states to repeal laws impeding drug screening in ERs

Physicians at the American Medical Association Interim Meeting voted to support the repeal of State statutes permitting insurance companies to refuse to pay for treatment for intoxicated patients' injuries. Because of these statutes, based on a model law, the Uniform Accident and Sickness Policy Provision, ERs are less likely to screen for alcohol and drugs because visits will not be covered by insurance. More than 40% of patients treated in ERs are believed to be under the influence of alcohol or other intoxicants, according to information presented at the meeting. However, studies estimate that less than 15% of injured hospital patients are screened for alcohol and referred for counseling. Better alcohol and drug screening and intervention in ERs could result in a \$1.82 billion in net savings in direct medical costs over a three-year

period, according to a cost-benefit analysis by the University of Washington. The AMA joins a call put forward by the National Association of Insurance Commissioners in 2001 proposing a new model law that would prohibit insurers from denying payment for intoxicated patients' care. Until states change their laws, screening will not be a priority in most ERs. (AMNews, 1/5/04)

Persons with addictions find little help in workplace

A new report by Hazeldon Foundation shows roughly 25% of human-resource officers at U.S. companies report their businesses are less likely to hire someone recovering from drug or alcohol addictions. The report says executives are sensitive to the problem, but often ignorant about how to handle it. More than 50% of human-resource workers said they lacked expertise to detect the problem. Hazeldon offers advice for employers, including: examine the company's approach to addiction, options for employees and prevalence of alcohol and drug abuse in workforce; encourage forums to discuss treatment, recovery and addiction; and explain how to access treatment and how to support colleagues with addiction. (Seattle Post-Intelligencer Reporter, 12/15/03)

Supreme Court rules on workplace rights

The Supreme Court gave companies some leeway to refuse to rehire persons recovering from drug and alcohol addiction, but without the broad ruling employers had hoped for. The justices unanimously ruled Hughes Missile Systems has a legitimate reason to refuse to rehire workers who break rules, including former employees with addictions. The court, however, did not offer an opinion on the more significant question – whether the more than 5 million workers with substance use disorders have workplace protection under the 1990 landmark Americans With Disabilities Act. The case is Raytheon Co. v. Hernandez, 02-749. Visit www.supremecourt.gov. (ABC News.com, AP/12/2/03)

Reasons for not receiving substance abuse treatment

A new report based on data in The 2002 National Survey on Drug Use and Health found that about 7.7 million persons aged 12 or older needed treatment for an illicit drug problem and about 18.6 million needed treatment for an alcohol problem. About 18% of those needing treatment for an illicit drug problem and about 8% of those needing treatment for an alcohol problem received specialty substance abuse treatment in the past year. The primary reasons for not obtaining treatment were not being ready to stop using illicit drugs, thinking the cost of treatment would be too high, stigma associated with receiving treatment and not knowing where to get treatment. The survey was conducted by the Office of Applied Studies in the Substance Abuse and Mental Health Services Administration. Visit www.samhsa.gov/oas/. (Alcoholism and Drug Abuse Weekly, 11/24/03)

Few choices for elderly persons with alcoholism

A new study conducted by the University of Iowa shows elderly persons needing alcohol treatment have few options. Less than one in five existing substance abuse programs in the country offers services specifically designed for older adults. Researchers said older populations need specialized detoxification services because they may not feel comfortable attending rehabilitation with younger persons. "Only 17.7% of all known public and private facilities in the county offer specialized substance abuse treatment for elders. The research article was published in the September issue of the "International Journal of Geriatric Psychiatry." (Iowa City Press-Citizen, 10/14/03)

15 states expanding AOD Services

Fifteen States have been chosen to participate in a new \$3 million Robert Wood Johnson Foundation program that helps states identify and implement strategies to expand alcohol and other drug treatment services. The program, "Resources for Recovery: State Practices That Expand Treatment Opportunities," encourages states to work within existing state resources. A new website for the project was launched by program's National Program Office: www.resourcesforrecovery.org. The NPO offers a monthly e-newsletter; summaries of state strategies, research and news of interest, and program administration guidelines. (Resources for Recovery Vol 1 Issue 1, info@resourcesforrecovery.org)

Source: SAMHSA Behavioral Health Headlines

Learning More

Check out these web addresses for more information on the relationships among alcoholism, suicide and mental illness:

Dying for a drink: Global suicide prevention should focus more on alcohol use disorders

www.hopeline.com/Learningmore/01

Position paper appearing in the Oct. 13, 2001, issue of the "British Medical Journal."

SAMHSA's National Clearinghouse for Alcohol & Drug Information (NCADI)

www.hopeline.com/Learningmore/02

The nation's one-stop resource for information about substance abuse prevention and addiction treatment, staffing information specialists available 24 hours a day, seven days a week at (800) 729-6686.

Alcohol-Alcoholism Associations & Organizations

www.hopeline.com/Learningmore/03

Comprehensive listing including national, international, state and local association, society, college, academy, research, council and other websites.

Alcoholism and Psychiatric Disorders: Diagnostic Challenges

www.hopeline.com/Learningmore/04

Including psychiatric disorders commonly associated with alcoholism, diagnostic difficulties in assessing psychiatric complaints in alcoholic patients and basic approach to diagnosing patients with alcoholism and coexisting psychiatric complaints.

Underage Drinking: A Major Public Health Challenge

www.hopeline.com/Learningmore/05

An "Alcohol Alert" issued by the National Institute on Alcohol Abuse and Alcoholism in April 2003. Includes injury and social consequences including suicide, alcohol's effects on the adolescent brain, the link between early alcohol use and alcohol dependence, prevention and treatment, and policy and community strategies.

10th Special Report to the U.S. Congress on Alcohol and Health: Highlights from Current Research

www.hopeline.com/Learningmore/06

Issued in June 2000.

Alcohol Research: Achievements and Promise

www.hopeline.com/Learningmore/07

From the "American Journal on Addictions" (American Academy of Addiction Psychiatry), Volume 10, Number 1 Supplement 2001. Includes "New Developments in the Pharmacotherapy of Alcohol Dependence," "The Community Reinforcement Approach to the Treatment of Substance Use Disorders" and "Alcohol Intoxication and Violent Crime: Implications for Public Health Policy."

Results of the 2003 National Alcohol Screening Day (NASD)

www.hopeline.com/Learningmore/08

Conducted in April 2003, this fifth annual NASD was sponsored by NIAAA and SAMHSA.

Alcoholism primer

www.hopeline.com/Learningmore/09

Reader-friendly all-encompassing alcoholism primer. Includes what is alcoholism, definition of alcohol use and abuse, what causes alcoholism, who becomes an alcoholic, how serious is alcoholism, how is alcoholism diagnosed, general guidelines for treating alcoholism, treatment for alcohol withdrawal, psychotherapy treatments for alcoholism, and measures or drugs used to prevent relapse.

The Cool Spot

www.hopeline.com/Learningmore/10

A website for youth with facts on underage drinking. From NIAAA and SAMHSA.

Helping Patients With Alcohol Problems: A Health Practitioner's Guide

www.hopeline.com/Learningmore/11

Two free publications from NIAAA

MyStudentBody.com

www.hopeline.com/Learningmore/12

MyStudentBody.com — Alcohol is an interactive online prevention and education tool for college students designed to reduce drinking and alcohol-related risk behaviors.

"Using Performance Measurement to Improve the Quality of Addiction Treatment"

www.hopeline.com/Learningmore/13

A new primer released in January 2004 from Ensuring Solutions to Alcohol Problems (affiliated with the George Washington University Medical Center and funded by The Pew Charitable Trusts). Includes leading addiction treatment indicators in a performance measurement tool, the Health Plan Employer Data and Information Set (HEDIS).

College Drinking: Changing the Culture

www.hopeline.com/Learningmore/14

Award-winning website launched by NIAAA with content for parents, college presidents, community leaders, students, resident advisors, campus health administrators, high-school guidance counselors and the media.

NCADI Referral List

www.hopeline.com/Learningmore/15

A comprehensive listing of more than 80 referral organizations including clearinghouses and those whose focus is criminal justice, crisis counseling, drug education, elderly, fetal alcohol syndrome, health and safety, HIV/AIDS, homelessness, hotlines, impaired driving, mental health, prevention, recovery, research, self-help, smoking cessation, support groups, tools for professionals, violence, women and workplace.

Alcohol Policy Information System (APIS)

www.hopeline.com/Learningmore/16

An NIAAA web-based resource that provides authoritative, detailed and comparable information on alcohol-related policies in the United States, at both state and federal levels.

SAMHSA Substance Abuse Treatment Facility Locator

www.hopeline.com/Learningmore/17

An online resource for locating drug and alcohol abuse treatment programs that lists private and public facilities that are licensed, certified, or otherwise approved for inclusion by their state substance abuse agency; and treatment facilities administered by the Department of Veterans Affairs, the Indian Health Service and the Department of Defense.

Harvard School of Public Health College Alcohol Study (CAS)

www.hopeline.com/Learningmore/18

An ongoing survey of more than 14,000 students at 120 four-year colleges in 40 states that is supported by The Robert Wood Johnson Foundation.

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The Noonday Demon: An Atlas of Depression

A book review by Andrew E. Slaby, M.D., Ph.D., M.P.H.

The Noonday Demon: An Atlas of Depression, by Andrew Solomon (Scribner April 2002, paper, 576 pages, ISBN: 0684854678)

Marcel Proust, the French writer who was recurrently depressed (but did not suicide) wrote: "Just as a lover listens to his beloved, so too does a person in pain listen to his body." People who die by suicide do not want to die; they simply want to end the pain often caused by depression. If there were another way to end the pain, they would seek it. Failing to find a source of reprieve, they become hopeless. More than depression, hopelessness predicts who will die by suicide.

No current book could be described more aptly as a discussion of the anatomy of melancholia, a term used by Robert Burton for his 17th century treatise on his own depression, than Andrew Solomon's *Noonday Demon*. The title of the book is taken from Cassian, who wrote in the fifth century of the "sixth combat" with "weariness and distress of the heart"; that, he said, was the "noonday demon," spoken of in the 19th psalm, and which produced disdain, disgust, sluggishness and contempt for other men.

In this well-researched, documented and skillfully crafted volume, Solomon has woven his own struggle with depression and the impact of the death of his mother with a state-of-the-art review of what is known about the etiology of depression and its treatment. He describes medical interventions as well as alternative therapies used throughout the world (some of which he sought out and experienced himself) and places them in a historical and cultural context. He also discusses his experiences with various forms of treatment, including self-medication with drugs. The impact of depression on various populations (including women, the aging, and medically infirm) is discussed, as are factors that converge to make them consider, or in fact die by, suicide. In addition to a detailed discussion of the pain he has experienced, he includes a number of other examples drawn from interviews of friends, patients both within and outside of hospitals, in other cultures and in multiple social strata.

The chapters on addiction and suicide and the discussion of animal models of depression are particularly thought provoking. Reflecting on the use of drugs and alcohol at times of despair, he characterizes depression as enabling addiction. Resisting desire takes too much will and energy. When you are depressed, it is hard to say no to drugs, alcohol or, for some, food. Depression weakens the person, and Solomon feels this weakness is the surest way to addiction. This may explain why substance abuse is so often the presenting sign of depression in adolescents – a group that does not show the same degrees of sleep, appetite and sexual interest disturbance we see in depressed adults.

Suicide, the author contends, is at least as independent of depression as is substance abuse. Some who suicide have not demonstrated symptoms of depression or at least have not experienced it for some time. As our understanding of self-inflicted death grows, we are learning that impulsivity even independent of depression may be important in understanding who is at risk for suicide. Some people suffer all their lives and daily think of dying or wanting to be dead,

but, despite the ravages of psychiatric disorders, the pain associated with chronic illnesses or poverty, or existence in concentration camps or psychological, physical, and sexual abuse, do not kill themselves.

The discussion of animal models of depression illustrates the complex role of environmental stress, corticosteroid production in the body, neurotrophin and neurotransmitters. Human beings are not alone in experiencing the pain of loss, depression or suicide. Attachment to another can lead both to experiencing the pain of loss, as well as the limitation of life's experiences, even for subprimates. Solomon cites what appears to have been a suicide of an octopus trained to perform in a circus. When the circus was disbanded, the color hue of the octopus changed, indicating to zoologists an alteration in mood after no one paid attention to the repertoire of tricks it had learned to entertain spectators, and it stabbed itself. In other instances, serotonin levels in the brains of monkeys were found to decrease when separated from their mothers in infancy, resulting in psychotic behavior. Dominant males moved from colonies of marsupials into other colonies where they were not dominant experienced weight loss, disrupted sleep and lowered sexual performance. Antidepressants that increase serotonin were shown to reverse the trends in both instances. In fact, as monkeys rise in dominance in peer groups, enhancing their power, their serotonin levels rise.

Solomon ends the book with an optimistic note. He explains that while he does not enjoy experiencing depression, he "love(s) the depression" itself and what he learns of himself while in it. It forces him, he contends, to look deeper into life and find and cling to reasons for living. He finds it a "rare joy" to choose each day, sometimes gamely and sometimes against reason, to be alive.

Whether or not you agree with his affirmation that depression not only obliterates joy, but also teaches us a great deal about joy, it is hard to disagree with him when he says:

"If you read these pages closely, you can learn how to be depressed; what to feel, what to think, what to do. Nonetheless, the individuality of every person's struggle is unbreachable. Depression, like sex, retains an unquenchable aura of mystery. It is new every time." (p. 400).

Solomon leaves the reader with an understanding of the complexity of the struggle to live for one who is depressed, and sometimes of their decision to die.

Book reviewer Andrew E. Slaby, M.D., Ph.D., M.P.H., is clinical professor of psychiatry at New York University and New York Medical College, and is in private practice in New York City and Summit, N.J. Past president of the American Association of Suicidology (AAS), Slaby has authored or edited numerous books, including "No One Saw My Pain: Why Teens Kill Themselves."

Award-winning book author Andrew Solomon is a regular contributor to "The New Yorker," "ArtForum" and "The New York Times Magazine." He is the recipient of the 2001 National Book Award and was a finalist for the "Los Angeles Times" First Fiction Award. ■



Frontline

Bullying and Suicide Prevention

Lorinda Lonie, L.S.W., L.C.D.C.
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I first started researching and collecting data on bullying (emotional, physical, sexual) in relation to suicidal ideation about eight years ago. At this time there was hardly any information on prevention of bullying mentioned on the Internet and I could not see any research that had been done in the United States. Most of the information came from Britain, Australia, Japan and Norway.

However, I started to see that one of the contributing factors in youth suicides appeared to be bullying. This fascinated me, and I thought of my own experiences of being bullied in school and asked other adults how it affected them. Most adults had a great need to tell their story and felt like it had affected them emotionally into adulthood. Many talked about feeling suicidal as teenagers due to bullying. Feeling helpless and hopeless with no one to talk to were key factors.

Before Columbine the topic of bullying even when talked about in relation to suicide was not taken seriously - even in the mental health field or school district. After Columbine I was inundated by phone calls from school personnel asking me to come in and educate the staff and youth on bullying prevention. In one year I talked to 8,000 individuals (children, teenagers, adults) in our local school district.

To make bullying and suicide prevention a component of Youth Services at Crisis Intervention of Houston, Inc. (CIH), I first had to sell it to the staff and board of directors. I did this by presenting the topic at a strategic planning meeting. I had prepared a packet of information containing the following:

- Goals and objectives
- Outcome measure tool
- Research
- Statistics on how many people I had already presented workshop to show the need
- Centers for Disease Control and Prevention guidelines for bullying prevention
- Newspaper articles on recent bullying/suicides
- Curriculum for youth and one for mental health and school faculty
- Evaluation form

Staff and board members were given the opportunity to ask questions and give input. The program was accepted and implemented; Crisis Intervention received funding through two foundation grants to implement this program.

The curriculum regarding bullying and suicide for adults addressed the following areas (youth curriculum was similar but appropriate to the grade level):

- Definition of bullying
- Prevention strategies
- Intervention and assessment
- School safety and creating a safe environment
- Cultural awareness and diversity issues
- Suicide/homicide assessment
- Community and mental health resources.

Crisis Intervention of Houston and The Harris County hospital district recently updated their suicide lethality assessment forms to include school-related difficulties with a category for bullying information.

I have now added "Bullying in the Workplace" to the topics of workshops CIH presents. At a recent workshop requested by NASA, 100 people attended, and the question and answer session had to be extended as many people had inquiries about their situations. Afterwards adults approached me to discuss how they were being bullied by employers and coworkers. One gentle man talked about feeling suicidal and hopeless because he was constantly singled out and jokes were made about him in the presence of coworkers. He stated that he knew he would not get promoted. And because of the economy he could not change jobs, yet often thought of suicide as an option. He said he had no suicidal plans at the time, but it was made clear to me from this workshop that there is a need for education on bullying and suicide prevention among all age groups – including adults. ■

Lorinda Lonie, L.S.W., L.C.D.C., is Hotline services director for Crisis Intervention of Houston, Inc. She has been with CIH for 15 years and is responsible for all Hotline services, plus program evaluation and development. Lonnie is speaking on suicide and bullying at this month's conference of the American Association of Suicidology in Miami. She can be reached at (713) 533-4513 or Lorinda@crisishotline.org.

Research suggests link between bullying and suicide

- One of the few studies to examine bullying problems in the United States revealed that 10 percent of a group of American third- through sixth-graders experienced chronic victimization. (Perry, Kusel, and Perry, 1988).
- A recent study of American fifth-graders found that 18 percent of the sample was regularly targeted (Pellegrini, Bartini, and Brooks, 1999). By conservative estimates 10 percent of school children are chronic targets of bullying, while the number may be as high as 20 percent. Almost all children have experienced occasional bullying or seen others being bullied, which can lead to fear of becoming a regular target.
- In recent years the United States has witnessed several school shootings, resulting in the deaths of both students and teachers. Although the extent to which bullying contributed to these tragedies remains unclear, this possibility has been raised (Timms).
- Hatred in the Hallways: The Human Rights Watch report suggests that high school can indeed be a terrifying experience for gay teens. Based on interviews with more than 250 students, teachers and parents in seven states, the study finds that treatment of gay students in American public schools constitutes a human rights issue.
- Social and cultural factors have been cited as the origin of many crises, especially among those disadvantaged by the economic, political, and related factors stemming from personal and institutionalized racism and homophobia (Hendin 1987, Remafedi 1994, 1991, Rofes 1983)

Spate of prison suicides spurring action in Vermont, Oregon, Montana and Arizona

Actions and policies of the Vermont state correctional system are partly to blame for the deaths of some of seven inmates in the past two years, several self-inflicted. This is according to an independent investigation launched last December by the state Agency of Human Services at the urging of lawmakers concerned by a rash of suicides at state prisons. The investigation's report criticizes a "culture within the department (of Corrections) that fails to embrace accountability." In response Vermont Human Services Secretary Charlie Smith promised a sharp reaction from the state including steps to reform the state's prison system and promote humane treatment of prisoners.

Meanwhile the hanging of an Oregon inmate on Valentine's Day brings the number of suicides of inmates in the disciplinary segregation unit at the Oregon State Penitentiary to three in the past 11 months. After the latest death the top mental health administrator of Oregon's 12,300-inmate prison system vowed to conduct a detailed review.

Suicide has hit the front pages of Montana newspapers in recent weeks on the heels of four inmate suicides since last July at the Montana State Prison. After the last suicide occurred Feb. 2, the state hired consultant Thomas W. White to determine if operations at the prison were a factor in the unusual rash of suicides, reports the Associated Press. While White found no common factor among the four suicides, he recommended the prison review its policies on suicide prevention and handling mentally ill inmates to ensure the policies comply with national standards. He said some policies are vague about assigning responsibilities. White also suggested the staff make a greater effort to converse with inmates who spend most of their days isolated in maximum-security cells. And in Arizona, the

Department of Juvenile Corrections (ADJC) is scrambling to make changes to the state's juvenile prison system in the wake of a U.S. Justice Department report detailing a wide array of problems that puts youths at risk. A Jan. 23 report to the Arizona governor cited deficiencies in the state's juvenile prison system that violated the Civil Rights of Institutionalized Persons Act (CRIPA). These include teenage inmates being beaten, sexually abused, isolated for weeks at a time, left unsupervised, and denied mental health and medical care. The CRIPA report also states that nearly two-thirds of the staff at one of the prisons had no suicide prevention training, which is a standard. In response, Gov. Janet Napolitano has appointed an independent task force that is set to start work in April, according to Patti Cordova, spokesperson for ADJC.

School-based SOS suicide prevention program shows success

For the first time, a school-based suicide prevention program has been shown to reduce suicidal behavior in high-school students. This, according to "An Outcome Evaluation of the SOS Suicide Prevention Program," by Robert H. Aseltine, Jr., Ph.D., and Robert DeMartino, M.D., just published in the March 2004 issue of "American Journal of Public Health." Students who participated in the SOS program showed a 40 percent reduction in suicide attempts, according to the study. "For the first time in 20 years of research on school-based suicide prevention programs, we are seeing a program that is not just increasing knowledge and changing attitudes about suicide - it is actually reducing suicidal behavior," says Aseltine in a March 3 press release from the University of Connecticut Health Center. For more, see www.ajph.org or www.mentalhealthscreening.org.

investigator

Federal Investigator



Nation's poor get reprieve with Senate vote to preserve Medicaid funding

It was a plan that "puts people with mental illness at grave risk ... disastrous for the mental health of Americans," according to the National Mental Health Association (NMHA). Federal plans to slash Medicaid funding for the poor by as much as \$11 billion were dropped on March 10 in a U.S. Senate vote. The decision is a welcome reprieve for millions of Americans who rely on Medicaid to fund critical health benefits including mental health services. Medicaid funds more than 50 percent of public mental health services administered at the state and local levels, according to NMHA. "States are currently emerging from the most severe budget crisis since World War II, and nearly every state has already enacted difficult cuts to its Medicaid program, including both eligibility levels and provider payments," said a letter to Senate budget leaders from Governors Dirk Kempthorne of Idaho and Mark Warner of Virginia. "Federal funding reductions would force states to implement even deeper cuts by restricting eligibility, eliminating or reducing critical health benefits, and cutting or freezing provider reimbursement rates. As a result, Medicaid funding cuts could add millions more to the ranks of the uninsured and would harm our nation's health care safety net," the governors said.

\$30 million to combat youth suicide brought to U.S. Senate

On March 8 four U.S. senators introduced bipartisan legislation to support the planning, implementation and evaluation of statewide youth suicide early intervention and prevention strategies. The Youth Suicide Early Intervention and Prevention Expansion Act of 2004 (Bill # S.2175) was brought forward by Sen. Christopher J. Dodd (D-Conn.), Sen. Gordon Smith (R-Ore.), Sen. Mike DeWine (R-Ohio), and Sen. Harry Reid (D-Nev.). This key legislation would provide \$30 million for each fiscal year from 2004 to 2006. It authorizes the secretary of Health and Human Services to award grants to: first, develop and implement youth suicide early intervention and prevention strategies; second, collect and analyze data on statewide youth suicide early intervention and prevention services; and third, assist states in reaching goals for youth suicide reductions. The bill was referred to the Senate Committee on Health, Education, Labor, and Pensions on March 8. To voice your support for this and other key legislation pertaining to both suicide prevention and mental health visit www.spanusa.org.