Legislative Analysis

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SUICIDE AND DEPRESSION PROGRAMS

House Bill 4375 as introduced
Sponsor: Rep. Chris Ward
Committee: Education

First Analysis (3-28-06)

BRIEF SUMMARY: The bill would encourage the board of a school district, or the board of directors of a public school academy, to provide age-appropriate instruction for students, and professional development for school personnel, about the warning signs and risk factors for suicide and depression.

FISCAL IMPACT: The Department of Education may incur costs in developing model programs and materials. There also may be some additional costs to the local school districts or public school academies for instruction and professional development.

THE APPARENT PROBLEM:

Suicide is the eighth leading cause of death in the United States—about 30,000 people take their life each year. However, among adolescents, suicide is the third leading cause of death; about 12 young people between the ages of 15-24 die every day by suicide. While suicides account for 1.2 percent of all deaths in the United States annually, they comprise nearly 13 percent of all deaths among 15-24 year olds.

Only recently has suicide been approached as a preventable public health problem. The Suicide Prevention Resource Center (SPRC) headquartered at the Education Development Center in Newton, Massachusetts, is the new national resource center that provides technical assistance, training, and information in order to strengthen suicide prevention networks, and advance the National Strategy for Suicide Prevention. Some 24 states have prevention plans in place; those in the Great Lakes region include Minnesota, Wisconsin, Ohio, and Pennsylvania. See Background Information below. The national center is funded by a grant from the Substance Abuse and Mental Health Services Administration.

According to a study released by the Substance Abuse and Mental Health Services Administration in July 2002, close to three million Americans age 12-17 considered suicide in 2000, and more than a third of those tried to kill themselves. The suicide rate among those surveyed increased as children aged: 9 percent of children age 12-13 considered or tried to commit suicide; while 13.7 percent considered or tried suicide in both the 14-15 and 16-17 age groups. Only 36 percent of those who were at-risk of suicide received mental health treatment, despite that fact that suicide is nearly always preventable. The government survey indicated that girls were twice as likely as boys to have thought about or tried to commit suicide. Among those surveyed, White, Black, Hispanic, and Asian youths reported similar rates of suicide risk. Further, youths in

Western states were the most at risk (14 percent), followed by young people in the South (13 percent), the Midwest (12 percent), and the Northeast (11 percent). (Detroit News 7-15-02).

Suicide rates for 15-24 year olds are 200 percent higher today than they were in the 1950s, and they have remained largely stable at these higher levels between the late 1970s and the mid 1990s. For example, suicide rates for 15-19 year olds increased 11 percent between 1980 and 1997. During this same period, however, the rate of suicide among younger adolescents grew exponentially—for those between the ages of 10-14 an increase of 99 percent. The good news is that according to the American Association of Suicidology, both age groups have shown small declines in rates in the past two years. Unlike the results of the government's recent poll which indicated similar rates of suicide risk regardless of race or ethnicity among those polled, national statistics tell us that Black male youth, ages 10-14 have shown the largest increase in suicide rates since 1980 compared to other youth groups categorized by sex and ethnicity, increasing 180 percent. Among 15-19 year old Black males, rates since 1980 have increased 80 percent. Yet overall, White suicide rates are about twice those of non-Whites, and it is Native Americans who have the highest suicide rate of all, but tribal group differences exist.

Most often suicidal teens use guns to kill themselves. Firearms are the most commonly used suicide method among youth, regardless of race or gender, accounting for almost 60 percent of completed suicides. Research has shown that the access to the availability of firearms is a significant factor in the increase of youth suicide.

A common cause of teen suicide is depression, and at least 90 percent of suicidal individuals have been diagnosed with at least one of these psychiatric disorders: major depression; bipolar disorder; conduct disorder; substance abuse; or anxiety disorder. The risk of suicide in people with major depression is about 20 times that of the general population; and people who have had several episodes of depression are at greater risk for suicide than those who have had one. However, only one out of every sixteen people who is diagnosed with depression end their lives through suicide. People who are depressed and exhibit the following symptoms are at particular risk for suicide: extreme hopelessness; a lack of interest in activities that were previously pleasurable; heightened anxiety and/or panic attacks; global insomnia; talk about suicide or a prior history of attempts/acts; and irritability and agitation. See Background Information below.

Suicide prevention groups list the warning signs, and they encourage the friends of suicidal people to intervene. They note that 80 percent of suicidal people give definite warning signals of their intentions, and they ensure that talking about suicide never causes someone to become suicidal.

In order to make the warning signs, intervention approaches, and treatment options better known, legislation has been introduced to encourage school officials to include instruction and professional development about suicide prevention and depression, as topics in the school curriculum.

THE CONTENT OF THE BILL:

House Bill 4375 would amend the Revised School Code (MCL 380.1171) to encourage the board of a school district, or the board of directors of a public school academy, to provide age-appropriate instruction for students, and professional development for school personnel, about the warning signs and risk factors for suicide and depression. The instruction and professional development would have to be designed to achieve the following goals:

a) to prevent both fatal and nonfatal suicide behaviors among youth;

b) to increase students' awareness of the warning signs and risks factors for suicide and depression; and,

c) to improve access to appropriate prevention services for vulnerable youth groups.

Under the bill, a school board is encouraged to work with school personnel and local or state organizations and resources specializing in suicide prevention and awareness.

Further, the Department of Education would be required to develop or select model programs and materials on suicide prevention and awareness that were appropriate for the purposes of the bill, and make those available to school districts and charter schools.

The bill specifies that if a school district or charter school provided suicide prevention instruction, the board would be required to notify parents about the instruction (using the communication method the district normally used).

BACKGROUND INFORMATION:

House Bill 4375 is similar to House Bill 5059 of the 2003-04 Legislative Session. Information in this analysis is derived from the analysis of that bill dated 5-26-04.

The National Strategy for Suicide Prevention. The National Strategy for Suicide Prevention was released in 2001 by the Substance Abuse and Mental Health Services Administration of the federal government. The strategy provides a framework of specific goals and objectives for action to address suicide as a public health problem. The National Strategy's goals and objectives are as follows:

Awareness: 1) promote awareness that suicide is a public health problem that is preventable; 2) develop broad-based support for prevention; and 3) develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.

Intervention: 4) develop and implement suicide prevention programs; 5) promote efforts to reduce access to lethal means and methods of self-harm; 6) implement training for recognition of at-risk behavior and delivery of effective treatment; 7) develop and promote effective clinical and professional practices; 8) improve access to and

community linkages with mental health and substance abuse services; 9) improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.

Methodology: 10) promote and support research on suicide and suicide prevention; and 11) improve and expand surveillance systems.

The Suicide Prevention Resource Center. To implement the strategy, the Suicide Prevention Resource Center, headquartered at the Education Development Center (EDC) in Newton, Massachusetts, was created to gather and disseminate evidence-based suicide prevention practices, and enhance capacity for state and local prevention planning, implementation, and evaluation. The resource center works to develop and provide technical assistance to prevention networks in the ten public health regions of the United States. The networks are coalitions of change-oriented organizations and individuals working together to promote suicide prevention. The networks include statewide coalitions, community task forces, regional alliances, or professional groups, and are organized at the national, state, territorial, community, and tribal levels.

The Suicide Prevention Resource Center mounts regional conferences, and also operates a call center to access technical assistance, information, materials, programs, and experts in the field. The telephone number of the call center is 877-GET SPRC (487-7772). The web site of the Suicide Prevention Resource Center is www.sprc.org

Other national, regional, state, and local organizations include the following:

The American Association of Suicidology, 4201 Connecticut Avenue, NW, Suite 408, Washington, DC 22208; (202) 237-2280, and also the Michigan Association of Suicidology which publishes a directory of Survivors of Suicide (SOS) groups in this state: www.cuicidology.org and info@suicidology.org

The Yellow Ribbon Youth Suicide Prevention Program of Michigan, dedicated to saving lives through awareness and education within schools and communities, is part of a national organization based in Westminster Colorado. The Michigan chapter can be reached at www.michiganyellowribbon.org

The Michigan Suicide Prevention Action Network is headed by Larry G. Lewis, MSW, and headquartered at 24760 Arsenal Road, Brownstown Township, Michigan 48134. The group can be reached by e-mailing spanmich@comcast.net

The University of Michigan Child and Adolescent Depression Program is headed by Dr. Cheryl A. King, and headquartered at 1500 East Medical Center Drive, Ann Arbor, Michigan 48109-0296. The telephone number is 734-764-3168, and Dr. King can be reached by e-mailing kingca@umich.edu

The Warning Signs of Suicide. According to the American Association of Suicidology, a suicidal person may:

Talk about suicide, death, and/or no reason to live;
Be preoccupied with death and dying;
Withdraw from friends and/or social activities;
Have a recent severe loss (especially a relationship) or threat of significant loss;
Experience drastic changes in behavior;
Lose interest in hobbies, work, school, and similar activities;
Prepare for death by unexpectedly making out a will and final arrangements;
Give away prized possessions;
Have attempted suicide before;
Take unnecessary risks, and act reckless, and/or impulsive;
Lose interest in their personal appearance;
Increase their use of alcohol or drugs;
Express a sense of hopelessness;
Be faced with a situation of humiliation or failure;
Have a history of violence or hostility; and,
Have been unwilling to "connect" with potential helpers.

The association points out that nearly everyone at some time in his or her life thinks about suicide, but comes to realize that their crisis is temporary. However, people in the midst of a crisis often see their dilemma as inescapable, and they feel an utter loss of control. Frequently they can't stop the pain; can't think clearly; can't make decisions; can't see any way out; can't sleep, eat, or work; can't get out of the depression; can't make the sadness go away; can't see the possibility of change; can't see themselves as worthwhile; can't get someone's attention; and can't seem to get control.

The association says that people who display these warning signs, or experience these feelings should get help from a community mental health agency, a school counselor or psychologist; a suicide prevention/crisis intervention center; a private therapist; a family physician; and/or a religious/spiritual leader. And their friends should tell them they are not alone, help them get care, and assure them they are very much cared for.

ARGUMENTS:

For:

Among adolescents, suicide is the third leading cause of death. About 12 young people between the ages of 15-24 die every day by suicide. While suicides account for 1.2 percent of all deaths in the United States annually, they comprise nearly 13 percent of all deaths among 15-24 year olds. The rate of suicide among 15-24 year olds has doubled in the last 50 years. For example, the rate for 15-19 year olds increased 11 percent between 1980 and 1997, while during this same period, the suicide rates for those between the ages of 10-14 increased 99 percent.

A common cause of teen suicide is depression, and at least 90 percent of suicidal individuals have been diagnosed with at least one psychiatric disorder—such as major depression, bipolar disorder, conduct disorder, substance abuse, or, anxiety disorder. The risk of suicide in people with major depression is about 20 times that of the general

population, and people who have had several episodes of depression are at greater risk for suicide than those who have had one.

Suicide often can be prevented, because depression is a treatable illness. First, however, its symptoms must be recognized, and its diagnosis followed by treatment. This legislation will help the adults and young people in schools learn to recognize the symptoms of depression, and to talk about its treatment. In that way, the despair that sometimes occurs in young lives can be confronted directly, and suicide can be prevented.

Against:

Although suicide awareness among school personnel is a good idea, it would be better to heighten parents' awareness of depression symptoms. Ideally, discussion of suicide and depression should occur at home with members of an adolescent's family, and not at school. The topic is sensitive, and the risk of tragedy is too high to be left to school personnel. Parents must be involved in a young person's diagnosis, treatment, and recovery from depression, in order to prevent suicide.

POSITIONS:

The Michigan Department of Education supports the bill. (3-22-06)

L'Anse Creuse Public Schools supports the bill. (3-22-06)

The Michigan School Counselors' Association supports the bill. (3-22-06)

The University of Michigan Depression Center supports the bill. (3-22-06)

The Michigan Association of School Social Workers supports the bill. (3-22-06)

The Michigan Association of School Psychologists supports the bill. (3-22-06)

The Michigan School Counselors Association supports the bill. (3-22-06)

Blue Cross Blue Shield of Michigan supports the bill. (3-22-06)

Positive School Support Program supports the bill. (3-22-06)

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